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Proof Committee Hansard

PARLIAMENTARY JOINT COMMITTEE ON HUMAN RIGHTS

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

(Public)

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SYDNEY

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PARLIAMENTARY JOINT COMMITTEE ON HUMAN RIGHTS

Tuesday, 20 August 2019

Members in attendance: Senators Chandler, McKim and Mr Goodenough, Ms Hammond, Mr Perrett, Dr Webster.

Terms of Reference for the Inquiry:

To inquire into and report on:

The committee is particularly interested in seeking evidence in relation to:

- whether the restrictions in the instrument on the use of physical and chemical restraints by approved providers sufficiently protect the human rights of aged care consumers;
- how the regulation of the use of restraints in the instrument compares to the regulation of the use of restraints in comparable jurisdictions and sectors (i.e. state and territory jurisdictions, the disability sector and broader health care settings);
- whether it would be appropriate for the instrument to be amended to provide additional safeguards for the use of both physical and chemical restraints; and
- whether the substitute decision making arrangements set out in the instrument sufficiently protect the rights of aged care consumers.

Following this hearing the committee will consider the evidence and determine its next steps.

WITNESSES

BURGESS, Ms Mary, Public Advocate, Office of the Public Advocate, Queensland

PEARCE, Dr Colleen, Public Advocate, Office of the Public Advocate, Victoria

SIEGEL-BROWN, Ms Natalie, Public Guardian, Office of the Public Guardian, Queensland

WALKER, Ms Beth, Public Guardian, Office of the Public Guardian, Northern Territory

Evidence from Ms Burgess, Ms Siegel-Brown and Ms Walker was taken via teleconference—

Committee met at 09:01

CHAIR (Mr Goodenough): I declare open this public hearing of the Parliamentary Joint Committee on Human Rights. The committee is hearing evidence today on its inquiry into the Quality of Care Amendment (Minimising the Use of Restraints) Principles 2019. On behalf of the committee, I welcome all here today. This is a public hearing and a *Hansard* transcript of the proceedings is being made. The hearing is also being broadcast via the Australian Parliament House website. Are there any media present? No.

Before the committee starts taking evidence, I remind all witnesses that, in giving evidence to the committee, they are protected by parliamentary privilege. It is unlawful for anyone to threaten or disadvantage a witness on account of evidence given to a committee, and such action may be treated by the Senate as a contempt. It is also a contempt to give false or misleading evidence to a committee. The committee generally prefers evidence to be given in public, but, under the Senate's resolutions, witnesses have the right to request to be heard in a private session. If a witness objects to answering a question, the witness should state the ground upon which the objection is taken, and the committee will determine whether it will insist on an answer having regard to the ground on which it is claimed. If the committee decides to insist on an answer, a witness may request that the answer be given in camera. Such a request may, of course, be made at any other time.

I now welcome representatives from the Victorian Office of the Public Advocate, the Queensland Office of the Public Guardian, the Northern Territory Office of the Public Guardian and the Queensland Office of the Public Advocate. I understand that information on parliamentary privilege and the protection of witnesses and evidence has been provided to you. I now invite those who wish to make a brief opening statement to do so. At the conclusion of your remarks, I will invite members of the committee to ask questions. Alternatively, to maximise the time available for the committee to ask questions, in lieu of reading an opening statement you may choose to provide a hard copy of your opening statement to the committee. Beginning with Dr Pearce, do you wish to make an opening statement?

Dr Pearce: Yes. Thank you for the opportunity to attend today's hearing. On behalf of the four presenters, I'd like to acknowledge that we are meeting on the lands of the Gadigal people of the Eora nation, the traditional custodians of this land, and I pay my respects to their elders past, present and emerging.

I note that public advocates and public guardians from seven of Australia's states and territories have signed a letter to the committee supporting our concerns in relation to the Quality of Care Amendment (Minimising the Use of Restraints) Principles 2019. And the four of us today are going to speak briefly on different aspects of our concerns. I have tabled a paper, which you have before you, and I'll just briefly speak to that. I want to say that, in short, we consider the principles: are inconsistent with people's human rights; would preferably be contained in legislation; introduce, in the case of physical restraints, a new flawed and ambiguous substitute decision-making regime; provide virtually no regulation of chemical restraint usage; and lack the safeguards of other restrictive practices regulatory schemes—for instance, those that apply when disability service providers in Victoria use restrictive practices. The detail of that is contained in the paper.

I want to turn really to the latter part of the paper where I talk about what should happen next. To the extent that the committee is interested to hear OPA Victoria's thoughts on other possibilities, I'll briefly raise these issues. In the short term, I'm advised that there is still some time for a notice of disallowance to be introduced in either house of parliament, which would disallow and therefore effectively repeal the principles. That is OPA Victoria's preferred outcome. The committee could consider that in its short-term deliberations. In the longer term, as mentioned, OPA Victoria takes the view that any authorisation process resting upon the consent of a person or their representative is not the optimal model. The consent model requires point-in-time consent by people who are not experts in restrictive practice usage, and this model does not tend to require or result in meaningful ongoing monitoring of restrictive practice usage. We prefer the situation that applies in Victoria concerning restrictive practice usage by disability services. The external scrutiny model requires restrictive practice usage to be authorised by people who are practised in the field, with authorisation clearly time limited and with clinical oversight of behavioural support plans in which the need for restrictive practice usage is articulated and provided by an independent expert, a senior practitioner.

There has already been considerable work done with regard to what type of model there might be. I draw the committee's attention to two reports from the Australian Law Reform Commission, in particular *Elder abuse—a national legal response* 2017 recommendations 4-10, 4-11 and 4-12, which are outlined in the paper, and, *Equality, capacity and disability in Commonwealth laws* recommendations 6-2 and 3-1.

In conclusion, whilst I'm pleased that the government has acted to regulate the use of restraint in residential aged care, my office has serious concerns about the legality and execution of the principles, which are inconsistent with the human rights of the affected person and lack the necessary safeguards. The safeguards required to ensure the promotion and protection of human rights of residents in receipt of aged care include, for example, monitoring and oversight of the use of restrictive practices. These safeguards already exist in respect of disability services.

I'd now like to invite the Public Advocate from Queensland, Mary Burgess, to say a few words.

CHAIR: Certainly. Before you do, does the committee wish to accept this document by Dr Pearce as tabled?

Senator CHANDLER: Yes.

CHAIR: Okay. The document is accepted as tabled. Please proceed, Ms Burgess.

Ms Burgess: I would like to thank committee members for the opportunity to speak today about this important human rights issue for older Australians. I have two key points that I want to make this morning. The first is whether the Quality of Care amendment effectively authorises the use of restrictive practices in residential aged care. The use of restrictive practices in residential aged care will inevitably restrict a person's human rights in some way, ranging from limiting their freedom of movement, which can amount to an assault or deprivation of liberty, to the unlawful administration of medical treatment. International human rights law recognises that rights may be limited as long as the limitation is prescribed by law, among other considerations. There's a common law presumption that parliament does not interfere with the fundamental rights of individuals. In the High Court case of Coco v the Queen, the court explained this presumption as follows:

> Statutory authority to engage in what otherwise would be tortious conduct must be clearly expressed in unmistakable and unambiguous language.
>
> … … …
>
> … the presumption is that, in the absence of express provision to the contrary, the legislature did not intend to authorize what would otherwise have been tortious conduct.

Despite the Quality of Care amendment stating that an approved aged-care provider must not use physical or chemical restraint in relation to a consumer unless they have done certain things listed under other sections of the instrument, in my submission the amendment falls short of expressly, formally and positively authorising the use of physical or chemical restraints that it's proposing to regulate. It's also concerning that key provisions relating to the use of restrictive practices in aged care should be contained in subordinate legislation. It's reasonable to expect that a legislative instrument intended to formally authorise the use of restrictive practices in residential aged care—acts that would otherwise constitute tortious or criminal acts against a resident—should be contained in the primary aged-care legislation and be subject to the scrutiny of the Australian parliament.

The second issue I want to raise is that any formal legal framework to authorise the use of restrictive practices in residential aged care must recognise and successfully navigate the complex intersection of legal issues and frameworks that operate in the aged-care space. The Commonwealth government can clearly legislate about issues relating to the funding and quality of aged-care services. However, it is unclear what head of power the government is relying on to authorise restrictive practices in this amendment. The amendment also requires 'the informed consent of the consumer or the consumer's representative to the use of the restraint', at least for the administration of physical restraint. There is legal uncertainty about whether state and territory guardians and advocates can consent to the use of restrictive practices on a person for whom they are appointed to make decisions and in what circumstances, and this varies from state to state depending on the structure of their legislation. This raises challenges for implementation of an aged-care restrictive practice regime that must rely on state and territory substitute decision-making regimes for consent. The issue is further complicated by the informal representation arrangements provided for under the Aged Care Act, which the amendment appears to rely on as another avenue for consent to the use of restrictive practices. Again, this issue raises questions about the head of power the Commonwealth government is relying on to confer authority on these informal representatives to consent to restrictive practices outside of established guardianship regimes.

The regulatory frameworks for medical practitioners and the legal requirements for obtaining informed consent to medical treatment must also be considered. The amendment relating to chemical restraint appears to completely disregard the professional and legal requirements for obtaining informed consent to medical treatment and

transfers responsibility for the notification of residents' representatives, as well as documentation of the basis for the treatment, to aged-care providers. This approach is dangerous and is inconsistent with the Medical Board of Australia's code of conduct for doctors. There is no reasonable basis for treating older people in residential aged care differently from the rest of the community in terms of the obligations of medical practitioners.

The problem with the Commonwealth's approach to this issue to date is that it does not acknowledge the complex interplay between these legal frameworks, leaving a number of significant and potentially dangerous legal and regulatory gaps and exposing aged-care providers and their staff, medical practitioners and consumers to risk. In the circumstances, I would support the options going forward that have been recommended by my colleague Dr Pearce—that is, request that the committee consider issuing a notice of disallowance and consider a much more accountable model of regulatory practice in this space. I also think it is absolutely critical that the government consult very closely with the state and territory substitute decision-making agencies and medical regulatory agencies in order to gain a model that is appropriate and that actually navigates the complex interplay between all of these frameworks. I thank the committee for the opportunity to speak and invite my colleague Beth Walker, Public Guardian of the Northern Territory, to make her statement.

Ms Walker: Thank you for the opportunity to speak about these very important issues. It is critical that Australia moves towards the reduction and elimination of restrictive practices in all areas, including aged care. This requires any use of restrictive practices having a lawful authorisation through a human rights compliant regulatory mechanism. The information I provide today strongly supports the submissions of my counterparts presenting this morning. I would like to take the opportunity to highlight the ongoing disadvantage that First Nations people in Australia continue to face in education, employment, access to justice, housing and health. The relationship between the social determinants and health is well evidenced nationally. In northern Australia, we see the impacts of this disadvantage on a daily basis. However, to be clear, I am speaking through my observations and learning from over 25 years in the Territory, not personal lived experience. First Nations people have been and still are subject to significant human rights violations across a range of systems in our society. The quality of care—mental and physical—does not provide adequate protection for the human rights of aged-care consumers generally, particularly for First Nations consumers.

Finally, culture and connection to country are integral to First Nations people and their subsequent wellbeing. It is especially traumatic for them when they need to move away from these important connections to obtain services. Complex support needs require people to move from their country to receive essential care. The services in remote communities do not have the capacity to meet complex health, disability, aged-care or palliative care needs. Additionally, many First Nations people speak English as a second, third or fourth language, making adequate communication more challenging. There are well-documented linkages between unmet needs and behaviour of concern for aged and disabled people. The isolation from family, community and culture, as well as language barriers, exacerbate a person's behaviours. If these behaviours are not responded to appropriately, it can then lead to the overuse or misuse of physical and chemical restraints, even in a well-regulated system. The inappropriate management of behaviours can also lead to the risk of incarceration for First Nations people, who are already over-represented in the national incarceration figures and make up 85 per cent of the Northern Territory's prison population. The need for clinical oversight for the use of restraints and a person-centred approach to addressing a person's needs is increased for First Nations people who experience these additional challenges.

Service providers working with First Nations people must have an understanding of the importance of kin, culture and country. This is especially crucial when considering less restrictive ways of supporting the person and the use of restraints. A robust authorisation framework that considers the person and their unique needs to address any behaviours of concern is essential to protect the person's rights and to ensure that any restrictive practices are minimised with the ultimate increase of the person's quality of life. The principles do not provide this in their current form. The substitute decision-making regime introduced by the principles does not recognise who may be culturally appropriate to make decisions on behalf of a First Nations person and also creates uncertainty as to the recognised decision-maker. That then places vulnerable groups who are isolated at greater risk of overuse or misuse of restraints.

The issue of restricted practices is a complex area for anyone to clearly understand and be able to provide informed consent to either physical or chemical restraints. Obtaining informed consent is made significantly more complex by the barriers that I have discussed, increasing the likelihood that human rights abuses will occur. Consistency across service sectors is critical to achieve the reduction and elimination of restrictive practices. There is a clear discord between the level of regulation and authorisation of restrictive practices for NDIS participants compared to that provided by the principles for aged-care consumers across Australia.

In conclusion, I strongly support the recommendations provided by my counterparts. It is critical that there be human rights consistency in the Australian approach to restrictive practices in aged care. The current principles enable the limitation of a person's agreement on their human and common rights. Consequently, the key provisions should be in a legislative form to protect the human rights of all Australians using aged-care services.

Thank you for your consideration of these issues. I would now like to introduce Ms Natalie Siegel-Brown, the Public Guardian of Queensland, to continue raising the human rights concerns that are held in relation to the principles.

Ms Siegel-Brown: I want to thank the committee for the opportunity to attend the hearing this morning. Firstly, I want to applaud the Commonwealth for any attempt at all to regulate restraint, but, unfortunately, in their current form, the principles actually regress the recognition of human rights for people living in aged care. This is particularly the case with respect to the provisions regarding chemical restraint, but the entire suite itself lacks any monitoring, enforcement or oversight in any event, and this can lead to greater problems—let alone the issues relating to the consumer representative aspect.

I believe that, when you look at the regulation of restraint in other sectors, such as disability, the current principles fall significantly short of industry practice and standards in other sectors—in particular, the national standards in the NDIS and disability sector, where we had effectively already been here quite some years ago and really thought through comprehensively human rights and how to properly regulate restrictive practices. Unfortunately, the principles now create many more problems than they may have solved.

I don't just make my submission as a guardian of last resort; in Queensland, I effectively hold a role that is akin to what one would call a senior practitioner—that is, I am a regulator of restrictive practices here in Queensland, and I am familiar with good and bad restraint regulation. There is no requirement under the new principles to consider or address how the aged-care facility will reduce or eliminate restraint; no requirement to develop positive behaviour support plans, which are now industry standards within the disability sector; no authorisation scheme; and there is no independent oversight. It in effect appears to be a tick-and-flick for the service provider without any real obligation to seek the consent of the person themselves. Effectively, the aged-care provider can choose who they go to to obtain consent for physical restraint, and they don't have to do so at all with respect to chemical restraint. The person they go to may in fact have no real, close connection with the adult who is being affected.

As guardian for 3,000 Queenslanders—and I hold power of attorney for a further 2½ thousand—I can see this law directly impacting the role and functions of state and territory based guardians and appointed decision-makers. This also applies to the hundreds of private guardians out there as well. Right now, a solicitor who is holding someone's power of attorney or who might be appointed under a power of attorney just for financial decisions can be contacted to make a restraint decision for someone they've met maybe only once, because the laws effectively give powers to guardians, regardless of what area they have been appointed as a decision-maker for, in a person's life. This is really asking guardians to act outside of state guardianship law, and it certainly places my agency, my colleagues' agencies and the community in a really compromising position. This is a significant impact that the law has upon formally appointed guardians under state law. I find it quite astounding that the law would pass without any consultation with states or territories, particularly state based guardianship agencies.

The most pressing and disturbing concern that we've already come across as result of the law, not to mention the impacts of restraints and what appears to be lip-service for authorisation, is the issue that arises where no consent is given. We're being contacted by aged-care providers who are asking us to make restraint decisions under this law, which is outside the state guardianship and administration law, and when we refuse to do so they refuse entry to the aged-care facility for our clients. So people have to remain longer in hospital beds or in really precarious situations because aged-care providers are refusing our clients entry, simply because we will not make the decisions under the new principles. There's a lot of pressure that can be placed on representatives to consent. As a result, if a representative doesn't consent, my fear is that there's going to be a resort to the use of chemical restraint. So I fear there'll be a surge in the use of chemical restraint.

Even if none of the concerns I just raised were live, my question is: how will the new principles, or any aspects of the Commonwealth legislative amendment, have any real impact if they're not going to be monitored by an empowered legislated community visitors scheme? One might observe that the new principles actually give way to greater potential for abuse in an environment where no-one is really watching. I really think that any regime regulating the use of restrictive practices must prioritise the view of the people being subjected to their use. The principles enable the reverse. They effectively authorise the voice of the person to be ignored. There must be a strong legislative state guardian regime. We don't need to reinvent the wheel here. There already are very high

standards—in fact, world-leading restrictive-practice regulation regimes—here in Australia. Colleen, my colleague, talked about one. Queensland is certainly very proud of the regulatory regime and independent oversight it has for restrictive practices in the disability sector in Queensland. Why wouldn't we look to emulate something like that?

In light of all that my colleagues and I have proposed today, I also strongly recommend that the committee find that the principles are not compatible with human rights and that the principles should be disallowed by either house of parliament. I think that the report should also find that public consultation should be undertaken to develop laws that respect and recognise the rights of people living in aged care based on best practice models regarding the regulation of restrictive practices such as those we already have in Australia in the disability sector.

CHAIR: Thank you, Ms Siegel-Brown. As chair, I will ask Mr Perrett to commence questioning.

Mr PERRETT: Thank you very much for your evidence, folks. I want to go particularly to chemical restraints to start with. I realise you're not speaking as medical practitioners, but the *Medical Journal of Australia* says that the risks associated with using psychotropic medicine include falls, strokes and death. So it's clear that there are risks associated with the medication—falls, pneumonia and death. It also says, if I've got the maths right, that about 19 out of 20 people prescribed this medication will continue to be prescribed it forever, basically, not for the 12-week sessions that are recommended; they will continue to be prescribed something that has risks associated with it. I was just wondering if anyone would like to make a comment on their understanding of chemical restraints generally.

Dr Pearce: I'm happy to start and then just very briefly hand over to my colleagues to make a comment. The question is: when is a pharmaceutical aid a chemical restraint? And I think the answer to that is when the aim in its provision is not to provide a therapeutic response to an illness or disorder but to change or affect a person's behaviour, and therein lies the difference. So, while it may be necessary to provide a pharmaceutical or a chemical restraint for a particular illness, what happens is we often see that it's actually provided to address behavioural issues and then continues for much longer than is necessary.

Mr PERRETT: So the treatment for the condition—say, uncontrollable shaking—would be legitimate but then the side effect might actually become the intent of why the person is prescribed that, which would be to subdue them or make them easier to control.

Dr Pearce: In the disability sector, we have—at least in Victoria—senior practitioners who are experts in the area of restraint. They provide oversight, so there is guidance, training and support. What we often see is the use of chemical restraints when in fact there are behavioural issues, and there are other strategies that can be used to deal with those issues. That's what we see with the senior practitioners, and their guidance is really helpful in relation to providing mechanisms to deal with behavioural issues.

Mr PERRETT: So the senior practitioner would be a medical practitioner, a nurse practitioner or something else—in terms of prescribing chemical restraints?

Dr Pearce: No, in Victoria the person is neither a nurse nor a medical practitioner but is an expert in the field with access to expertise as required.

Ms Siegel-Brown: May I offer a view as somebody who holds a senior practitioner role here in Queensland. I share the senior practitioner role with QCAT, our Civil Administrative Tribunal, and the Department of Communities. Depending on what restraints are used and for how long, the three of us will be the authorising body for those restraints. So in my office the way it works is I have a team of experts who provide me advice as to whether I should or shouldn't consent to particular chemical restraints and, although I'm not a medical practitioner per se—in fact I'm a lawyer and of course the people at QCAT who are making these decisions are also lawyers—we gain a lot of insights into and understanding about particular chemical restraints, but the point is we are asked to provide consent based on human rights principles that are enshrined by law. So we run a series of particular tests where a doctor might prescribe something but the service provider has to come to us for consent to be able to use that chemical restraint. And you're absolutely right: very often what we see is that a particular drug like diazepam or other drugs will be prescribed for the purpose of originally treating a problem and then it becomes convenient—for example, they will originally control a behaviour and then suddenly we'll see a diagnosis come into being so that there's effectively an excuse to use that chemical restraint.

The idea of a senior practitioner is more as an oversight body, not a prescribing body. So the doctors will still make their prescriptions but the beauty of being a senior practitioner is that you get to ask a bunch of questions that you or I might ask when we go to a doctor's surgery, are prescribed some medication and want to understand side effects, what it's for and what it will do to us.

One thing that I have experienced a lot in my time undertaking this role is discourse in the medical and disability sector where people will say to you that in fact chemical restraint is one of the most egregious restraints that can be applied. There are some people who argue—and I can see why; I'm not saying I'm necessarily a proponent of this myself—that, if you chemically restrain somebody, you're effectively imprisoning them within their own body, and that that is in fact far more restrictive than a type of physical restraint or it can be the same level of restraint as a physical restraint. Differentiating between physical restraints and chemical restraints, as these principles do, can in fact be an artifice in terms of the different regimes required under the new principles. You will see that it's very differently approached in the disability legislation, because chemical restraint is not just dangerous but is, in fact, more restrictive than some of the other practices.

Ms Burgess: Can I add something to that discussion to answer Mr Perrett's question about some of the research. I think it's really important to be clear—and I think Natalie Siegel-Brown has also made this point—that these decisions about chemical restraint are not medical treatment decisions. It's really important to be clear about that. They might be prescriptions of medication by a medical practitioner, but the medical profession itself recognises this is not medical treatment; this is the administration of a drug for another purpose—to manage behaviour. So these decisions are not medical decisions; they are, essentially, legal decisions that have to be made to respond to challenging behaviour. And it's really important to look at these decisions and the decision-making in that context.

In terms of the research around these drugs, I'm aware that there was a very, very large study done by Harvard in the US around the use of antipsychotic medications. They found very, very high rates of heart attack and stroke associated with the use of antipsychotics and benzodiazepines. In particular, the first-generation antipsychotics have much worse side effects, in terms of people's health, and I am aware that those antipsychotics are still being used fairly widely in Australia by general practitioners who are prescribing medications in aged-care facilities. So we are actually using the medications that are going to have the worst side effects for people. Also, it's really important for the committee to appreciate that there has been material provided to the aged-care minister—and I think it was provided to the aged-care royal commission—that an analysis of these prescriptions of benzodiazepines and antipsychotics in aged-care facilities found that 90 per cent of those prescriptions could not be justified even in terms of managing behaviour. It's a bit of a plague at the moment on the system.

Mr PERRETT: Thank you, Ms Burgess. If I could go back to my question: I hear those concerns raised by Ms Burgess about consent, and that the risks will include falls, stroke and death, to ensure that the representative is making an informed decision before the patient actually goes onto a course. From my understanding, it is a course of medicine that will continue until a person either does fall or does die of stroke or something else. It's a big decision to remove a person's freedom with these medications. So I want to go to who makes that decision, particularly when it comes to the chemical restraints. We heard the evidence, I think from Ms Siegel-Brown, about people not being allowed into aged-care facilities until they have, effectively, signed on to the facility being able to provide that consent to give the medication. Is that understanding of your evidence correct, Ms Siegel-Brown?

Ms Siegel-Brown: What's happening is that, when people want to enter an aged-care facility, when we say that we won't be making decisions about restraint, whether consenting or otherwise, they say: 'Well, we're not going to let your client into the facility, because if we do, and you won't make a decision, then we're effectively going to be in breach of these new principles if we then go and use chemical or physical restraint on them without your consent.' So the fact that we won't agree to be a decision-maker for restraint—particularly where we think the person has the right and the ability to make their own decisions about restraint—means they won't even let them in the door.

Mr PERRETT: Often people have a relationship with their GP, and I would have thought their treating GP would be involved. But I've had it put to me that, basically, aged-care facilities almost require a severing of the relationship with the treating GP and that basically the aged-care facility would have their own visiting GPs when it came to prescribing this medication.

Ms Siegel-Brown: That certainly has been my experience too. But think about when you go to a GP and they prescribe you a medication. You still get a say over whether you want that and whether you are going to take that medication. This is an instance where the GP might have a view, or the GP might be influenced by the aged-care facility, and I've certainly had my own informal discussions with general practitioners who say, 'Look, we know that an aged-care facility is struggling because they're low on staff numbers and the staff don't have enough training, so we just make a series of scripts for chemical restraint to keep people sedated so that they don't have to manage as many people at once—effectively, to keep these people bedbound so they don't have to worry about attending to as many people.' So there's an incentive for some of these GPs associated with an aged-care facility

to prescribe the chemical restraints, and the same thing could be said about the use of physical restraints. At the end of the day, what's missing here is the ability of the person to make their own decision about the use of restraint. And, on top of that, even where a guardian is appointed, you've got to ask yourself: 'If I'm appointed as a guardian to make decisions only about where somebody lives—QCAT has appointed me to do that because they think the person is capable of making decisions in all other areas of their life—why should I be the person then to make the decision about the use of restraints, when it has been decided by QCAT that the person's capacity to make decisions is only impaired with respect to decisions about accommodation and nothing else?' It—

Mr PERRETT: Sorry—if I could just finish off, Chair?

CHAIR: Yes, Mr Perrett, being mindful of time.

Mr PERRETT: And you suggested there that there could be a possible conflict of interest if the aged-care facility has an ongoing relationship with certain GPs, with their visiting—

Ms Siegel-Brown: I would say that there's an almost certain chance of a conflict of interest. That may sound dramatic, but I've seen numerous instances of it.

Mr PERRETT: So if part of their business model is to go to that same facility every week or whatever, then they're not being a free decision-maker, in terms of advocating for the best interests of the patient. So the person who's going to have their freedoms removed does not actually have someone going in to bat for them, I guess.

Ms Siegel-Brown: You are correct, absolutely. But the point I'm trying to make is that a GP is not necessarily a person's advocate. I think that what we're missing here is that it should be the person's decision as to whether a restraint is used against them. Guardianship principles have grown up, over the decades, out of human rights legislation, which says, 'You must always presume a person has capacity to make their own decisions'—just the way you and I do when we go to the GP. If a doctor said to us, 'I think that you need to be chemically restrained and your behaviour needs to be controlled,' we'd probably have something to say about that. Why should the presumption be that it's the GP's decision? We're effectively taking away a person's autonomy.

CHAIR: I'm mindful of the time allocated. I'd just like to open up the floor to any members of the committee who have further questions. Senator Chandler?

Senator CHANDLER: We've talked a lot about the issues that other witnesses today might perceive in the current framework. If I were to ask, from a purely academic, theoretical perspective: 'What are the key components of what you would see to be an effective use-of-restraint scheme?' could you perhaps just step through, at a very high level, what they would be?

Dr Pearce: Yes. As I said in my introductory remarks, the Australian Law Reform Commission has already done considerable work in this regard—and the recommendations from the Law Reform Commission are in your paper. They set out, in their recommendation 4-10, that:

> Aged care legislation should regulate the use of restrictive practices in residential aged care. Any restrictive practice should be the least restrictive and used only:
>
> (a) as a last resort, after alternative strategies have been considered, to prevent serious physical harm;
>
> (b) to the extent necessary and proportionate to the risk of harm;
>
> (c) with the approval of a person authorised by statute to make this decision;
>
> (d) as prescribed by a person's behaviour support plan; and
>
> (e) when subject to regular review.

In recommendation 4-11, they consider further safeguards in the use of restrictive practices, including:

> (a) establishing an independent Senior Practitioner for aged care, to provide expert leadership on and oversight of the use of restrictive practices;
>
> (b) requiring aged care providers to record and report the use of restrictive practices in residential aged care; and
>
> (c) consistently regulating the use of restrictive practices in aged care and the National Disability Insurance Scheme.

Senator CHANDLER: I'm not a medical expert. Could you explain what a behavioural support plan is?

Dr Pearce: Yes. Where restrictive practices are required, a behavioural support plan in the disability sector is developed. That looks at alternatives. It looks at whether there are other mechanisms that can be put in place to assist with a person's behaviour. Often they are strategies that service providers can employ, and they have a clinical background and support and training attached to them to enable us to look at alternatives to restrictive practices.

Senator CHANDLER: Can you give some examples of what those alternatives might look like in a practical sense?

Dr Pearce: Yes. In the disability sector, where we have, for example, the use of anti-libidinal drugs for the suppression of sexuality, there might be other strategies that can be employed to look at the behaviours and how we can help a person to engage in more constructive relationships. They are often practically based around alternative strategies to particular activities. But I might call on one of my colleagues to provide some examples.

Ms Siegel-Brown: I am happy to do so, because I do hold that senior practitioner role here in Queensland. Here in Queensland we call those plans something slightly different; we call them positive behaviour support plans. Many of the recommendations by the Australian Law Reform Commission are currently part of the suite of restrictive practice regulation here in Queensland. Under the Disability Services Act and the Guardianship and Administration Act in Queensland, you'll find that many of those recommendations are in place for the disability services sector. For example, I can think of an instance where a person had been provided anti-libidinal medication because it was believed he was trying to grab people's breasts. It was a person who was non-verbal. When we asked further questions, it became clear that this gentleman, who was restricted to a wheelchair, was only able to communicate by using his hand in an upwards motion. He would do an upwards pinching motion with his hand when he wanted something. It was realised that no-one had actually sat down and done what we call a communication assessment with him to understand how he communicated. He had no intention of trying to grab somebody's breasts; he was trying to indicate that he wanted food, that he was hungry. So a communication assessment assisted them in understanding his communication needs and that, because he was non-verbal, he was using these particular behaviours to communicate. So we were able to remove the anti-libidinal drugs, which had horrific side-effects such as weakening bone density and increasing the chance of heart failure and kidney failure. There are numerous instances like this, where, in our senior practitioner role and in our advocacy role, we're able to reverse and eliminate the use of chemical restraints as a result of getting people to understand the client better. A GP seeing a client for five minutes, and only hearing the nurse's side of things because a client is non-verbal, will never elicit that kind of information.

May I also add that an effective restrictive practices regulatory regime must entail at least two areas as a source of authorisation for the restrictive practices—it's why we have broken up authorisation for consensual restraint in Queensland in the way that we have—and it is absolutely integral that it also have a monitoring and oversight element to it. In Queensland that's achieved through a community visitor scheme. One of the chief things that my community visitors look for when they go out to disability services and to mental health services is whether restrictive practices are being used in the way for which they were authorised. You can't possibly regulate restrictive practices that have nobody watching to see whether the conditions upon which you provided consent are in fact being maintained.

Mr PERRETT: To all of you: from the evidence you've provided, you're suggesting that the title is actually going to be a misnomer, that this is actually going to increase the use of restraints because consent isn't going to be required?

Dr Pearce: That is our concern.

Mr PERRETT: At the moment, 15 per cent of Australia is over 65; we are about to get to 22 per cent in the next 10 to 15 years. This is going to be affecting more and more Australians, where their freedoms are going to be removed under this current set of regulations.

Dr Pearce: That's why I think there is such a strong voice from public guardians and public advocates around Australia, because we are very concerned about the potential human rights abuses that will arise as a consequence of this legislation.

Ms HAMMOND: Following up Mr Perrett's question: we have a situation at the moment where we have no regulation, and we're moving to a situation which was a response to the need—the commentary put out by the minister at the time was very clear about the government wanting to regulate the use of restrictions. You are saying that it will increase the use. I find that hard to follow.

Ms Siegel-Brown: May I try to answer your question. There are two aspects to it. We're certainly encouraged by the fact that the government is seeking to regulate restrictive practices. The problem is that regulation of restrictive practices requires a regime where consent is given by a body that is informed and that has proper jurisdiction to give consent, and also one that prioritises the ability of the person to consent to restrictive practices that are going to be used against themselves. If you look at the way it's done everywhere else, there's a presumption of what we call capacity. There's a presumption of decision-making by the person. Effectively, what's happening here is that you're explicitly allowing an aged-care facility to ask somebody who's not qualified—and who may not even know the person that well—to make that decision in an arena where you would have hoped that they would have given that decision-making to the person themselves.

What I think we're saying is that the use of chemical restraint is likely to go up when you've created a regime where the requirement is to go and get consent for physical restraint but you simply need to notify someone of chemical restraint. I think that the result would be that, in a highly resource-stretched environment, where aged-care facilities don't have the numbers of staff et cetera, they're going to go for the option that means that they can do what they want using a notification system rather than an acquisition of consent arrangement. What we're also saying is that the arrangements for consent, and who is being required to give consent, actually breach human rights. We're talking about an increase in the use of chemical restraints. We're saying that when it comes to physical restraint the decision-making regime actually impedes the decision-making of the person who's subject to that restraint.

Mr PERRETT: Ms Siegel-Brown, you're suggesting that the community visitor program would be some way to oversee the aged-care sector and might mitigate the possibility of, as this tsunami of dementia comes across society, people having their freedoms taken away by these psychotropic medications?

Ms Siegel-Brown: I think that community visitors are fundamental to any regime where we are effectively institutionalising people. Aged-care facilities are effectively institutions, something that we've tried to move away from in the disability sector and in the child protection sector. Anywhere we have an institutionalised environment I think there is a heightened need for monitoring and advocacy. My argument with respect to community visitors in this context is not that they will mitigate the damage that I think these new principles will do but rather that any regulatory regimes must have some independent eyes and ears monitoring whether the requirements of the regulations are being met. Let's say these principles were never touched at all; how will you know that aged-care facilities are seeking consent from consumer representatives? How will you know that chemical restraint notifications are being made? How would you know that somebody's health isn't seriously declining as a result of the use of a particular chemical restraint? Community visitors visit facilities monthly, sometimes fortnightly. In Queensland and Victoria they have legislated powers to raise complaints and advocate on a consumer's behalf. In fact, in the federal disability regime they can raise these issues with the national quality and safeguard commission, and, depending on the egregious nature of the concerns identified by community visitors, a service provider can even lose their registration, which is a pretty big incentive to do the right thing.

Mr PERRETT: So you're saying: don't reinvent the wheel; just duplicate what's already taking place in the disability sector?

Ms Siegel-Brown: That would be the view of many of my colleagues as well. We've spent decades on this. Aged care is where we were with disability decades ago. Would that be correct amongst my colleagues?

Unidentified speaker: Yes.

Mr PERRETT: We'll ask the questions.

Ms Siegel-Brown: Sorry.

CHAIR: Mindful of the need to keep to time, I thank all for appearing before the committee and for giving your time today.

PEARSON, Ms Elaine, Australian Director, Human Rights Watch

[09:58]

CHAIR: I now welcome Ms Elaine Pearson of Human Rights Watch. I understand that information on parliamentary privilege and the protection of witnesses and evidence has been provided to you.

Ms Pearson: Yes, it has.

CHAIR: I now invite you to make a brief opening statement. At the conclusion of your remarks, I will invite members of the committee to ask questions. Alternatively, to maximise the time available to the committee for questions, in lieu of reading an opening statement you may choose to instead provide a hard copy of your opening statement to the committee. Do you wish to make an opening statement?

Ms Pearson: I will make a brief opening statement. Good morning and thank you very much for inviting the Human Rights Watch to testify today. We wish to share our concerns regarding the quality of care amendment principles on minimising the use of restraints. We have urged this committee to recommend the disallowance of this regulation. We wrote a letter to this committee and we followed up with a written submission.

Our concerns with this new regulation are that the new rule is really trying to regulate instead of eliminate the practice of using physical and chemical restraints. The opening of a parliamentary inquiry into this matter is an important opportunity to examine the regulation's serious shortcomings. Human Rights Watch is an independent, non-governmental human rights organisation. We conduct research and advocacy in over 90 countries on a range of human rights issues, including on the rights of older people and the rights of people with disabilities. We've done extensive research on overmedication of older people living in nursing homes in the United States. We're also currently doing similar research in Australia. Our US research has shown how aged-care facilities have regularly given antipsychotic drugs to residents with dementia to control their behaviour for the convenience of the facility. Essentially, older people with dementia are being sedated in order to make life easier for the overworked staff in aged-care facilities. The use of antipsychotic drugs on older people with dementia is very dangerous. It's associated with a nearly doubled risk of death and other adverse reactions, including stroke, falls and the inability to stay awake long enough to eat or spend time with loved ones. People can also lose the ability to communicate.

This regulation is inconsistent with Australia's obligations under several core human rights treaties that Australia has ratified, including the International Covenant on Civil and Political Rights, the International Covenant on Economic, Social and Cultural Rights and the Convention on the Rights of Persons with Disabilities. The use of physical or chemical restraints for control, punishment or retaliation or as a measure of convenience for nursing facility staff should be prohibited. This regulation does not prohibit such measures. Medicines should only be used for therapeutic purposes and with the free and informed consent of the person receiving them; but this regulation does not require informed consent for chemical restraint, although it is required for physical restraint.

The UN Committee on the Rights of Persons with Disabilities—that's the committee that monitors compliance with the convention—has stated numerous times that laws that condone the practice of restraining persons with disabilities or other coercive measures to control them should be repealed. It criticised the use of restraints in its 2013 review of Australia, expressing serious concerns that persons with disabilities are subjected to unregulated behaviour modification or restrictive practices such as chemical, mechanical and physical restraints and seclusion. The committee called on Australia to take immediate steps to end such practices.

This committee itself—the Parliamentary Joint Committee on Human Rights—has also commented previously on restrictive practices in its December 2018 report on the National Disability Insurance Scheme, which sought to regulate restraint in NDIS funded services. This committee said that Australia's obligations regarding the prohibition on torture, cruel, inhuman or degrading treatment or punishment are absolute and therefore cannot be limited. This committee further said:

> … a nationally consistent approach which prohibits restrictive practices that could amount to torture, cruel, inhuman and degrading treatment or punishment would be desirable from a human rights perspective.

We agree: there should be a prohibition on restrictive practices, including physical and chemical restraints, being used on people with dementia in aged-care facilities.

In conclusion, Human Rights Watch urges you to recommend the disallowance of this legislation that seeks to regulate practices which are incompatible with Australia's international human rights obligations. Any new law should contain a robust prohibition on such practices, ensure informed consent for all treatment or interventions, and ensure independent monitoring and effective, accessible, independent complaints mechanisms, including for individuals in aged care and their families. Thank you.

CHAIR: I will ask the deputy chair to commence questions.

Mr PERRETT: Thank you for your evidence, Ms Pearson. Dementia is the second-leading cause of death of Australians. In 2019 it's estimated that there are 447,115 Australians living with dementia. That's expected to increase to 589,000 in less than 10 years and to a million by 2058. It's a significant social problem with costs associated with it. Now, if we want to give out $95 billion in tax cuts or dividend imputation credits to people, isn't it only fair that society is able to hand out medications so that we can control these dementia patients while we get on with society? Old people don't have the same rights as young people, surely!

Ms Pearson: Everyone is entitled to the same human rights under all treaties that Australia has ratified.

Mr PERRETT: But surely six-month-olds have more rights than 86-year-olds, don't they? Shouldn't we be able to take away the freedoms of people in aged-care facilities because it's convenient for us? Can't society make those decisions?

Ms Pearson: No, we can't make those decisions. Under international law, it's very clear that everyone has the right to be free from cruel, inhumane and degrading treatment.

Mr PERRETT: Even old people?

Ms Pearson: Even old people.

Mr PERRETT: Are you sure about this?

Ms Pearson: I'm absolutely sure about it.

Mr PERRETT: I thought that young children had more rights than elderly people, and that we can just take away their freedoms with medication.

Ms Pearson: No, absolutely not. As far as children are concerned, you have the best interests of the rights of the child, but as far as adults are concerned everyone has the right to be free, the right to health, the right to life and the right to be free from cruel, inhumane and degrading treatment. All of these things are set out in numerous treaties that Australia has ratified.

Mr PERRETT: I don't see any social groups picketing out the front of aged-care facilities that are, on a daily basis, handing out these psychotropic medications that remove the freedoms of elderly people. Why is that?

Ms Pearson: Precisely. That's because we haven't regulated a prohibition on it, so these practices are going on. I think at the royal commission it was very clear in some of the early hearings the extent to which chemical restraints are being used in a completely unregulated manner, and that has become a serious cause for concern. I think that was initially the objective of the minister for aged care; he wanted to do something to address this problem. The problem is that the way that this regulation has been drafted it's not going to meet the objective of ending the use of chemical restraint.

Mr PERRETT: The evidence this morning, which I think you heard, was that it will achieve the opposite result and in fact liberalise the administering of these chemical restraints and physical restraints.

Ms Pearson: Yes, I think it will certainly normalise the use of chemical restraints, and that's absolutely against—

Mr PERRETT: As the percentage of people over the age of 65 goes from 15 per cent to 22 per cent, and as the number of workers supporting those people who are no longer economic units adding tax to the Treasury declines, that's going to become even more problematic, I'd imagine.

Ms Pearson: Yes. You can use medication in these facilities if it's for a prescribed medical purpose, and that absolutely is fine; we're okay with that. Where it's not okay is where it's being used simply to control the behaviour of residents, and that's what we're finding time and again when we're talking to people. It's being done without any consent of the person involved. In fact, often the family members are only informed when they receive the bills for the medications that have been prescribed.

Mr PERRETT: So the consent has effectively been given by the facility.

Ms Pearson: By the facility—that's right.

Mr PERRETT: But surely, if you've got one person working overnight with 40 people in their care in the dementia ward, they should be able to administer drugs rather than try to track down a couple of supervisors. This is probably someone with a certificate—

Ms Pearson: They can administer drugs if it's for a therapeutic purpose, but not if it's simply for the purpose of behaviour control—part of this is really about ensuring that the people who are working in aged-care facilities have the proper training. Many times, the way in which they're seeking to modify behaviour can be done through other means; they don't have to resort to these very dangerous drugs. We know there's a very high risk of death,

falls and strokes affecting people. It's basically turning people into zombies, affecting their ability to communicate. For instance, if they're taught how to de-agitate people, if they understand and if they know the person, often there are very simple techniques that trained staff can use. And we know that that can happen, because there are facilities that don't resort to the use of chemical restraints.

Mr PERRETT: If there were some checks and balances—you heard about the visitor program idea—do you think they wouldn't go down the easy road of psychotropic medications every time?

Ms Pearson: I think there absolutely needs to be independent oversight. I think this regulation also needs to be redrafted so that it doesn't basically set out the parameters of using chemical restraint and doesn't normalise that practice but sets out a broader prohibition on the practice.

Mr PERRETT: I referred earlier to a *Medical Journal of Australia* media release that basically said that 19 out of 20 people who are started on this medication will continue on it until that person is no longer around. However, if they tried these other activities, such as, as we heard from Natalie Siegel-Brown earlier today, something as simple as listening to the patient's demands—God forbid you actually do that!—they can actually then work out other behavioural adjustments and the like, and the use can decline by 13 per cent, or by 21 per cent for benzodiazepines. There is obviously research out there that shows reaching for the pill bottle is not necessarily the way to go.

Ms Pearson: Yes, that's right. We have interviewed people who have been able to make a recovery after they've been subjected to using these drugs for a period of weeks, and the good thing is they've been able to then communicate again with their family members, talk to their family members. But while they're under the influence of these drugs—we had a case of a woman who had a urinary tract infection. She couldn't communicate that to the people who were looking after her. You can imagine, if you're in one of these facilities, just how difficult it is. I think that's why often, for people who are in this situation, they just end up on those drugs permanently.

Mr PERRETT: So their freedoms are removed permanently. I want to be clear about this: you are removing someone's freedom?

Ms Pearson: Yes, by administering these drugs as a chemical restraint without their consent.

Mr PERRETT: Okay. Well I know people who are passionate about protecting freedoms, so I'm sure we'll communicate that to them.

Dr WEBSTER: I'm fairly new to this. My understanding is that these psychotropic drugs and others that would control behaviours are prescribed by medical practitioners and nurse practitioners who have the training and the skills, I would think, to know what they're doing and what they're prescribing. By removing the ability to prescribe those drugs, are we not taking away the responsibility and the authority of those medical and nurse practitioners?

Ms Pearson: You can still prescribe those drugs if they're for a therapeutic purpose. What we're calling for is a prohibition on using those drugs as an actual restraint in order to modify behaviour. So the position under this regulation at the moment, I think, is that a medical practitioner or a nurse practitioner can assess the person and they can decide to go ahead and use the chemical restraint. They then have to report it and they then have to inform the person's representative. Now, the person's representative could be someone that they have picked themselves; they could pick one relative who has been visiting the facility, the person who is most pliable. This is the problem: it actually doesn't require getting the informed consent from the individual involved.

Dr WEBSTER: With regard to dementia, my understanding is that patients, or residents in this case, have a medical guardian—what's the correct term?

CHAIR: Representative?

Mr PERRETT: It's 'consumer's representative'.

Dr WEBSTER: No, I'm thinking of another one. It's the one where they actually have the oversight of the medical care of someone.

Mr PERRETT: Not the adult guardian?

Dr WEBSTER: The guardian? Anyway, they normally would be the person who would be giving approval to particular medical treatments, and I'm wondering why that isn't the case in this situation.

Ms Pearson: Well in this regulation it says the 'consumer's representative', and then it sets out who that consumer representative could be. It could be a family member who is visiting the facility, it could be the legal guardian—

Mr PERRETT: It could be the next-door neighbour.

Ms Pearson: but it's not clear. This is also a part of the problem.

Senator CHANDLER: Ms Pearson, you've raised some pertinent points around the expertise of staff in aged-care facilities, and their ability to deal with behaviour that's been exhibited by facility residents. Do these principles prevent any staff from being able to deal with behaviour in another way, other than chemical or physical restraint? What we're talking about here, it really is a last resort option.

Ms Pearson: They don't prevent it, but they don't set out what would be the other supportive interventions that they should use. Ideally, we would prefer a regulation that actually would set out those other methods that they should use instead. Effectively, this regulation doesn't have any sanctions if you do use a chemical restraint, and so that's also a problem. There is no real incentive, I guess, for the practitioners necessarily to try these other things if they're not going to be sanctioned for the inappropriate use of these medications.

Senator CHANDLER: Yes. I guess it's quite a philosophical question then as to whether having these regulations is obviously trying to create some level of control around something that we hope happens at the very end, as the last resort. The reason we are regulating this is that it should be the last resort, whether we necessarily need to have a step-by-step guide of everything—all of the actions that could possibly be taken leading up to that point—or whether we leave that to the professionals in the aged-care facilities.

Ms Pearson: We would be more comfortable if there were an outright prohibition on the use of chemical restraints.

Senator CHANDLER: I got that impression from the submission.

Ms Pearson: In the US, they have a federal regulation and it says that the resident has the right to be free from any physical or chemical restraints imposed for the purpose of discipline or convenience and not required to treat the resident's medical symptoms. If we had something like that in the regulations—

Senator CHANDLER: A proactive definition of when restraints can't be used?

Ms Pearson: Exactly. That's what's missing in this regulation. That's the first thing that's missing. The second thing that's missing, as we've already discussed, is the lack of free and informed consent when it comes to chemical restraint.

CHAIR: I have one question. Human Rights Watch states in its submission that the instrument is inconsistent with Australia's human rights obligations. What are the key human rights issues raised by the instrument? Do you have any suggestions as to how the substituted decision-making processes in the instrument could be amended to make them more consistent with Australia's human rights obligations?

Ms Pearson: Yes. In terms of the actual rights that are being violated, it includes the rights to be free from cruel, inhumane and degrading treatment, and the right to health—to have the highest standard of health. The Convention on the Rights of Persons with Disabilities includes the right to liberty and security of person; the right to be free from violence, exploitation and abuse; the right to integrity of person; and the right to health. These are the specific rights that we're concerned are being violated in this regulation.

The second question is about how we avoid a situation of substituted decision-making. This is the point that the Convention on the Rights of Persons with Disabilities talks about at length. It talks about the need to have supportive decision-making instead of substituted decision-making. What does this mean? This effectively means trying to get the free and informed consent of the person. Where that is not possible, because they have a cognitive impairment, a disability or dementia, it might mean having someone who can communicate with them by repeating it several times, speaking to them in a language that they understand or perhaps drawing a diagram or a picture to make it clear, but making sure that it reflects the choices of that person and that they understand what is happening to them and making all best efforts to have the decision or the choice of that person at the heart of the matter.

CHAIR: Are there any other questions? Ms Hammond, do you have any questions?

Ms HAMMOND: Thank you, Chair. Ms Pearson, thank you for your submission and for answering these questions. I go back to a question you just answered. You said that you'd be more comfortable with outright prohibition, and you cited that in the US it's prohibited for the purposes of discipline or convenience. Would you see that there might be an approach where it is allowable in cases of safety or emergency—the safety of the individual concerned or those around them—and that it might be needed? Again, going back to the very last resort: the last resort can't be for discipline or convenience but is for safety reasons, the immediate safety concerns of the individuals or those around them. Would some enhanced reporting and oversight capacity be something that would be considered better than what is there at the moment?

Ms Pearson: If there were a clear prohibition on how it shouldn't be used, such as a matter of convenience, and if it had a very narrow set of prescribed circumstances, such as in an emergency situation, yes, that is actually in line with a lot of jurisdictions elsewhere: I think the US, New Zealand, the Netherlands, Germany. That is the general position that these jurisdictions have taken with regard to chemical restraints.

Ms HAMMOND: Thank you.

Mr PERRETT: I go back to the idea of who makes decisions on behalf of the person. It says, 'The consumer representative can consent to the use of restrictive practices on the consumer's behalf.' In terms of who that consumer representative is practically—and I'm not sure if you work in this area, particularly—could the aged-care facility theoretically have the consumer nominate a manager or employee of the facility as their consumer representative when they sign the residential agreement? Do you see what I'm saying? And I'm not sure if you heard the evidence—I think it was from Natalie Siegel-Brown earlier this morning—about people not being allowed to go into the facilities. I'm not sure if you were here for that bit of evidence; it was the first witnesses this morning.

Ms Pearson: I heard that. I think part of the problem is that this whole idea of who is a consumer representative is very broad and very vague. There is a whole bunch of people who could be the consumer representative, and that's also quite problematic for us.

Mr PERRETT: If we can go to that just to explain to the millions listening out there, it could be: I live next door to an elderly person. I'm concerned about them. They can't live on their own anymore and, I, as their neighbour—say, they've got no family—end up getting them into an aged-care facility. So I could then be the person making decisions about that person.

Ms Pearson: Potentially. I think—

Mr PERRETT: I could be their consumer representative effectively.

Ms Pearson: Yes. Potentially, I think that's one of the problems with this legislation—

Mr PERRETT: It could be their daughter—

Ms Pearson: It could be their daughter.

Mr PERRETT: their spouse.

Ms Pearson: I mean if they have several children, they could just pick the one child that they think—

Mr PERRETT: Who turns up.

Ms Pearson: is going to be most amenable to supporting this restraint. So that's why, again, we think it should be the person involved to give their consent and, where that's not possible, it should be someone that that person themselves has chosen and not just someone that the facility has determined is that person's representative.

Mr PERRETT: Obviously, in a perfect world, everyone would have their own version of an advanced healthcare directive. I think in Queensland they don't actually have a legal document but have something where people can say what kind of care they want such as: 'I like country music' or 'I like this sort of food.' So you try and make decisions when you have capacity about when you don't have capacity.

In this sort of situation—I think we heard last year from Minister Wyatt that about two in five people in aged-care facilities have nobody visit them—no neighbour, no friend, nobody. So two in five Australians don't have anyone involved in their decisions. I'm interested in who speaks for them. Could it be the facility itself that is making the decisions?

Ms Pearson: I have to say this is sort of outside of my area but—

Mr PERRETT: Sorry.

Ms Pearson: I think that's why the Office of the Public Guardian were saying that often it is their office that would then be getting the call and would be being told: 'We want to administer this drug. Is it okay with you?' And they're saying that it's difficult for them to know because in some cases they don't even have access to these facilities so they're not in a position to be able to make those decisions.

Senator McKIM: Good morning, Ms Pearson—sorry, I'm running late. Please just let me know if these questions have already been asked by any committee members. In your submission you've recommended the disallowance of this instrument and say that it should be 'replaced with a robust prohibition on such practices'. Do you think that would be best done by legislation?

Ms Pearson: Yes, I think it would best be done by legislation, and there needs to be proper consultation with groups that are working on aged care and groups that are working with older people. There needs to be consultation with older people living in these facilities themselves.

Senator McKIM: Thank you. In your view—I've just heard some committee members asking you about the details that are in this instrument—is this instrument redeemable in any way?

Ms Pearson: No, I think we really need to scrap this regulation and go back to the drawing board and start again because what this regulation seeks to do is regularise and normalise the practice of chemical restraint. Instead what we want to move towards is eliminating the use of chemical restraints from these facilities.

Senator McKIM: So in your submission any use of chemical restraint is contrary to Australia's international human rights obligations?

Ms Pearson: Yes, that's right. Under international standards UN committees, UN experts and special rapporteurs have all suggested that laws should be repealed where they allow for chemical restraint. And, instead, we're initiating a law that will regularise the practice.

Senator McKIM: Do you think it is fair to say that this regulation imposes less regulation around the use of chemical restraints compared to physical restraints?

Ms Pearson: Yes. The position is worse in terms of chemical restraint. We also heard from the witnesses who testified before me that there may be a concern that there will be more of an incentive to use chemical restraints precisely because there is an even lower standard afforded by this regulation.

We do want the government to have a regulation on these issues—for example, there should be a prohibition on the use of chemical and physical restraints, and that is not there right now in Australian law—but it is really important to get this right. If the legislation or the regulation is drafted in a hurry, and if there is not proper consultation, we are going to see the consequences—and there are going to be very dangerous consequences for people with dementia who are living in these facilities.

CHAIR: Thank you for appearing before the committee and for your time today.

Proceedings suspended from 10:26 to 10:40

BREEN, Dr Juanita, Senior Lecturer, Wicking Dementia Research and Education Centre, University of Tasmania

IBRAHIM, Professor Joseph, Head, Health Law and Ageing Research Unit, Department of Forensic Medicine, Monash University

CHAIR: Welcome. I understand that information on parliamentary privilege and the protection of witnesses and evidence has been provided to you?

Prof. Ibrahim: Yes, it has.

CHAIR: Before we continue, do either of you have anything to say about the capacity in which you appear?

Prof. Ibrahim: The views are generally my own as well as occasionally representing the university.

Dr Breen: Again, the views are generally my own.

CHAIR: I now invite you both to make a brief opening statement. At the conclusion of your remarks I will invite members of the committee to ask questions. Alternatively, to maximise the time available for the committee to ask questions, and in lieu of reading an opening statement, you may choose instead to provide a copy of your opening statement to the committee. Dr Breen, do you wish to make an opening statement?

Dr Breen: I think we've agreed Professor Ibrahim will speak first.

CHAIR: Please proceed.

Prof. Ibrahim: I don't have a formal statement, but I just want to be really clear that I think that the law as it's framed is stupid; I don't want there to be any confusion about it being okay or tolerable. It is a silly formulation. As a law it doesn't work. There is no monitoring mechanism. There are no sanctions associated with it. There's no way of implementing it or making sure that the law comes into effect.

I've previously given the example in terms of road rules, about preventing deaths from speeding, where you have a system that has sanctions, is monitored, is enforced, and there are penalties that have meaning to the individual. On that level it's not a good law. The content of it is vague and open to broad interpretation. There's no clarity about what 'last resort' means. 'Last resort' in aged care typically means 'when I've exhausted what I have at hand, not what is possible'.

The third reason that it's a foolish law at the moment is that it doesn't solve the underlying problem. The law is framed to promote a reduction in restraint use by aged-care providers. If the goal in Australia is to reduce restraint use for people with dementia in aged care, we would look to understand why restraint is used and deal with the

contributing factors for that, not to frame a law that is going to be prone to abuse and pays lip-service to people with dementia.

The first death that we published was in 2006—so almost 14 years ago—when a resident died from asphyxiation in a residential care facility. It's taken us 14 years to frame something new, and we've done that in a hurry because the minister was disturbed by the vision that was seen that prompted him and the department to act. The problem has been longstanding for 20 years, and how we could come to the conclusion that we could sort it out in three months beggars belief. I'm happy to take questions.

CHAIR: Before we proceed, I refer to the graph provided by Dr Breen. Does the committee wish to accept this document as tabled? There being no objections, the document is accepted as tabled. I'll go to the deputy chair to start the questions.

Mr PERRETT: Thank you, Professor Ibrahim and Dr Breen, in anticipation. Are there health risks associated with antipsychotic drug use for older people with dementia?

Prof. Ibrahim: Yes, that's well established; and there are black box label warnings about them in the United States. No-one contests that.

Mr PERRETT: Could you go to them? The *Medical Journal of Australia* talks about falls, strokes, pneumonia and death. Are there others?

Prof. Ibrahim: Yes. I don't know that we need more complications than death and stroke; surely it is enough that it does that.

Mr PERRETT: The drugs continue to be prescribed because the risks are mitigated by the benefits. That's one proposition.

Prof. Ibrahim: That's a wrong proposition. There is evidence that they are inappropriately prescribed. I don't know why that is being debated. There is strong evidence that they are inappropriately prescribed; it's generally accepted by the community, the medical profession, researchers and academics. It is not a question for debate: they are inappropriately used.

Mr PERRETT: Overprescribed?

Prof. Ibrahim: They are overprescribed.

Mr PERRETT: Dr Breen, would you like to add to that?

Dr Breen: I can cover that in my introductory statement, if you like.

Mr PERRETT: I beg your pardon. We should have waited for that.

CHAIR: Dr Breen, do you wish to make an opening statement?

Dr Breen: Yes. I first started reviewing medications in nursing homes as an accredited pharmacist. That was in 1997. In 2007, I commenced a doctorate at the University of Tasmania, and it was on psychotropic drug use in aged-care homes. A large reason why I did this was that there had been continual reports in the media and in the government about the high use of psychotropic medication—and that has been highlighted since the 1980s. Although there was much data on the extent of the issue, there was little research on what to do about it. Psychotropics are basically drugs that act on the brain. They are defined as 'medications capable of effecting the mind, emotions and behaviour' and they are designed and mainly used to treat mental illness.

I have submitted as evidence a list of psychotropic medications in Australia, if people want to note the agents used. There are three main classes. There are antidepressants. Examples are citalopram and mirtazapine. There are anxiolytic-hypnotics. They are mostly benzodiazepines—diazepam, temazepam and oxazepam. And the final class that is used extensively in aged care are antipsychotics. Most of these drugs sedate, calm and settle residents. Some use is entirely appropriate for conditions such as severe depression, schizophrenia and severe anxiety. But we know that many residents are prescribed these types of medications for indications such as wandering, for resisting care, for calling out and to try to get to sleep at the right time. For those sorts of symptoms, the effects of psychotropics are often minimal. They all come with risks. In older people, all psychotropics are associated with falls, pneumonia and, in the case of antipsychotics, death. They also cause confusion and movement problems and impair the social engagement of residents.

The data shows that 20 to 28 per cent of residents in aged care are prescribed a regular antipsychotic every day. So, at the moment, one-fifth to one-quarter of all residents are taking an antipsychotic every day. We know also that about 10 per cent of residents are taking them on an as-required basis, or a PRN basis. Often they are prescribed a medication regularly, and then they have the capacity to give them a little bit more when required. We know that one-quarter of residents are also prescribed benzodiazepines daily. On top of this, over one-third

are charted for them on an as-required basis. Over 40 per cent of residents are taking antidepressants. The most prescribed one is a drug called mirtazapine, which sedates at low doses. In fact, the resident that was shown on, I think, the ABC's *7.30* report was prescribed a large dose of mirtazapine.

Usage of low-dose antipsychotics and oxazepam is rising. I've given you that PBS graph, which actually shows the rate of prescribing. You can see what I've done with that particular graph. I've got the years on the X-axis at the bottom and then I've got the number of scripts that are actually produced. The top graph is low-dose antipsychotics. It did dip after a couple of prescribing restrictions, but it has come back up. But, at the same time, what's happened is that the use of oxazepam, which is a benzodiazepine, has risen, and you can see that a slow rise is happening again with the latest data.

Mr PERRETT: Per capita it hasn't risen?

Dr Breen: The actual rate of use in Australia is going up at the moment.

Mr PERRETT: The Y-axis has got the numbers. Surely there are more people going into the facilities.

Dr Breen: The number of people in aged care is rising, though not at an incredible rate, and the number of people with dementia is obviously rising as the population ages. But these medications are used to a great extent; about one-quarter of residents are taking them.

Mr PERRETT: I'm just interested on a per capita basis in aged-care facilities rather than numerically overall. I thought that would be a better graph.

Dr Breen: I did a study looking at 150 aged-care homes around the country. We found that the use, especially of as-required prescribing, was going up, and also the use of benzodiazepines. The use of antipsychotics has stayed static; it hasn't decreased. But the overall use in Australia is starting to go up again after some prescribing restrictions were made.

Mr PERRETT: Okay.

Dr Breen: There have been various strategies to reduce psychotropic use, but I believe additional strategies are needed, and that's why I was personally really encouraged to hear about the new legislation at the beginning of the year. However, when I looked at it, it was with much dismay that I read the new principles. There was no public consultation on the legislation before these principles were passed, and there also seemed to be a consensus amongst some individuals that it was a step in the right direction—that something was better than nothing. But I disagree with that. I think the principles, in their present form, especially for chemical restraint, don't endorse professional recommendations, as Joe was alluding to, of ensuring detailed assessment before use. The doctor doesn't even have to come in and physically examine the resident to exclude perhaps contributing factors such as infection and pain. There doesn't have to be a documenting or a trial of all available non-drug options or the use of the least restrictive option. There is no stipulation that you need to use the lowest effective dose. There's no monitoring for effectiveness or for side effects. There's no setting of a maximum duration of use, let alone planning for dose reduction or cessation, as all guidelines really stress. These general recommendations are included in all national and international guidelines for psychotropic drug use. It's perplexing that the new principles go against a 2012 federal publication called *Decision-making tool: supporting a restraint free environment in community aged care*. The thing about that is that it was endorsed by the present government.

Most importantly, in marked contrast to the recommendations for physical restraint, consent, let alone informed consent, is not mentioned when it comes to chemical psychotropic use. The prescriber just needs to inform the resident or their legal proxy that psychotropics have been given, if it's practical. This contravenes basic human rights. I think that these new principles do little to address the high rates of inappropriate psychotropic prescribing in aged-care homes. In fact, by making chemical restraint the easier or preferable restraint, it could well increase use further as other restraint methods are made more restrictive. I can't help but query who exactly these principles are written for. Were they written to protect residents' rights, or to appease the prescribers?

Mr PERRETT: Dr Breen, you're suggesting consent is often sought after the fact?

Dr Breen: Research published just last year showed that, in New South Wales, which has the most stringent state legislation, documented consent was only sought in eight per cent of cases.

Mr PERRETT: Did you say eight per cent?

Dr Breen: That's right.

Mr PERRETT: And we have got at least one in four people taking it?

Dr Breen: Yes. And this is eight per cent of all people taking antipsychotics. It was in a study called the Holt study, which was conducted here in Sydney.

Mr PERRETT: You are taking away people's freedoms. The evidence we have had heard is it is a big decision for a person to have this medication and to start on this course. I am not sure if you were here earlier but it was suggested that once people start on these courses it is very hard to get off that drug train; barely one in 20 people would ever get off this medication.

Dr Breen: There isn't really a systematic review process and that's why this is such a missed opportunity, because you could actually embed it within the principles and regulate that after a certain period it is recommended—

Mr PERRETT: Say, 12 weeks?

Dr Breen: Twelve weeks is what is recommended in the PBS and in the therapeutic guidelines and I think it is actually licensed with the Therapeutic Goods Association for 12 weeks; that's right.

Mr PERRETT: And that is a chance to make a reassessment. So if it is currently rolling on and on and they set it and forget almost—it seems to be the way it is approached in some aged-care facilities—then that consent is not being sought?

Dr Breen: No. As part of my PhD, I interviewed about 20 relatives about the use of medications. Most of them said the first they heard of it was when they saw it on the pharmacy bill, so they queried, 'What is this?' and were then told, 'It is something to settle mum.'

Mr PERRETT: You don't have to name them but they were concerned for their care of their relative?

Dr Breen: I think they just wanted to know why they were there and what they were used for. But as I said, that was the first they heard they were being used, when they saw it on the bill. So obviously it is retrospective.

Mr PERRETT: And that was despite being available, despite being engaged in the care process and the like?

Dr Breen: Yes.

Prof. Ibrahim: I will just expand on that issue of consent. There is this belief that if you are asking the carer or the loved one of a person with dementia for their permission or consent that it is informed and not under duress. The issue when you are asking a loved one to give consent is that the choices they face are quite stark: you could consent to the use of an antipsychotic or you get the staff offside or you are bargained with—'well, you can take them home'. So when we say that loved ones are giving consent, I would say that in most cases it is under some form of duress and is not truly informed and not truly voluntary: you either consent to the medication or you take someone home that you are not able to look after and have not been able to look after, which is why you accessed aged care in the first place. So I think we need to be very cautious when we say that consent from a single person and/or a loved one is sufficient.

Dr WEBSTER: Professor Ibrahim, you made the comment before regarding the instrument that it doesn't address the underlying problem and that is why restraint is used in the first place. I was wondering if you could expand on that?

Prof. Ibrahim: The research that our team has conducted and literature throughout the world show there is a misperception that physical restraint improves safety, that it stops people from falling over, stops them acting impulsively, stops them injuring themselves, other staff and other residents. That has not been the case with physical restraint; there is more harm that occurs from physical restraint to the individual. We believe that physical restraint is under reported and that the consequences—pressure injury, malnutrition, confusion, delirium which may occur subsequent to being restrained—don't feature when the person either is injured or dies because they are not restrained. Staffs restrain residents to get through their day because they don't have enough hands to get through what is needed or they don't have the skills, knowledge or ability to assess why a person has responsive behaviours or unmet needs to address that. So making a law that says that restraint should be illegal is, to me, almost nonsensical. It's about saying, 'You should behave nicely to each other.' Do we need a law for that? It seems we do, these days. But a law that isn't monitored and has no sanctions and no way of checking will drive practice underground, especially if there is no support to address the myths around its use. Family members still think that restraint is useful and protective, when it's not. So we don't have a public campaign.

We don't have the staff campaign around education and training. Personal care workers are not obligated to undertake any training in dementia care of any level of sophistication, and the supports provided by mental health services and specialty services and by the public hospitals are insufficient and slow, generally speaking, to assist residential aged-care facilities. So what we're doing is beating the aged-care workforce around the head on a practice that we all want out, but we're not actually helping them by saying: 'If you have problems, the severe-behaviour response team will be there shortly; the local hospital will help you look after this person in the meantime; you are able to get additional staff, and we will reward that.' That's not what occurs. So people are left

to manage through the day, and the way it's written is: 'It's when you've exhausted what's in your head that you can restrain someone; and if you think someone is dangerous, you can restrain.' There's no gradation about what is dangerous or what is reasonable. And we're leaving those decisions to relatively inexperienced, junior people with limited training. There are not psychiatrists in every aged-care facility to make these decisions. And that's quite a contrast with disability services.

Dr WEBSTER: Thank you. You've addressed two of the key issues that I agree with wholeheartedly—that the workforce ratio and the skill level of the workforce are key contributors to where we're at in aged care. And you're right—it's structural as well, in terms of the other allied health support services.

Prof. Ibrahim: I think one of the recommendations that we'd made back in 2017 was that anyone who was being considered for a form of restraint required a specialist multidisciplinary team assessment. If you seriously believe someone needs restraint because they're a danger to themselves or someone else, that problem is not solved by shackling them or giving them a medication. That does not solve the underlying problem. So anyone who requires restraint ought to have a very formal, structured assessment that includes, I'd say, at least a psychiatrist and a psychologist in that team, to work out what is happening.

Dr WEBSTER: What kinds of safeguards would you recommend, including in the law, to protect the rights of aged-care residents in relation to the use of chemical restraints?

Prof. Ibrahim: I think the first comment is that we seem to park our rights when we move into residential aged care. I've been through this before, to say that neither the state nor the Commonwealth care about the individual in a residential facility. The state will look to the Commonwealth, saying, 'It's Commonwealth funded,' and the Commonwealth will come back and say, 'It's a state jurisdictional issue.' So that is just—I don't have words to describe that shift of responsibility. The safeguards around the use of chemical—

Mr PERRETT: We don't really like people appearing and saying, 'I don't have the words'!

Prof. Ibrahim: Yes, well, I do have the words, but not in a public space, for that! I think the issue around chemical restraint can be dealt with in a much better way by a whole-of-system approach. Where is big pharma in this? The people making the medication—where is their responsibility? Where is the PBS's responsibility in allowing it to be used? Where is the medical board, in terms of certification and ensuring doctors are behaving appropriately in what they prescribe? Where are all of those levers being used to improve the care of older people? We wouldn't tolerate it for a younger population. We're not looking at those mechanisms. We come back to say that the aged-care provider is responsible for getting consent or notifying. They're not a prescriber and they don't have the medical knowledge, and we think that's all right?

Dr Breen: It's a complex problem. I agree with you. It requires a complex solution. It isn't just about doing one thing or just legislating and putting in a couple of principles for it to be improved. I was talking about the PhD I did. We did an intervention project as part of that, but it was interdisciplinary. It involved three types of professionals working together. It involved a lot of awareness raising. We did auditing and got feedback and we compared an individual home's use with an average home's use, and then staff discussed it in an interactive session. Staff knowledge about these medications is really poor. A lot of the time I had people in my training session saying: 'Do these cause falls? Maybe that's why Mrs Smith is falling.' They just didn't link the two together. They thought that when someone was old they just fell. They often think they're quite harmless and you often hear, 'They're only really small doses,' but they're really small doses because people have impaired brain transmission. The amount of drug that gets to their brain is higher because they're older. Just because you give them small doses doesn't mean it's okay.

Prof. Ibrahim: Just to confirm the point, the PBS requires approval for drugs that are inordinately expensive or particularly dangerous. What I don't understand is why PBS can't seek to approve the prescribing of antipsychotics for all residents in aged care. You've got the setting; there's an approval process in place. If, again, we're serious about addressing the problem, that's one step forward. The issue with clinical practice is that clinicians are generally smarter and will find another way to achieve an outcome. So, if you act simply on antipsychotics, you'll see an increase in the use of benzodiazepines or other sedating agents. It's got to be a much broader approach than a single method.

CHAIR: Are there any other questions from committee members?

Ms HAMMOND: I note your comments about it requiring a whole-of-system approach. I think that you're right. Obviously, education and training—and culture change, as much as anything—in all of these organisations takes time. Is there anything in your mind that could be done to the regulations? We've got to start somewhere. I think we all agree that nobody wants any of this to continue, so we've got to start somewhere, knowing that some

of the whole-of-system approach will take a lot longer. Is there anything that could be done to the regulations, in your mind, to address the issues that you have with them?

Prof. Ibrahim: Starting somewhere is to have a regulation that addresses the whole system. The notion that we will have an interim solution with a simple regulation and then we will come to the system is going to be lost again. We've known about the problems for 20-plus years and they've not been addressed. A statement that says that the use of restrictive practices is not what we stand for is vital, but so would be a statement in the regulations that starts to address the system as a whole. I don't understand why it's not possible to do that at some level, particularly within PBS, AHPRA and big pharma. Those relationships already exist within government, within the health department, for a range of other medications that are used, and those levers are used to contain costs and limit the use of prescribing dangerous drugs. I do not understand why we think it's not needed here or why we wouldn't use the same mechanisms we use elsewhere.

Dr Breen: Can I add, more specifically for the legislation or the principles, restraint is restraint. Whether it's chemical, whether it's tying someone up to a chair, whether it's restricting them to a room, I think you should have a consistent approach. You can't say that, with all other forms of restraint, apart from chemical, you need informed consent but it's okay with chemical. There are quite strict stipulations for physical restraint but not for chemical restraint, and I just think we need to recognise that it's not more acceptable. Restraint is restraint, and it should be legislated against and treated equally.

Senator CHANDLER: My question is to Dr Breen, and as a senator for Tasmania I want to thank you for all of the good work that you and the Wicking research centre do in this area. You've included in your submission the types of psychotropic medications that are being used. Through your research, can you describe to the committee the alternative practices that could be utilised before we reach the point that, say, a chemical form of restraint needs to be utilised? I guess I'm just trying to understand and tease out what other processes could possibly be used before we get to that last resort.

Dr Breen: That's right. We always say they should be used as a last resort, because, for a start, they're not incredibly effective; they're modestly effective, in a lot of cases. For certain symptoms, like wandering or calling out, they're not effective at all. The evidence suggests they're not effective at all. The process is, first of all, there's a really good detailed assessment of that particular person, and it's very resident-centred. You exclude things like pain because, often, someone who has cognitive impairment can't express that they've got pain. They may have osteoarthritis. They also may have an infection. They may have a urinary tract infection or a respiratory tract infection. And older people present differently. Often they can develop behavioural and psychological symptoms in response to those sorts of infections.

There could be certain triggers. Some people are very private. They're put into a residential care facility where there are lots of people and they've got to interact, and they're shoved in for meals or daily hygiene tasks or having a shower or whatever. So it's also, really, catering to the individual person and working out, on a case-by-case-basis, what may be contributing to the symptoms of this particular person, and then addressing that, doing holistic care, providing a better environment, in a lot of cases, providing meaningful activities for people to do, providing some time outside, in a lot of cases. If you go to a lot of aged-care homes, there isn't a lot of time outside; it varies from facility to facility. It's about improving the environment and working out the reasons behind some of the symptoms.

I did want to say as well that there are times when not to give a psychotropic medication. In certain cases, when someone is extremely distressed, or they have a psychosis or hallucination that is really causing a lot of distress or it could be harmful—they could be striking out at staff or they could be a threat to other residents—the guidelines all endorse using a very small amount, after other non-pharmacological things have been tried. You use a very small amount, monitor its effect and only use it for the shortest period possible, for that particular time.

Senator CHANDLER: I think your comments certainly raise a broader question, which isn't really within the remit of this committee today, about what role government should play in regulating that entire care process. We're speaking to some health peak bodies later today, so I suspect they'll have a position on that. You said that the evidence suggests that some of these drugs aren't effective at achieving the means of what they're being prescribed to do. Why are they being prescribed, then?

Prof. Ibrahim: I'm happy to take that question. The use of antipsychotics as a chemical restraint is not a therapeutic treatment, so there is no benefit from using an antipsychotic. If I were to prescribe an antipsychotic for each one of you today, you would settle very quickly and be passive and quiet because you can't move and you can't think.

Mr PERRETT: That will be the afternoon session!

Prof. Ibrahim: That gives the illusion that the drug works as you would have a passive resident who is not doing anything because they are incapacitated. The drug has not worked on the brain to fix the underlying problem; what it has done is essentially put them to sleep. You can achieve the same effect using a benzodiazepine or anaesthetic, because that's essentially what you are doing. It's not of therapeutic benefit. Antipsychotics are being used because dementia has a constellation of symptoms that appear as a psychosis and which were traditionally treated with antipsychotics. We know better now than we did 20 years ago—that they're not anywhere near as effective. An antipsychotic will put you to sleep. Any drug that puts you to sleep stops you misbehaving as it's perceived by staff. It does not work.

Dr Breen: There have been a lot of clinical trials where they have actually tested these antipsychotic drugs robustly and what they've shown just in one measure, and that's aggression, is that they significantly reduce aggression to a small amount in 18 per cent of people who take them. That's over 80 per cent for whom those antipsychotic drugs have no effect apart from making them settle.

Prof. Ibrahim: And I'd argue that it's staff perception that the person has settled. You've given them a drug, wanting them to behave in a particular way, and you start to look for the positive effects because you're desperate to do something. The drugs do not solve the underlying problem, which is that the aged-care sector is ill equipped to look after people with dementia who have responsive behaviours. Drugs are not the solution. A law banning the use of drugs does not solve the underlying problem.

Senator McKIM: I'll be quite quick because we haven't got a lot of time. Firstly, can I ask you both for a really simple answer to this question: in your view, should the instrument in its current form be allowed or disallowed by the parliament? Perhaps you, Professor Ibrahim, could go first.

Prof. Ibrahim: I think that the principle of saying that we don't want restraint or restrictive practices is good. The way it's written I could drive a truck through all of them; I could go out tomorrow and prescribe with a clear conscience and I could say 'I'm following the law' with no hesitation.

Senator McKIM: So should it be allowed or disallowed?

Prof. Ibrahim: It should be disallowed the way it exists.

Senator McKIM: Dr Breen?

Dr Breen: Definitely disallowed.

Senator McKIM: Do either of you know of any good reason why the regulatory regime contained in this instrument should be less onerous than, for example, the NDIS rules around restraints?

Prof. Ibrahim: I see no reason at all, and I would also be advocating that the NDIS should expand to people over the age of 65 because, if I'm 65 with a disability, I am disadvantaged and discriminated against in Australia.

Senator McKIM: Dr Breen, do you have a response to that?

Dr Breen: I think it's discriminatory against old people, particularly people with dementia, who really don't have the capacity to contribute to this discussion, and that's probably part of the reason.

CHAIR: I thank you both for appearing before the committee today and for your time.

The media has requested permission to film and take photographs of proceedings, and the committee has agreed to this. I remind the media that this permission can be revoked at any time and the media must follow the direction of the secretariat staff. If a witness objects to the filming, the committee will consider their request. The media are also reminded that they are not able to take images of senators' or witnesses' documents or of the audience. Media activity may not occur during suspensions or the adjournment of proceedings. Copies of resolution 3 concerning the broadcasting of committee proceedings are available from the secretariat.

BOLGER, Ms Christina Mary, Executive Director, Regulatory Policy and Performance, Aged Care Quality and Safety Commission

DUGGAN, Professor Anne, Acting Chief Medical Officer, Australian Commission on Safety and Quality in Health Care

HERKES, Dr Robert, Acting Chief Executive Officer, Australian Commission on Safety and Quality in Health Care

WROTH, Dr Melanie, Chief Clinical Adviser, Aged Care Quality and Safety Commission

[11:20]

CHAIR: I now welcome representatives from the Australian Commission on Safety and Quality in Health Care and the Aged Care Quality and Safety Commission. I understand that information on parliamentary privilege and the protection of witnesses and evidence has been provided to you. I now invite both organisations to make brief opening statements and, at the conclusion of your remarks, I will invite members of the committee to ask questions. Alternatively, to maximise the time available for the committee to ask questions, and in lieu of reading an opening statement, you may choose to instead provide a hard copy of your opening statement to the committee. Dr Herkes or Professor Duggan, do you wish to make a brief opening statement?

Dr Herkes: If the committee is comfortable, I will just make a brief opening statement about the commission, so that you can understand why we are appearing today. The Australian Commission on Safety and Quality in Health Care is a statutory health corporation. It is one of the unusual organisations that is COAG funded. So we are funded jointly by the federal government and the states and territories. We have a legislative remit to oversight safety and quality in health care. We are not a regulator, but we do have stakeholders of patients, their relatives, clinicians, states and territories and the Commonwealth, and we oversight and protect quality within health care. We publish standards and guidelines for health services and clinicians, and we operate the accreditation system that accredits hospitals.

As I said, we are not a regulator, but one of the things we have been doing is looking at variation in health care. Professor Duggan is the chair of the variation group. Within variation, we looked at the use of psychotropics and antipsychotics in different age groups and explored the variation there.

Prof. Duggan: The reason that we look at variation is because of the implications for patient safety and the quality of care provided. In our *First Australian Atlas of Healthcare Variation* we looked at antipsychotics in different age groups. In those over 65 we found a very high rate of use of antipsychotics—27,000 of 100,000 people with marked variation. We were concerned about this and we wrote a number of recommendations along a spectrum of soft to hard recommendations. Rather disturbingly, that was 2013-14 data and we looked at it again in the *Australian Atlas of Healthcare Variation* which we published last year and we found very little change in the use of antipsychotics. In fact, what is called the defined daily dose was unchanged. There was a little drop in the overall number of prescriptions dispensed, but nothing marked. So it remains a major concern for the commission.

The commission has done a lot of work and continues to do a lot of work in relation to antipsychotics. Within the healthcare sector, we are doing that against a background of the National Safety and Quality Health Service Standards. So we have a framework in which to work to ensure that good governance occurs in health systems and, partnering with patients, that there is informed consent—all of which is designed to improve health care overall, but obviously applied to the use of antipsychotics in the system in which the standards are mandated.

CHAIR: Ms Bolger or Dr Wroth, would you like to make an opening statement?

Ms Bolger: Yes, I would; thank you. By way of introduction, the Aged Care Quality and Safety Commission is an independent statutory authority governed by the Aged Care Quality and Safety Commission Act. We have regulatory, complaints-management, education and consumer-engagement functions. The primary role of the Aged Care Quality and Safety Commission is to promote the provision of quality care and services by approved providers of aged care, and also to protect and enhance the safety, health, wellbeing and quality of life of aged-care consumers.

Because of the high potential for harm arising from the use of restraints, the commission is looking very closely at this in our regulatory practice. We've taken steps, since the introduction of the new regulations, to communicate our expectations very clearly to residential aged-care service providers to provide information and resources for the sector, including a self-assessment tool, and we've sharpened our focus in our reaccreditation audits and our compliance monitoring on the use of chemical and physical restraint. We have work underway that we can provide some advice on to establish a clinical pharmaceutical advisory unit and also to look at how we can

support consumers to better understand the risks associated with chemical restraint. We're seeing some evidence of early increased awareness in the sector as a result of these activities. We know there is a way to go with this. We'll continue to monitor that closely and to look for further evidence that we're seeing the behaviour change that's necessary to improve outcomes for consumers and ensure that restraints are used only as a last resort and not until alternative strategies have been considered.

CHAIR: Dr Wroth, would you like to make an opening statement?

Dr Wroth: I've got no specific opening statement, but I can elaborate on some of the measures that the commission has undertaken. Would you like me to do that now?

CHAIR: Yes, please.

Dr Wroth: The new standards came into play on 1 July, and along with that we put out the self-assessment tool, which Ms Bolger just spoke about, for providers to start looking very closely at their own behaviour, and in response to that tool we've been fielding quite a number of questions. It has been quite clear in some areas where some of the misconceptions and some of the misunderstandings are, and we're responding to that with further guidance material, which we hope to release this month. Very much we are making the consumer the focus, as it is in the new standards, but in terms of minimising restraint we're really working hard to make sure that consumers understand what their rights and responsibilities are.

In terms of restraint, the person being restrained is usually not the person capable of giving consent, so we are putting out some material that's for consumers and their representatives to explain their role in the consent process. It's along the lines of: consent isn't just agreeing with what the doctor says; these are questions you can ask; it's weighing a risk-benefit; consent is usually time limited; and knowing the harms of what you're saying yes to is just as important as knowing what the potential gains are in that process.

In terms of the clinical pharmacy unit, we have some specific projects that are already underway. A lot of the work has been done in the big cities, in aged-care facilities that are easy to access. We're starting with remote and very remote facilities. We're actually engaging clinical pharmacists who can go out to those facilities in person wherever feasible, which will be most of them, and perform a type of review of medications, really speak to the providers and understand what they see as the challenges and barriers to working in areas where clinical pharmacists are not freely available. We're hoping to then be able to understand whether their practices are therefore worse or maybe better and what we can do further to support people in those areas.

That's going to have a dual role of education. We'll be able to feed back to general practitioners. We'll be able to feed back to residents and their representatives, and also to the providers, to provide some sort of early education resources, at least on our website, that we hope will be sustainable. You can imagine that's logistically quite a large thing to do. The next thing we are doing is starting to develop a consumer app so that consumers can track their own medication—much the same as the way we are asking the facilities to do—so that the consumer is able to put in such information as what medication is prescribed for, what the possible harms are, what benefits we're looking for and when it's going to be reviewed. We're hoping that that will enable them not only to have a more empowered role, if you like, in the whole process but also to address some of the high-risk areas, which would be if people change facilities or if people go from the hospital to the nursing home, where medication may have been changed and that's not picked up by the facility in some way. It's an added layer of intervention.

The third thing we're looking at doing is providing a telepharmacy type hotline to field some of the confusion and questions but also to promote that as a resource for consumers who don't really know what's happening or what they can do, and for providers who have difficulties that can be answered by a clinical pharmacist. We're going to be doing that for a year or so and, at the end of that, evaluating whether that's something that could potentially continue.

Mr PERRETT: Thank you for your evidence. I'm interested in that focus on the rights of the consumer. We heard evidence earlier about perhaps one in four people in aged-care facilities having their freedoms taken away by these medications. I also have my own evidence: the idea that perhaps two in five people in aged-care facilities have no interaction with anyone outside the facility. I might come back to that. My first question is about someone having a family member advocating for them, perhaps looking at a complaint about the use of restraints. How effective is this process in protecting these freedoms, the rights of the person in the aged-care facility?

Ms Bolger: From the commission's integrated regulatory functions, we're tackling this with the consumer at the centre across all the regulatory levers we have available. That goes to our quality assessment and monitoring; our complaints function, as you've mentioned; our consumer engagement function; and to the type of education and outreach support that Dr Wroth outlined earlier. The complaints function has, and has for some time, been dealing with the broader responsibilities that providers have under the Aged Care Act, which includes the new

principles around minimising the use of restraint. We know that one of the most common causes of complaint is around medication management, and that has been the case for quite some time. The complaints are responded to by the commission with the support of a clinical advisory group—

Mr PERRETT: That's an independent medical decision?

Ms Bolger: within the commission to review cases where there are complex medical issues that are related to the consumer's complaint. The commission works with the complainant and with the provider to not only resolve the issue to the complainant's satisfaction but also, if that's not the case, follow-up and be able to issue directions which require the provider to take action. Now that the commission is one commission—from 1 January, when the commission was established, it brought together the complaints and the regulatory functions—it means that other regulatory levers are available to us to be able to respond where we're not seeing that providers are taking the appropriate actions.

Mr PERRETT: Is that punitive repertoire in there as well?

Ms Bolger: Yes, it is. We are able to vary or revoke accreditation of a service, which has serious consequences for providers, because that means that they are unable to receive Commonwealth subsidies. From 1 January next year we anticipate having the compliance and enforcement functions, which currently remain with the Department of Health, to also come into the commission, which actually gives us a broader range of enforcement powers than we've previously been able to exercise. What we're looking at is a stepped approach with sanctions and enforcement action available.

Mr PERRETT: Could you talk us through it. If the provider is not using restraints appropriately, what might be the consequences if, let's say, their family speaks up on their behalf?

Ms Bolger: If the commission finds that the provider is not meeting their legislative requirements—

Mr PERRETT: So, step 1—they phone the commission. There's a hotline, is there, a 1800 number or something like that?

Ms Bolger: Yes. We have numerous ways—

Mr PERRETT: They've gone to the provider first, I assume? The first step is to try and get it resolved. I'm talking very practically here so that I understand the process.

Ms Bolger: Yes, okay. So currently it can come in through our regulatory function or through complaints. If it comes in through complaints, it's managed initially as a complaint and resolution is sought. If that is not the case then complaints will escalate it. They may take a direction—

Mr PERRETT: Resolution—we won't do that again, or we will phone you before?

Ms Bolger: Yes, or a restorative justice approach, with the consumer, their families and the provider involved in a mediated conversation about what happened, what the issue is, in terms of the overprescription or the use of restraint. That's sort of the initial—

Mr PERRETT: Restorative justice. So the freedoms are restored, are they?

Ms Bolger: Well, when you say 'the freedoms are restored'—

Mr PERRETT: Someone's effectively been restrained against their will—restrained when there was no need to restrict that human right, basically.

Ms Bolger: Yes. So the outcomes—

Mr PERRETT: I'm approaching it as that their freedom has been taken from them.

Ms Bolger: The outcome that would be sought by the representative and the consumer would be that that was no longer the case, yes. So that would be a—

Mr PERRETT: I'm just interested in that concept of restorative justice. I normally associate it with break and enter and things like that, where there is some remediation or repayment. I'm just interested in this concept in the human rights sense.

Ms Bolger: It's in the sense that harm has occurred.

Mr PERRETT: Yes.

Ms Bolger: We also have, in the Aged Care Quality Standards, a positive obligation on providers to openly disclose when harm has occurred.

Mr PERRETT: How do they make good, if I can put it in lawyers' speak? Is it this thing we call money, or is there some other measure of value to make up for their wrongdoing?

Ms Bolger: It's a resolution process. I think that the correct term is probably a resolution, a mediated resolution. It's not really restorative justice in the sense that I think you are seeing it.

Mr PERRETT: Okay.

Ms Bolger: Further to that we have the regulatory functions. There are mechanisms by which consumers can contact the commission at any time and flag concerns. In fact, any member of the public can do so. We have an open line. We also require providers to notify all consumers of a service and their representatives when a reaccreditation audit is due to be undertaken. By that mechanism we provide a means by which consumers can directly contact the commission and provide input into the quality assessment of the service. In that instance we'll often pick up complaints from the complaints side of our activities. Those matters are followed up during the audit to understand the quality of care that's been given. I understand that most of the focus of this committee has been on the amendments to the Quality of Care Principles.

Mr PERRETT: Correct, yes.

Ms Bolger: They sit within this broader regulatory framework of the Aged Care Quality Standards. I think that it's worth understanding that context, because the standards themselves put very broad and powerful obligations on the providers to put the consumer at the centre of care. We consider this to be quite a paradigm shift from the old accreditation standards. Across many of the standards we are now assessing how the outcomes are being achieved for consumers—for example, in the case of restraint, whether or not there is a comprehensive assessment based on their needs, goals and preferences and how those assessments are being used to optimise health, wellbeing and care.

There are a number of standards in the new Aged Care Quality Standards under which restraint would be considered by quality assessors when they're undertaking the reaccreditation audits and indeed in any compliance monitoring activity. Standard 1, which is about consumer dignity and choice, is where consumers are being supported to live the best life that they can in a residential setting. Standard 2 is about assessment and planning in partnership with consumers. We would very much be looking for evidence that the comprehensive assessment considered ways in which consumers could be supported to optimise health and wellbeing without the need for chemical and physical restraint. Personal and clinical care is standard 3. This standard is about safe and effective personal and clinical care, evidence based and best practice—and we heard this morning about the scarcity of evidence around the efficacy of chemical restraint—and that the care is responsive to the consumer's functioning and changes in function and triggers that might trigger certain behaviours.

Mr PERRETT: Could I go to that, Ms Bolger. My opening remarks were about the fact that three in five of these people have no advocate apart from the people providing the services, who make a profit from the provision of those services to them. I'm just wondering: how do they come into play if there is no random audit or no consumer advocate person wandering in like there is in the mental health or disability sectors? If we have a megaphone for those who have someone to speak for them but a muffler for those who have no voice, that would seem to be the most obvious, jarring gap in our whole system. A complaints based system that only responds to complaints rather than looks at things systemically would be problematic. I realise I'm asking you a policy question.

Ms Bolger: I think that the Department of Health would probably be able to assist you with that query. But I think there's also the Older Persons Advocacy Network, OPAN, which I believe is appearing later this morning.

Mr PERRETT: I thought they looked at things systemically rather than individually. Have I misunderstood?

Ms Bolger: They do pick up cases.

Dr Wroth: I think they do both.

Mr PERRETT: Okay. Thank you.

Ms Bolger: They will often flag concerns with us as well. They are on our consultative forum, so we do share information regularly about trends and information that definitely alert us to problems in services, and even thematic issues that we need to focus on in our campaigns.

Just going back to the point you were making about the unrepresented consumer who is more vulnerable to this type of restraint, we are conscious of that and are really trying to make sure that they are included in the focus of our assessments. When we are sampling, our assessment methodology instructs the quality assessors to go to those places and seek out evidence about the most vulnerable people at the service. That's both in the planning of the audit, so that we understand the profile of characteristics of the consumers at the service, and onsite when we ask the risk-screening questions of providers that help to focus their attention on areas of highest risk. So we are alert to the most vulnerable in the service when we are conducting the assessment. We will also reach—

Mr PERRETT: Do you do unannounced assessments as well as announced?

Ms Bolger: Unannounced. Last year there was a policy change which enabled us to arrive at the service unannounced through reaccreditation audits, which means that we are now observing care on any given day and are able to make more acute observations of care in practice.

Mr PERRETT: Okay. Thank you.

Dr Wroth: Can I just add to that really briefly. We're making it explicitly clear that not having a representative does not mean that that person does not need to have someone providing informed consent for chemical and physical restraint as well. That's absolutely going to be explicit.

Mr PERRETT: Chemical as well?

Dr Wroth: Absolutely.

Dr WEBSTER: Professor Duggan, you spoke earlier about two pieces of research—one done earlier and then repeated more recently—where 27,000 out of 100,000 were on antipsychotics.

Prof. Duggan: Over the age of 65, yes.

Dr WEBSTER: Is there a clarification in the research that shows what percentage are on antipsychotics for the purpose of restraint or for the purpose of therapeutic good?

Prof. Duggan: No. Unfortunately, this is very high level data that we get from the PBS. We are able to break it down by the regions where people live, and age and sex standardise the data, but we can't look at it in any more granularity. But it is provided to the system, so the system can look at it—a PHN or whoever they are—and see why the rates in their area are so high.

Dr WEBSTER: Are the PHNs able to report that to you?

Prof. Duggan: They don't report to us. We certainly provide the data across the system for anyone who wants to address this as an area of concern. In the second edition of the national standards, we have inserted a criterion in the government standard that people should look at areas where they have high rates of variation. It may not come from our atlas data, but they are actually looking at high rates of variation. The use of restraints or antipsychotics would be relevant to that. The system requires people to provide the data to clinicians and to work on trying to benchmark with other groups and to understand why they are where they are and put improvement strategies in place. And we provide some of those improvement strategies. For example, our clinical care standard on the management of delirium is a guide to how to manage people who are at risk of delirium and who may develop delirium. As you would imagine, it uses all those figures to identify possible underlying causes, such as infection, constipation et cetera, and it only uses restraint as a last resort to prevent harm.

Dr WEBSTER: What do you think needs to be done in terms of developing the workforce skill level to understand some of these complexities around the perceived need for restraint?

Prof. Duggan: Certainly the commission has brought together many clinical experts to try and look at the possible strategies. And we did put forward some education. There is a lot of education going across the system. The clinical care standard for delirium is an example of the education that is available. The way the clinical care standards are written is that we write them for the health service, for the clinician and for consumers. So everybody gets to understand what 'good' looks like and has the capacity to ask questions or get involved in care. That is also on a background of the commission's work which we do in terms of ensuring informed consent, so discussions occur as to why the situation might be the way it is and what may be going on and trying to understand. And then we ensure that people or the carers—and I'm talking about the sector that the standards apply to—are able to manage the situation in a sensible and thought-through way that involves the patient or their carer.

Dr WEBSTER: Do you think there ought to be greater levels of training or skill than we currently have in the aged-care sector? Do you think the workplace issue plays into where we are at right now?

Prof. Duggan: I would take the general view that medicine is complex; and, in most problems we look at at the commission, education has a major role. There are lots of ways to improve the situation, but the commission's view has always been that there is a role for more education. That's why we do so much work in relation to clinical care standards as part of some of our atlas work, and that applies to a number of areas.

Senator McKIM: Were either of the organisations represented at the table consulted by the government during the preparation of this instrument?

Ms Bolger: Yes, the commission was.

Dr Herkes: We had a representative on a committee that helped frame not the actual words but the background to it, yes.

Senator McKIM: Ms Bolger, I won't ask what the feedback during that process was; that wouldn't be appropriate. But could you just explain for the community what the process for that consultation was?

For example, did you see a draft of the instrument? Were you engaged very early in the process around what principles should be enshrined in the instrument? Could you give us a bit more detail, please?

Ms Bolger: Certainly. There were two working groups. One was convened by the department through their chief clinical adviser, which focused on the subject matter expertise needed to understand the issues around restraint. There was a working group which was a stakeholder reference group. I can't remember the title of it, but it involved the sector, the commission and consumer representatives. That was the working group that I was on for the commission.

Senator McKIM: Were any human rights organisations on that working group?

Ms Bolger: There were definitely consumer representatives, and there was the Council on the Ageing and the Older Persons Advocacy Network. I'm not sure; I can't recall. The department will be able to tell you the membership of that group.

Senator McKIM: Thanks, Ms Bolger. I'll ask them that this afternoon. Could I ask both organisations represented: is there any good reason why the tests around chemical restraints should be less onerous than the tests around physical restraints? For example, with a chemical restraint, a medical practitioner or nurse practitioner is required to have assessed the person as requiring restraint, whereas for physical restraints the test is that the person be assessed as posing a risk of harm. There are different standards or different tests. Is there any good reason why the tests should be different for physical versus chemical restraints?

Dr Wroth: I might try to answer that; I'm afraid that predated by involvement with the commission. Consent for medication is governed by state and territory laws. In the principles, it does say that state and territory laws continue to apply. Unfortunately, the state and territory laws differ slightly between jurisdictions—I can give you examples of that if you like. We are taking the view that, to give any psychotropic medication, informed consent is still required as per all state and territory laws.

Senator McKIM: I understand that, Dr Wroth, and thank you, but this is not about consent. This is about the test that the medical practitioner or nurse practitioner would need to apply before exercising the chemical or physical restraint. It's a test issue, not a consent issue. Again, is there any good reason why the test for chemical restraint would be more easily met than a test for physical restraint?

Ms Bolger: I think the rationale in drafting the legislation was that that test was applied in the clinical relationship between the treating practitioner and the consumer. So that is the clinical—

Senator McKIM: What does 'requiring the restraint' mean in therapeutic terms, then?

Ms Bolger: Our expectation is that the service would provide the treating practitioner with the information around the context and the behaviours of the consumer, and that the treating practitioner is responsible for prescribing or determining the appropriate chemical care.

Senator McKIM: We've had evidence that psychotropic drugs are prescribed for the purposes of restraint as opposed to for therapeutic purposes. So let's take the therapeutic prescriptions out of this discussion and just talk about psychotropic drugs being prescribed for the purpose of restraint. Why should that test be lower and more easily met than the test around physical restraints? Is there any good reason? I've asked three times now, and, with respect, no-one's given me a good reason yet. Dr Herkes, did you want to have a crack at this one?

Dr Herkes: Within the healthcare system we would expect that clinicians would not administer anything—any medication or any restraint—without excluding causes for the problem that they're wanting to give restraint for, such as constipation, dehydration, malnutrition, fevers, urinary tract infections or what have you. Whether it's physical or chemical restraint, within the healthcare system the clinician has to be sure that there is appropriate justification for using a physical restraint or a medical restraint. To our mind, that should include informed consent. Informed consent means a conversation with the patient or their carers about the risks and benefits, the harms and potential benefits, of any medication. We would not see, within the healthcare system, any difference between any of those forms of restraint.

Senator McKIM: I hear that, but I'll go back. Would you accept that this instrument prescribes a lighter regulatory touch for chemical restraints compared to physical restraints? Would you accept that proposition?

Dr Herkes: I think there is a whole series of other legislative imperatives on clinicians within prescribing that mean that, effectively, they should be very similar.

Senator McKIM: So you don't accept that this instrument provides—

Dr Herkes: For instance, in New South Wales, to get informed consent, in the example of the deputy chair where there are no significant others, you need to approach the guardianship board. There is a series of extra restraints around what a clinician should do that are important to consider when you're looking at these.

Senator McKIM: Thank you. I appreciate that. If, as you're saying, other statutes in effect apply a higher standard around chemical restraints, why wouldn't those standards be reflected in this instrument? I'm at a loss to understand why this instrument seeks to prescribe a lighter regulatory touch for chemical restraints compared to physical restraints. I'm trying to get an understanding of why that is and, frankly, I still don't have one.

Dr Herkes: I'm unable to explain that either.

Ms Bolger: Could I add to that because I think it will help in terms of understanding the regulatory framework. The duty holder that is the subject of the regulation in the Aged Care Act is the approved provider, and some of the responsibility here clearly sits outside of the regulatory remit of the Aged Care Act. I think that's one thing that creates the complexity about a different treatment around chemical restraint. Secondly, the commission's regulatory remit, which includes the Aged Care Quality Standards, which are much broader than the specific regulation around the use of restraints, requires a clinical governance framework. Clearly, in that clinical governance framework, the service is accountable for having effective oversight to minimise the use of restraints. So, irrespective of the role of the treating practitioner, there are obligations on providers to ensure that they are achieving both regulatory compliance with state and territory law and effective clinical governance to minimise the use of restraints. That's set out in standard 8 and it explicitly references restraint.

Mr PERRETT: That would be the consent. Sorry, I'm adding to Senator McKim's question, Chair, if that's right.

Ms Bolger: That's where the consent issue starts and under which we would then seek to understand whether that's in place when we undertake our assessments.

Senator McKIM: If I could just pick up on that, in this instrument there is no requirement that the use of chemical restraints be used only with consent. It's not there.

Dr Wroth: It's only there in that it references the state and territory legislation.

Senator McKIM: That's right. So why wouldn't you put it in the instrument if it's going to happen anyway? If your argument is that it is required under state and territory law, why wouldn't you reflect that in this instrument?

Dr Wroth: I can't answer that.

Senator McKIM: Sorry, it's not a question for you. I guess it's a rhetorical question.

Dr Wroth: Could I just add a little bit to one of the areas of risk that we are looking at in terms of what Ms Bolger just said—looking at the clinical governance. Restraint, when it's used in a PRN fashion, which is when the prescriber says you can use it when necessary, that leaves the discretion to administer it with the provider. Sometimes that may be somebody who has very little understanding of the medication and restraint, and even what PRN means. We are going to make very clear that it's the provider's responsibility to make sure that anyone who's exercising the discretion understands the reason for its use and the situation in which it can be used, and adequately documents the response to it. That's another area of quite high risk in aged care with chemical restraint.

Senator McKIM: Chair, I know we're out of time, but I have one more question, if that's all right. You spoke about the development of instruments. I think that was you, Dr Wroth, in your opening remarks. I can't remember the name of it, but it commenced in July. Could you remind me of the name?

Dr Wroth: Do you mean the new standards?

Senator McKIM: Yes, the new standards.

Dr Wroth: And with that came the self-assessment tool we put to providers. I think that is what you are asking about, is it?

Senator McKIM: And do those new standards relate to chemical restraints?

Dr Wroth: Yes. They are very broad. They cover all aspects of care.

Senator McKIM: But that would include chemical and physical restraint?

Dr Wroth: Yes.

Senator McKIM: In those standards, is there a requirement that a chemical restraint only be used for the minimum time necessary?

Dr Wroth: Yes.

Senator McKIM: There is?

Dr Wroth: It is specified in our guidance and under standard 8 in the clinical governance arrangements.

Senator McKIM: If you are not able to answer, just say so but why would that not be reflected in this instrument? I mean, you've got a set of standards that do have things in them that simply aren't reflected in this instrument. Doesn't it seem quite bizarre that someone in your position in an organisation would be seeking to engage with the industry and develop standards and then, when the government brings in an instrument to regulate some of those behaviours, it fails to meet the standard that you in fact have set in the standards?

Dr Wroth: The standards are set by the Department of Health, not by the Aged Care Quality and Safety Commission.

Mr PERRETT: Dr Herkes and Professor Duggan, how do you think the use of restraints in the instrument compares to the regulation of the use of restraints in comparable jurisdictions and sectors, particularly the disability sector and broader healthcare settings?

Dr Wroth: I can only talk from the perspective of the area for which the commission is responsible. In terms of that, I would turn to the national standards, which actually have a requirement in standard 5, which is about comprehensive care. There are two elements about restraint, and we don't separate out chemical and physical restraint. It says that you should use best practice, you should try and be clinically sensible in terms of trying to prevent, early detect and treat, and you should comply with legislation. Overriding that is the concept, which is throughout the whole standards, of informed consent to care, so that care is aligned with people's goals and consistent with their comorbidities et cetera. I hope that answers your question.

Mr PERRETT: Yes, it does.

CHAIR: Thank you for appearing before the committee today and for giving your time.

BUCHER, Ms Hazel, Board Member, National Secretary, Australian College of Nurse Practitioners

KURRLE, Professor Susan, Member, Australian and New Zealand Society for Geriatric Medicine

McKAY, Dr Roderick, Fellow, Royal Australian and New Zealand College of Psychiatrists

NESPOLON, Dr Harry, President, The Royal Australian College of General Practitioners

[12:04]

CHAIR: I understand that information on parliamentary privilege and the protection of witnesses and evidence has been provided to you.

Ms Bucher: Yes.

CHAIR: Is there anything you would like to add to the capacity in which you appear today?

Ms Bucher: I'm a nurse practitioner. I am here representing the Australian College of Nurse Practitioners, but a lot of my comments will be from my own clinical experience.

Prof. Kurrle: I'm a geriatrician. I'm representing the Australian and New Zealand Society for Geriatric Medicine, but I will also be wearing a hat as leader of the Cognitive Decline Partnership Centre, which has done a lot of research on care for people with dementia. I will be speaking to some comments.

Dr McKay: I am representing the Royal Australian and New Zealand College of Psychiatrists. I am a former chair of the Faculty of Psychiatry of Old Age and also the community consultative committee, but I am not a current office holder with them.

CHAIR: I now invite you each to make a brief opening statement, and at the conclusion of your remarks I will invite members of the committee to ask questions. Alternatively, to maximise the time available for the committee to ask questions, and in lieu of reading an opening statement, you may choose to instead provide a hard copy of your opening statement to the committee. Dr Nespolon, do you wish to make an opening statement?

Dr Nespolon: I'll just make a brief statement, which is: GPs represent the medical workforce in aged-care facilities. They provide most of the care both in and out of hours. Our concerns, if there are any, regarding chemical and physical restraints would be that any regulation or legislation is not too prescriptive. It needs to reflect the reality of what happens in nursing homes and aged-care facilities. The patients are all very different, the facilities are all very different, the families are all very different and the workforce is very different in each one of those, so it needs to be individualised care.

Dr McKay: After hearing the earlier evidence, I feel compelled, with your permission, to actually start with three people who are in my mind as I think about what the college has to say. One is a person I've seen too many times—in other words, many people—and this will probably be similar to the information you've heard. This is a person who has, with well-meaning, received much too much psychotropic medication, and I'm thinking particularly where they have received that through injection. The current legislation would not appear to prevent that.

The second person is someone I've seen only through video, and that was indirectly, through my role with the consultative committee. That was someone who was pleading to be allowed to die sane, because they had repeatedly had their medication ceased due to concern about overuse of medication. Sorry; that video is one that will always stay with me.

The third person is more recent. This is someone I had to see who had had an incredibly frightening experience in residential care, and that was because, due to fears of overprescribing, the GP had actually ceased the medication, and they had gone into a frank delirium. The context to that is that I am—and so are other psychiatrists—having increased numbers of conversations with GPs who are very concerned about either commencing or continuing psychotropic medication for any purpose, and the difficulty with that is that to define 'chemical restraint' is very difficult. To define 'consent' is not.

With that, I might note that the college has got a number of specific concerns, and, with your permission, I might actually have those tabled, rather than go into particulars. Other than that, I just note that their major concerns are around the definitions of 'assessment' and what is required for assessment and what is an approved practitioner, particularly around the requirements regarding consent and their clarity. I note that there are significant difficulties with the issue of the definition of 'chemical restraint'. I'm happy to answer questions.

Prof. Kurrle: I'm a geriatrician, which is a medical specialist who looks particularly at older people, and, like my colleague Rod, I see a large number of older people. I go into residential care facilities in New South Wales, both urban and rural. Most importantly, I have a 92-year-old mother with dementia in a residential aged-care

facility, so I wear a consumer's hat at times as well, and I want to see us get it right for when I need that residential care, so self-interest is very important.

I want to speak to the position statement from our society on physical restraints and simply mention point 3, which says:

The use of physical restraint in both acute and long term care settings is not supported by evidence of efficacy or safety.

We're really into evidence based medicine. Why are we using something for which there is no medical evidence? So I mention that.

The next thing I want to mention—and, again, these have been tabled—are the *Clinical practice guidelines and principles of care for people with dementia*, which were developed as part of our Cognitive Decline Partnership Centre. They're NHMRC; they're gold standard. Recommendations 77 to 85, which were mentioned in the Carnell-Paterson report, relate specifically to the management of behavioural and psychological symptoms of dementia using non-pharmacological means. I think it gives really clear guidelines. If someone wants a copy, you've got the long version there.

Third, there are two papers I want to table. One is about the best model of residential care for people with dementia. Again, it was research we did as part of our centre. It shows that the cottage model of care—the group home, the domestic model of care—is better in terms of quality of life and quality of care. There are fewer hospitalisations, but, particularly, there are fewer psychotropic medications. The paper is in front of you. I'll come to the cost, which is actually slightly lower. But the important thing is the 76 per cent reduction in psychotropic medication in the group-home-type environment. I cannot understand why more providers don't do it. There's a whole lot of stuff on cost. It's about the same or less.

I made sure my mother was in a group home. Where she is, they have 12 residents. There are four staff during the day till three, three till the evening and two overnight. It's a standard, not-for-profit residential aged-care facility but it's modelled on the cottage model of care. Why are we not doing that everywhere if the quality of life is better and there are fewer psychotropic medications? The carers did not know what restraints were when I asked them, 'What restraints do you use?' They had no idea what I was talking about. They said, 'Well, maybe we shut the front door or, if it's raining, we shut the door outside.' They can go outside day or night. So that was restraint to them. It was quite interesting.

I do want to just make some quick comments about the amendments. People have made comment already. My feeling is you have to make the use of restraints harder to do than good clinical practice. I think the Dementia Behaviour Management Advisory Service, DBMAS, which is Commonwealth funded and available across Australia, should have to see residents before physical restraints are prescribed. In terms of chemical restraint for the treatment of dementia, only specialists can prescribe the dementia drugs initially. Why shouldn't specialists only be allowed to prescribe the psychotropic medications, in particular?

I say that, having discussed that with a lot of my general practice colleagues, who all say, 'That would be fantastic. It would save us being hassled by family and by residential-care staff.'

The consent issues have already been noted, and you came to it! I'm glad you kept hammering them. It's crazy that you don't have to get consent. In New South Wales, you do. We would not prescribe a psychotropic medication without speaking to the family.

Just on the other things: we—and Rod, in particular—do comprehensive geriatric assessments when we see the residents. It's important to have a really good look at what is going on—and you've heard this before: 'Why is the person behaving like they are?' And remember: boredom is a real cause of behaviours of concern in residential care, and I think we have to look at that as well.

Staffing is significant. I won't go there. But there is no-one in my mother's dementia high-care unit, or in a number I visit, who is on chemical restraint. They don't need it.

CHAIR: Ms Bucher, would you like to make a statement?

Ms Bucher: Thank you very much. We've also tabled a written document, so I won't talk about what our thoughts were too. I echo many of the sentiments spoken just then by Professor Susan and Dr Harry about the difficulty in defining 'restraint', and 'treatment' versus 'restraint'.

I just want to make a couple of points that I think have not been tabled yet, just out of pure interest. I, with a GP, look after a number of residents across six nursing homes in Tasmania, and many of our residents are on psychotropic and anxiolytic medications when they come into a nursing home. So their treatment has started external to residential aged care. They then move in, and they become an issue of restraint. And that pressure to reduce can cause problems. However, I think, historically, the difficulty with management of medication

treatments, which then are deemed restraints, has been a lack of regular follow-up, because, in the current or the previous historical model, nursing homes, residential aged-care facilities, are quite isolated, in that the GP who is the locus of control is external and struggles at times to come in and provide that support. So the college is looking at new models where nurse practitioners can be part of that solution and provide that follow-up care and ongoing support and review and start deprescribing. A lot of what I do is deprescribing, very gently, antipsychotics. That's what I'd like to say at this stage. Thank you.

CHAIR: Okay. I will open it up to questions, with the deputy chair to start off.

Mr PERRETT: I'm particularly interested in the roles played by GPs as to their patients who then go into aged-care facilities and then the ongoing relationships that you, Professor Kurrle, mentioned, in terms of treating physicians, in aged-care facilities. I regularly see my GP. Assuming he is still around, will he continue my treatment in my aged-care facility?

Dr Nespolon: It depends. If you were my patient, yes I would.

Mr PERRETT: So you have decided, as part of your business, that you will go to aged-care facilities?

Dr Nespolon: Absolutely. As part of my commitment to my patients, I would go and take care of you. But if you decide to go from where I practise in Neutral Bay to a nursing home in Liverpool, I probably won't be taking care of you there.

Mr PERRETT: Yes, of course.

Dr Nespolon: That's one model. The other model is that there are now groups of GPs who solely set up just to take care of patients in nursing homes, and that's their sole—

Mr PERRETT: They specialise?

Dr Nespolon: Yes, it's sort of a pseudo subspecialty, and that's all that they do. Nursing homes tend to like those groups because they provide a service. That's what they do. People like me have a day job, so to speak, so I would probably be seeing you outside of hours or on weekends, more often than during the day. So the answer is: it depends. There's a variety of different models. There are some doctors who don't want to go into nursing homes. It's fair enough that they don't want to do that, because they don't want to do that sort of care. But a lot of my colleagues are very keen to do it. They take care of their patients as a lifetime commitment to that patient, and as a college we, certainly, strongly promote that, and any way of restricting that choice for patients is, I think, wrong.

The other issue is also that you're getting—

Mr PERRETT: But it does happen.

Dr Nespolon: What's that?

Mr PERRETT: Practically, it does happen.

Dr Nespolon: Yes. Patients go into a nursing home and they can have Dr A, B or C because, 'They're our regular doctors,' and, 'Bad luck; you can't see your old GP.' The other thing about it, I would add, if you're talking about quality and safety, is that, if you have an independent GP who's not part of the system, so to speak, who comes in and sees their patient, that also offers a degree of safety for that patient inside a nursing home, where perhaps their choices aren't as good as they are when they're outside of a nursing home.

Mr PERRETT: As a lawyer familiar with the idea of conflicts of interest and when you can give legal advice and when you can't give legal advice for people and what you need to declare—even being aware of that as a politician, when we need to declare certain things—I'm interested in the relationship between a GP practice, perhaps, and a major aged-care provider, where they might have an ongoing relationship. I'm happy for any or all of you to comment on this. I think we heard in some evidence from Professor Kurrle that there's a suggestion there's more of an asking of GPs to prescribe medications for chemical restraint, effectively. That was your evidence, if I heard it correctly. I'm interested in what might prevent people from making free decisions for the benefits of their patient, the freedom of their patient, rather than—

Dr Nespolon: If I can give you a fourth model—

Mr PERRETT: Yes.

Dr Nespolon: which is where some of the larger nursing homes employ a GP so that there's a sort of employer-employee relationship, we have concerns about the conflict of interest—

Mr PERRETT: Like an in-house lawyer.

Dr Nespolon: That's correct. I'll go back to what I said before. It's probably better that patients get a choice of an external doctor, even if it's a group of doctors that provide those services on a regular basis, than someone who's in an employer-employee or principal-contractor relationship.

Mr PERRETT: A lawyer has a fiduciary duty, effectively, to their—

Dr Nespolon: Absolutely. The way I was going to answer the question before is that, as GPs or as doctors, we still have a much higher duty to our patients. We also have institutions that hold us to those higher duties—

Mr PERRETT: You're a profession.

Dr Nespolon: absolutely—and just like lawyers have, to manage their profession, doctors, no matter whether you're specialists or GPs, have that higher duty, and if you really breach those boundaries then you've got more than just the patient to answer to; you've got the profession to answer to.

Prof. Kurrle: I've certainly had experience with the first model that Harry talked about, which is where a person chooses their own GP and that GP—there may be a number going into a facility. That can be difficult. But I would say where difficulties occur—you're talking about that conflict of where the GP's being leant on to prescribe something or to say the person can be tied up because they're causing difficulties. That will often be where they get the second opinion and will call a geriatrician or a psychogeriatrician to get involved. That's when I think they should be talking to DBMAS. I do not understand why DBMAS is not used more often. Obviously, they'll kill me because they'll need more resources. But they provide a very non-pharmacological treatment. If it's urgent, there's the severe behavioural response team. They'll ring straight away and they'll be there within 24 hours, I think.

Dr McKay: Not on the ground.

Prof. Kurrle: But they're there and we should be using them. I use them regularly, particularly in the country, because it is harder. We should be doing that. The GP is the linchpin of the care of the older person, absolutely. We provide some extra help where necessary. There will be people in residential care that will never need to see a specialist, because their GP is dealing with all their problems. There will be others who do need it.

Dr WEBSTER: Thank you very much for coming in. Dr McKay, do you think that the Commonwealth government should seek to regulate the use of restraints in residential aged care, or is it sufficient to leave it to the states and territories?

Dr McKay: The reality in Australia is that there is always an interface between state and Commonwealth legislation. The important part is to do the very best to get that interface correct. If I were to look at the interface with regard to restraint, I guess I would highlight—I'm most familiar with New South Wales with regard to the legislation—that the legislation under the Guardianship Act with regard to both physical and chemical restraint, if properly regulated and enacted, is actually very strong. In many ways, if the clarity was that those provisions had to be audited and there were transparent processes to ensure that occurred, one could then question what the role was, other than ensuring the same law that applies to everybody also applies in residential aged care. The college does not have a specific position around that, other than the importance of transparency and auditing. Whatever processes are in the act, it should be very clear that there is a process to determine what actually occurs.

Dr WEBSTER: My second question is regarding your submission, Ms Bucher. You make the statement that the only type of physical restraint regularly in use in residential aged-care facilities is environmental. Could you describe that a little more for us?

Ms Bucher: Yes. Primarily, in Tasmania anyway, the only form of restraint I've ever seen used is environmental, where you have a secure unit. We are talking just purely physical restraint; I see chemical medications used as well. But, if it's purely physical, we don't use bedrails, we don't have ties, we don't use any form of—we can't even use belts to assist patients walking, because that's considered a restraint. If somebody is angry and upset and they need to be restrained, instead we move other patients, other residents, out of that space and we allow time for that resident to settle. So we don't place any restraints on residents in that situation. Typically, of course, we do try and prevent escalation into that extreme care. It's the environmental restraint—it's those environmental perimeters, where someone goes into a secure facility, that create a lot of agitation and anxiety and stress because the residents aren't where they want to be or where they feel comfortable, and there are all those kinds of problems. It's an inherent issue with secure environmental restraint.

Ms HAMMOND: My question is to Professor Kurrle. I was taken by your comment regarding good providers not using any form of restraint, physical or chemical. We're obviously aware that some providers do use these restraints. We obviously want all providers to lift to the same standards as the good providers you're familiar with—the ones that don't use unnecessary chemical or physical restraints. In your mind, does that regulatory

regime get there or not get there? How would you propose that we lift the bar of other providers in a way that doesn't penalise or impinge on the good providers.

Prof. Kurrle: That's a really good question. I think it frustrates me a lot that we know how to do things well but we don't do them. In the previous session we had the Australian Commission on Safety and Quality in Health Care. They changed the way we practise in hospitals by changing the accreditation standards. I was involved, particularly, with delirium and dementia. We changed the rules. We had a big stick to say, 'This is what you have to do and you don't get accredited, so you don't get funded, if you don't screen and do other things.' I fear we may need a little of that for residential care.

We know that the group home type or the domestic model of care is done all over the world. The Dutch models are held up constantly. We do it here, but a lot of the big providers don't. They build 160-bed edifices, which are not conducive to good care. I'm aware that the Royal Commission into Aged Care Quality and Safety is looking at that. I should probably declare a conflict of interest here, because I am actually the medical adviser to the aged-care royal commission, which means that at least I see the evidence they are getting.

I think there is a will there to look at how we make care better—like what incentives we give to providers now to develop the model of care. A lot of them are doing it on the basis of the publication that I tabled, which was tabled in the *Medical Journal of Australia* 14 months ago. We know what works. We know how much it costs. We know that it stops hospitalisations and all sorts of things. Why aren't we doing it? They say it takes 17 years to get good research into practice. I certainly hope, for the sake of a lot of my older patients, that it doesn't take that long. We are working on it. We need some regulation. We need the stick and the carrot and it is about how we mix them. I think by having 15F and 15G, we almost give approval to restraint by putting it in, and that was my concern. We are kind of saying, 'Yes, it's okay and this is how you do it,' when we should be saying, 'Actually, it's not okay. Yes, use psychotropics when they are appropriate but not otherwise.'

Dr McKay: I would give two experiences. One is that in New South Wales for a period we actually had a mental health promotion project in collaboration with industry to promote examples of work to promote mental health in residential aged care, which was quite successful. Why did it come to an end? Largely, it came to an end at that time with changing political areas but also change in accreditation. The pressure of different accreditation standards was probably a significant factor in it not continuing. It really was inspired by the idea of Tidy Towns, where you could have regulation but you can actually also have the idea of a community wanting to change. So there are other ways of looking at things. The other thing I would say is that the UK actually has nice guidance around promoting emotional wellbeing within residential aged care. We don't have any guidance of any form in that regard, and I think there is a stark contrast there—clear standards versus not.

Senator CHANDLER: I think all of the submissions that we've received thus far today have touched on this—and we've probably gone around the periphery of this issue already in this session. As a new parliamentarian, I am always trying to determine where the right place is for government to play a role in regulating any of these processes. We've heard a lot of submissions today and some have said that they should be regulating the whole care process because that would enable us to better establish that use of restraints is meant to be a last resort. I'm not sure that I necessarily agree with that point. So I am interested to know, from your perspective, what it is about the principles as they currently stand that might erode any concept that restraints should be the last resort. I don't think anyone here is saying that the reason these regulations exist is so that restraints can be used with reckless abandon, but is there anything about the way that the principles are currently written that would make you think otherwise?

Dr Nespolon: With the royal commission, I spoke to a whole lot of our members who work in aged-care facilities around Australia, and the message they sent to me was that they use this last. I think you've got to get some perspective. When you're sitting in a room like this and all you are talking about is chemical restraints, you have this vision of all these nursing homes where 90 per cent of the patients are in some sort of restraint. That's not what happens—and Susan will probably give a much better perspective. Using restraints is the last thing you do. You've got to understand that patients are all very different and families are all very different. You really don't want your mother or father in embarrassing situations in the nursing home: it does nothing for the patient, it does nothing for the family, it does nothing for the nursing staff and it does nothing for the other people in the nursing home.

In my introductory comments I said that less regulation is better than more. There is no perfect system; that's why we have standards and accreditation and all the rest of it. But most people are trying to do their best in the circumstances they are in, given the resources they have got.

Senator CHANDLER: So you would say that the framework that we have—where we have the professionals, the experts, coming up with these industry standards—does strike the right balance? So we know that chemical restraints and physical restraints are not meant to be the first thing used?

Dr Nespolon: Non-chemical or non-pharmacological approaches to behaviour are always the way you want to go first. Most doctors in nursing homes nowadays are trying to de-prescribe, not prescribe—although I will give you an example where I had a patient who I think got down to one drug and, for reasons best known to the nursing home, they sent them to the hospital and they came back on everything that they started off on and we started again. That's the relationship to the hospital system and it is often the experience of the doctors they see in the hospital. But, in general, most doctors are trying to prescribe the least amount of drugs, especially for older patients and patients who do have a tendency to delirium or behavioural problems. So putting too much regulation on top of this is not good. I will leave my comments there. I will leave it to Susan to say a few words if she wishes.

Prof. Kurrle: I still think we should make it harder to do bad practice than to do good practice.

Senator CHANDLER: Yes.

Prof. Kurrle: I think that's really important. And we've kind of done that by saying you got to have this, this and this. But do we know that is happening? If these residents are not being checked—constipation causes major issues. Have they got a bladder infection? Is it the medication? There are so many things we need to look at. The role of proper assessment is really, really, really important. I was rung yesterday by a GP who said: 'Can you tell me what we should do? The staff in the residential care facility are saying to the daughter, "We'll send your dad to hospital if you don't consent to a particular medication." What on earth am I to do? We want to keep him here. His advanced care directive says, "I want to be here," but the staff are saying they will do that.' That's really difficult. It's an imbalance of power—and it's been alluded to before.

People worry that their parent won't be able to stay in the residential care facility. That's wrong. They've got tenure. As long as they are not respite care, they can't be booted out. But a lot of people don't know that. So a lot of our work is saying, 'No, it's okay.' Let's look at how we make it better. Let them wander. Take them out for walks. Give them a beachball to kick around. Bring in the dogs. Bring in the children. There is so much more you can do to help make life better.

Senator CHANDLER: But these regulations, in and of themselves, aren't preventing aged-care providers from doing that?

Prof. Kurrle: No. My colleague Joe Ibrahim said you could drive a truck through them. He is absolutely right. There is always a way round and people will find a way round. And that's what worries me. We'll get more pictures like Terry Reeves, the guy who was presented at the royal commission. He was fine one day, but 10 days later he was drooling in a chair—tied. This, unfortunately, is what sometimes happens. How do we prevent that? Consumer directed care, giving the market to the consumers, will help a little. But it will only be the informed consumers who will say: 'This is a bad care provider. Let's take our package of funding and go to the good ones.' That is happening to a degree now: you can't get into a lot of the good ones. The problem is they look after people so well they don't die! I know that sound silly, but they don't.

Mr PERRETT: It's bad for their business model!

Prof. Kurrle: Well, you know, it is said they can only put one person in a bed. But there are those issues—that, in the good ones, people stay for long periods of time because they are so well looked after. There are all sorts of interesting issues. What do you do? You've got a care provider that is not-for-profit and then you've got a care provider that is paying its shareholders, and they get the same amount of money from the government. So money is not going to the residents' care; it is going to their shareholders. And that worries me a lot. It is something, I suspect, the royal commission will look at in terms of how we do it better.

Senator McKIM: I will start by asking the representatives of the four organisations whether you were consulted during the development of this instrument.

Dr Nespolon: No.

Dr McKay: As I am not the office holder currently, I probably wouldn't be aware if it was.

Prof. Kurrle: Yes, I was involved. There were two teleconferences and that was it. So it was kind of a shock when we got the email saying this is what is happening. It probably represents vaguely a clear consensus, but a lot of us had a lot to say.

Senator McKIM: During that process, were you ever shown a draft of the instrument?

Prof. Kurrle: No, absolutely not.

Senator McKIM: Ms Bucher, to your knowledge was the Australian College of Nurse Practitioners consulted during the development of this instrument?

Ms Bucher: No, we were not involved in that discussion.

Senator McKIM: Chair, I move that we accept Dr McKay's submission as tabled.

CHAIR: There being no objection, it is so agreed by the committee.

Senator McKIM: Dr McKay, I want to ask you a couple of questions of detail around what you said in there. Firstly, I am talking in the context of chemical restraints here. You have been very clear that the requirement to inform the consumer's representative—I prefer to use the term 'patient' myself in these circumstances but let's use the language that has been presented to us—of the use of chemical restraint is not sufficient and you have said it is strongly advised that informed consent should be sought. Can you very quickly explain to the committee why that is?

Dr McKay: Because it may be that the strongest protection in this act would be to be clear that informed consent is sought—probably not to prescribe informed consent, because of all the other regulation that does that, but informed consent means that you need to have a process. If you are in New South Wales, that would have to be a documented process, if you are following the guidance, where the person has had explanation of what the reasons are for a proposal, what the potential benefits and potential risks are, and a decision is made by someone who can make that decision. We can all make decisions to do things that are harmful to us, and it is our right to do that. A person in residential care or their representative has that same right as long as they are doing it in the person's best interests. If you don't have that consent mechanism, there is nobody to ensure that those rights are maintained. So, really, at the core for all of us in our protection in regard to the interface with health care is informed consent.

Senator McKIM: I am going to paraphrase what you've just said and put it back to you. Please feel free to agree or disagree. Would you say, therefore, that the instrument as it is currently formed would carry the risk that the rights of people in residential care facilities may be abused?

Dr McKay: There would appear to be the risk that the person may read this and overlook, even though it is in the broader instrument, their legislative rights under state legislation.

Senator McKIM: This goes back to questions I was asking previous witnesses. Can anyone give me a reason why the regulatory regime around chemical restraints ought to be less onerous than that which relates to physical restraints? It clearly is in this instrument, and I don't understand why that is. Professor Kurrle, were you—

Prof. Kurrle: No, I have no idea why. I strongly believe that, if you are going to have them, they have got to be consistent. I was certainly surprised when I read that.

Dr McKay: First of all, I have to say that, in principle, I agree that they should be the same. I think informed consent clearly should be the same expectation for both. There is a fundamental difficulty, though, with actually defining chemical restraint. On the ground, definitely psychiatrists' experience is that GPs are probably now not prescribing at times when they should be prescribing, because they fear that it will be considered chemical restraint. So there's a great difficulty around the definition, which makes everything else very difficult. As I said, that video that stays with me is before this but is, unfortunately, what I have seen too often. I too often have seen people whose required therapeutic medications have been stopped because the person doing it legitimately has thought it has been restraint.

Senator McKIM: The person prescribing it?

Dr McKay: The person prescribing, or deprescribing, has believed that it's there for restraint, because unfortunately, in residential care, many things do happen to continuity of care. It is not always clear why someone is on something. For a person who has their mental health condition effectively managed—especially if it's in the context of dementia developing, which is often when it's most difficult—once medication is stopped, sometimes the person gets back to where they were, their quality of life, but often they don't. So it's not an easily reversible condition. My suspicion around why there are differences is the difficulty around the concept of defining chemical restraint—and, to me, therefore, the real importance of informed consent.

Senator McKIM: If I could just test that, surely it would be clear in the mind of the prescriber the purpose for which they were prescribing psychotropic meds, wouldn't it? They would have it clear in their own mind whether it's a therapeutic intervention or whether it's for the purposes of restraint, would they not?

Dr McKay: No. I don't think that is always clear. The reason I say that is that there are therapeutic situations in which there appears to be a no-win situation, and the process of informed consent is actually a discussion with

the family around, 'These things have been tried; these things haven't worked,' and it's used in the situation that the person's at significant risk of harm, as are others.

Senator McKIM: Are you talking about restraint here?

Dr McKay: It may continue, so the person is very distressed, and it can be very difficult to actually know what is occurring, so therefore what is intended as a therapeutic trial can end up appearing like restraint. There is nothing other than the discussion around informed consent that actually may make that situation seem different. The clinician may well have the discussion with the family: 'Actually we're not quite sure what the end point will be.' Then the family will have a very difficult decision if the end point is—rather than what we want, which is the person being calmer, the person actually is sedated—'Will you consent to us then reducing medication so that they're not sedated but are more distressed'? So it's not always clear. I wish it were always clear. But the times I'm called in as a psychiatrist are often when it's not clear, and people have got into an utter mess. It would look as though this has been very inappropriate care, but there may well have been the best of intent at every step along the way. I think that is one of the challenges around chemical restraint.

Senator McKIM: Dr Nespolon, do you have any thoughts you'd like to share?

Dr Nespolon: I think it's quite an interesting question about whether you can look at a patient and say, 'We're just chemically restraining you,' as against dealing with other mental issues at the same time. Let's go back to the reality of it. Certainly Susan can disagree with me, but I don't see that many physical constraints anymore—in fact, almost zero. It's a nice sort of anachronism of the legislation, but in reality it's all going to be about chemical restraint, if you want a better term. But I find it really difficult trying to imagine a patient who's getting their medication just for chemical restraint. I think the patients that you see—and this is what I've been trying to say all along—are much more complex and it is much more difficult to just give them a single diagnosis. In fact, I doubt if there's anyone in a nursing home who has a single diagnosis.

Dr McKay: To be honest, diagnosis is incredibly difficult and complex. The reality is that most people in this context have got dementia—but not everybody, and that's important to realise too. But, in the context of dementia, diagnosis is incredibly difficult. We can't even agree on the diagnostic system to apply. So the concept that's applied of behavioural and psychological symptoms of dementia is not a diagnosis; it is a group of things you need to look at further, and then people will look at the same person and give quite different diagnoses.

Senator McKIM: Thank you. Ms Bucher, do you wish to add anything to this discussion?

Ms Bucher: It's a complex situation, and I totally agree that we need treatment versus purely for chemical restraint. If we could wind it back—often the reason restraints are needed is that residents and patients are in facilities they don't understand and are not comfortable in; they are not cottage style. We are trying to fix a broken system, I guess. I think regulation is needed, but also good follow-up as well. But, essentially, I concur with and support everything that has been said.

CHAIR: Thank you for appearing before the committee and for giving us your time today.

Proceedings suspended from 12:50 to 13:23

COAD, Ms Melissa, Executive Projects Coordinator, United Voice

REEVES, Ms Julie, Federal Professional Officer, Australian Nursing and Midwifery Federation

SHEPHERD, Mr Allan James (Jamie), Professional Officer Team Leader, Queensland Nurses and Midwives' Union

CHAIR: I now welcome representatives from the Queensland Nurses and Midwives' Union, the Australian Nursing and Midwifery Federation and United Voice. I understand that information on parliamentary privilege and the protection of witnesses and evidence has been provided to you. I now invite each of you to make a brief opening statement. At the conclusion of your remarks, I will invite members of the committee to ask questions. Alternatively, to maximise the time available for the committee to ask questions, and in lieu of reading an opening statement, you may choose to instead provide a hard copy of your opening statement to the committee. Mr Shepherd, do you wish to make an opening statement?

Mr Shepherd: Yes, please. Honourable members and senators, on behalf of the Queensland Nurses and Midwives' Union I'd like to thank the committee for the opportunity to appear at the hearing. The QNMU believes that human rights are an important issue for aged care, given that many of those receiving care are vulnerable and have diminished capacity to exert their basic rights. Relevant to those rights here today, aged-care consumers have the right to refuse to be restrained, unless, of course, there is imminent risk of serious harm to themselves or others. Today I will be speaking about our concerns regarding the proposed amendments, particularly the rushed and brief consultation with stakeholders, the lack of trained or qualified nursing staff in aged care, and the potential benefits of referring to relevant state regulation around restraint.

With regard to consultation, on 4 March and again on 18 March the department held two meetings by teleconference with stakeholders to discuss the potential for restraint to be regulated under the Quality of Care Principles 2014. I was one of the representatives of the Australian Nursing and Midwifery Federation at those two meetings, and provided email feedback to the department on behalf of the ANMF. Our feedback also advised the department that we believed the process of engaging stakeholders for their views was rushed, given that late on 19 March, the day after the teleconference, we were provided with draft outcomes from the meeting that would form the basis of amendments to legislation and given a feedback deadline of close of business the next day. Just a few days later, the Hon. Ken Wyatt, then Minister for Aged Care, announced the proposed amendments that would regulate restraint. We urge the department in future to give ample time for consultation on issues, particularly significant issues such as amendments to legislation that affect the day-to-day care of our elderly Australians.

On the issue of nursing staff, the QNMU considers that the use of any form of restraint must be in exceptional circumstances, where all other strategies have been tried and failed, due to the consumer's behaviour. Restraint must never be used as a fallback for an inadequate staffing and skill mix. The primary means of minimising the incidence of restraint is to ensure optimal evidence based care hours per consumer per day so that appropriate surveillance can occur. Residents who present a risk of harm to self or others can be assessed in a timely manner and alternative interventions engaged before the consideration of restraint even arises.

Along with care hours, the establishment of an evidence based optimal skill mix of nursing and care staff within residential facilities is also of critical importance to minimising restraint. In our view, all residential facilities should have access to a nurse practitioner skilled in the assessment, diagnosis and treatment of the comorbidities and challenging behaviours that present in residential aged care. An appropriate mix of registered nurses and enrolled nurses is also essential to minimising restraint. The critical-thinking expertise of registered nurses will assess and identify early warning signs that a consumer may pose a risk, and enable them to engage a nurse practitioner or a treating medical practitioner to assess and intervene in a timely manner. Enrolled nurses work with registered nurses, and if they're providing a significant amount of face-to-face care they have the skills to identify changes in consumer presentation and engage the registered nurse for assessment.

Currently, assistants in nursing, however titled—carers or whatever—provide around 75 per cent of the care of residents in aged care. They are dedicated and caring members of the care staff. However, in our view their work is so rushed that they do not have the time nor the standardised accredited and approved nursing education to pick up early warning signs in a consumer's physical or mental presentation that might indicate the need for early prevention. This is because the average of 2.8 care hours per consumer per day across the sector, and the skill mix of nurses and carers, is far below what the evidence suggests it should be. We recommend that the Quality of Care Principles 2014 be amended to mandate the evidence based average care hours of 4.3 hours per resident per day and a skill mix of 30 per cent registered nurse, 20 per cent enrolled nurse and 50 per cent assistant in nursing, however titled.

Regarding the state regulation of restraint in Queensland, the Queensland Mental Health Act 2016 contains prescriptive controls on the use of restraint in authorised mental health services. The act distinguishes physical restraint from mechanical restraint, where it defines the latter as:

… the restraint of a person by the application of a device to the person's body, or a limb of the person, to restrict the person's movement.

By and large, this is what the legislative amendments to the Quality of Care Principles refer to as 'physical restraint'. The Queensland act also requires the patient to be continuously observed while mechanically restrained, and it creates an offence of using a mechanical restraint on a patient in a way that does not comply with the Chief Psychiatrist's policies and practice guidelines. In the Chief Psychiatrist's policy, the use of mechanical restraint must be reported immediately on each occasion; this is a significant difference from the aged-care Quality of Care Principles. The human rights of aged-care residents should not be any less than that.

With regard to chemical restraint, the Mental Health Act in Queensland makes it an offence to administer medication to a patient unless the medication is clinically necessary for the patient's treatment and the care of the medical condition. Again, the Chief Psychiatrist has published a policy, titled Clinical Need for Medication, which must be complied with. We recommend that the committee review the restraint and medication policies and practice guidelines of Queensland's Chief Psychiatrist. I have a copy of them with me here today, if the committee wishes me to tender them now.

In conclusion, we recommend that the Quality of Care Principles be amended to mandate the evidence-based care hours of 4.3 hours per day for each resident, with a skill mix of 30 per cent RN, 20 per cent EN and 50 per cent carer AIN. We also recommend that Queensland's Chief Psychiatrist's restraint and medication policies and practice guidelines be considered by the committee for adaptation of the department's guidelines on restraint in aged care and that the amendments relevant to restraint prescribe that any such policies and guidelines are enforceable. Honourable member and senators, thank you.

CHAIR: Ms Reeves.

Ms Reeves: Thank you. The Australian Nursing and Midwifery Federation thanks the committee for inviting us to appear today as a recognised stakeholder in discussions about the use of restraint in the aged-care sector. The ANMF is Australia's largest national union and professional nursing and midwifery organisation. We represent over 40,000 registered and enrolled nurses and care workers in all aged-care settings across the country. Many more of our members are involved in the provision of health care for older persons who move across sectors, including acute, residential, community and in-home care, depending on their health needs. Being at the forefront of aged care and caring for elderly people over the 24-hour period, our members are in a prime position to see clearly the improvements that need to be made for people being cared for in residential aged-care facilities and in the community.

The ANMF shares many of the concerns expressed by Human Rights Watch and the Office of the Public Advocate about the use of physical and chemical restraint measures currently employed in aged-care facilities. In our submission to the Australian Law Reform Commission in 2016, we made it clear that concerns about restrictive practices in aged care—for example, the use of physical restraint or overmedication for behavioural issues—have been highlighted by the ANMF over a number of decades. At that time we recommended there be a national, consistent approach to regulation of restrictive practices such as chemical and physical restraint in both residential and community aged-care settings in harmony with the guidelines produced by the Australian Commission on Safety and Quality in Health Care for acute care facilities. However, while we have supported the regulation of restrictive practices, we have a major concern that this will be seen as the solution to the problem. Critically, it is only part of the solution.

The day before the government publicly announced its intention to establish an Aged Care Quality and Safety Commission, the ANMF released a statement saying that better staffing would fix the crisis in aged care. In this statement we maintain that increasing staffing levels is precisely what will solve the problem for elderly vulnerable Australians in nursing homes. Aged-care providers continue to employ fewer and fewer nurses to care for an increasing number of vulnerable residents with increasingly complex medical needs. ANMF members regularly cite staffing ratios of one registered nurse to 100 residents. While the provision of safe staffing remains unchallenged in some facilities, the ANMF considers that the use of physical and chemical restraints to control challenging behaviour is likely to continue.

Whilst successive governments have conducted myriad reports, reviews and inquiries looking for complex solutions to complex problems, they have ignored the core problem—chronic understaffing. They don't address the lack of staff availability as a possible contributory factor for ineffective behaviour management that may predispose the use of chemical and physical restraint. Research shows that, if the root causes for undesired

behaviours are determined and corrected, the use of restraints can be significantly reduced and alternatives can be implemented. There needs to be the right staffing numbers and the skill mix to enable effective assessment and monitoring to provide person-centred care. Evidence based mandated staffing and skills mix that match the assessed needs of residents is the first priority in fixing myriad issues in aged care, including reducing the need for physical and chemical restraint.

Ms Coad: Thank you for inviting United Voice to give evidence on this very important matter today. I am going to speak on behalf of United Voice members who work as direct care and ancillary staff in residential aged-care facilities around Australia. Our members who work with residents in aged care every day understand how the use of restraints impacts on these residents and on their work. We understand that this committee's remit is not to look at broader aged-care issues, but regulations such as these cannot be considered in isolation of the environment in which they will be applied.

These regulations have been introduced as an attempt to reduce the use of restraints, which is of course a desired outcome. However, they may have been introduced without consideration of the environment in residential aged care, and I speak here specifically of staffing issues—the number of staff and the training received by staff. A lack of staff in residential aged care is a constant theme we hear from our members. Our members continually report to us that they are rushed and overworked, and that rushing residents impacts negatively on them and their behaviour. I have a quote from a member to illustrate that:

Definitely a significant increase of staff is needed, so we have more time to provide for residents' social and emotional needs, as they aren't being met. More staff would mean less pressure and stress to meet time restraints, so we can spend more time and care on residents or not feeling as stressed and pressured. Residents pick up on how we are feeling, so they in turn would feel more relaxed and less of a burden. Increased staff numbers would mean less falls and other incidents. We would have more time to spend with residents with dementia, which would mean no longer searching for and redirecting wanders and reducing risks. More staff would result in less conflict and ill-feeling among staff.

When members are asked how being rushed and overworked makes them feel, these are some of the responses: 'It's frustrating because the more you have to hurry, the more agitated the resident can become'; 'They get agitated from being rushed and that causes behaviours'; 'Rushing a resident due to workload, they become angry and aggressive'; and 'It's very unsafe and it doesn't feel good that you have to rush everyone.'

Our members also report feeling unprepared and undertrained in dealing with some of their residents, and I quote:

A lot of the residents coming into care now have serious behavioural issues and mental health issues. But we as carers don't get enough training to deal with the huge gamut of them, and when you have two or three residents all with behaviours at the same time, it affects the behaviour of other residents as well. Not having adequate training for mental health and dealing with violent, abusive outbursts on a nightshift when only two staff are on duty and the residents are scared that this person is going to harm them.

It is currently within an environment of understaffing that restraints are regularly used in residential aged care. Conversely, a residential facility that is well staffed with well-trained workers means behaviours of concern and difficult behaviours may well be able to be diverted before the resident becomes a risk to themselves or others, and restraints would not need to be used with anywhere near the regularity that they are currently.

Any regulation governing the use of restraints should also require facilities to establish plans or other mechanisms to address issues to avoid restraint use. Such plans could be developed with residents and ensure staffing levels are adequate to meet the plans. This would highly likely require additional staff as well as increased training for staff. I have a final quote from a member:

I would love to spend time with them as people, not just when providing ADLs—

activities of daily living—

a simple task like a jigsaw, knitting, cooking a coffee and a chat, a walk in the gardens, doing gardening et cetera improves their happiness, which in turn improves their physical and emotional health.

United Voice believes regulation around the use of restraints is needed but that there should first be thorough consultation with all relevant parties to determine the most appropriate form and oversight of the regulation, and consideration of the environment in residential aged-care into which the regulation would be introduced,

CHAIR: We will move to questions, starting with the deputy chair.

Mr PERRETT: Thank you. I just want to clarify whether enrolled nurses are covered by you guys.

Mr Shepherd: Yes—registered and enrolled nurses.

Mr PERRETT: And then you'd have coverage of—

Ms Coad: Personal care workers or other direct care staff, but we also have enrolled nurse coverage in WA only.

Mr PERRETT: So they'd have some training before they went into the—

Ms Coad: Generally, a certificate III level.

Mr Shepherd: Sorry, we have assistants in nursing as members as well.

Mr PERRETT: Okay, got it. To summarise, it seems you're suggesting that more staff equals less need for medication. The instrument provides that chemical restraints mainly follow from an assessment of the medical or nurse practitioner that such restraint is required. I'm not sure if they said required clinically or just required. But we'll come back to that. You're seeing it through the Queensland prism, Mr Shepherd?

Mr Shepherd: Yes, that's correct. The only reason to give medication is for clinical need, to treat a medical condition.

Mr PERRETT: A clinical need. But it does not require that the consent of a resident or their representative or that alternatives to chemical restraint be used to the extent possible. In your opinion, are these restrictions sufficient to protect the rights of people in aged-care facilities?

Mr Shepherd: The issue of chemical restraint is written there at the moment. In our view, there should not be any need to chemically restrain a person—

Mr PERRETT: So your members would be governed by Queensland law at the moment? You are saying they would only be so doing if there was a clinical need?

Mr Shepherd: Our members are not prescribing the medication. The GPs are prescribing the medication. Under Queensland law, there are requirements about who can administer medication.

Mr PERRETT: A nurse practitioner could administer?

Mr Shepherd: A nurse practitioner can diagnose and prescribe medication and also refer on for further specialist tests.

Mr PERRETT: Do you have nurse practitioners in aged-care homes in Queensland?

Mr Shepherd: They are few and far between.

Mr PERRETT: At Ashleigh?

Ms Reeves: Yes, we do.

Mr PERRETT: On occasion would they have coverage of a couple of sites? Or would it be one site? Can you talk about the practical experience.

Ms Reeves: There are various models. For example, there is a nurse practitioner in New South Wales who has coverage of a number of residential facilities.

Mr PERRETT: Simultaneously?

Ms Coad: Yes, a few; and they work with the GP.

Mr PERRETT: How does that work practically? At 11 o'clock at night, when Mr Smith is in distress, does the UV person, or whoever is on duty, phone the nurse practitioner to get permission? How does it work practically? I'd be interested in that.

Ms Coad: Practically, our members would say to us that there is no-one to call at 11 o'clock at night, except the ambulance.

Mr PERRETT: Even though there is someone on duty?

Ms Coad: If there is someone on duty; there is often not someone on duty.

Mr PERRETT: So practically not? So someone on the books who has responsibility for the care of those people from 11 o'clock until the next morning, or until the shift arrives? But you are saying it would only be the ambulance if something kicked off.

Ms Coad: That's what our members report to us, yes.

Mr Shepherd: Generally the only person on call is the clinical manager or the facility manager of the residential aged-care facility.

Mr PERRETT: The clinical manager?

Mr Shepherd: Yes. Most facilities have a clinical manager and a facility manager. The clinical manager is generally a nurse—

Mr PERRETT: The head of health—is that the way to think about it?

Mr Shepherd: The head of clinical care, yes. And the facility manager manages all aspects of the facility. Our members' experience is that they will call the clinical manager and, if it is an urgent issue to manage and it is a clinical issue, they are often advised to call the ambulance and transfer the resident to hospital for assessment. Or they are advised to give what we call PRM medication, which is medication that is required occasionally to address a particular clinical presentation of a patient or resident.

Mr PERRETT: They can do that diagnosis over the phone according to the symptoms reported by the UV member or—

Mr Shepherd: It depends on who is making the call. An enrolled nurse doesn't have authority to administer PRM medication off their own bat. They have to get that approval from a registered nurse. After they relay all the patient's signs and symptoms to the registered nurse, the registered nurse makes the decision. Sometimes it can be the clinical manager who is on call. Sometimes it can be a registered nurse who is 600 kilometres away from the facility and doesn't know the residents.

Mr PERRETT: And has never treated the resident?

Mr Shepherd: Yes.

Mr PERRETT: And they can still make a diagnosis?

Mr Shepherd: Yes.

Mr PERRETT: It is starting to sound a bit like a tick-and-flick rather than a decision that involves medical considerations, or am I misunderstanding?

Mr Shepherd: Generally the registered nurse will know the enrolled nurse, will know what their skills and experience are and will make—

Mr PERRETT: Because they're supervising their health—

Mr Shepherd: Yes, the registered nurse is supervising that enrolled nurse if there is no registered nurse, particularly on night shift, in the residential facility.

Mr PERRETT: I'm going to ask you an industrial question, I guess, and that is: what are a nurse's responsibilities to their patient versus a nurse's duty as a servant, as an employee, which is, I assume, bread-and-butter for most unions?

Mr Shepherd: Nurses have two masters and they serve two masters. The first master they serve is the Nursing and Midwifery Board of Australia. They have to comply with all the professional requirements under the professional practice framework. The second master, of course, is their employer. But the message we often give our registered nurse and enrolled nurse members is that, if they don't comply with their professional practice framework, there is a risk they won't have an employer, because the Nursing and Midwifery Board and the Health Ombudsman in Queensland have the power to prevent them from working in any healthcare environment.

Mr PERRETT: So you see it as a higher duty?

Mr Shepherd: Yes.

Mr PERRETT: If I speak as a lawyer, I have a duty to the court that—

Mr Shepherd: Yes, and a duty to your client, but the duty to the court overrides that.

Mr PERRETT: Do you have any comment on that, Ms Reeves?

Ms Reeves: Yes. Just building on what Jamie has talked about, it is a very difficult situation that you raise, in the sense that registered nurses and enrolled nurses are regulated by the Nursing and Midwifery Board of Australia, and sometimes they get in situations, from their employer, that are not consistent with their professional obligations. As Jamie referred to, they ring the ANMF for advice, asking: 'How do I manage this situation?' But of course the Nursing and Midwifery Board of Australia's regulation is to keep people safe and keep the public safe, so that is what nurses want to do—they want to keep the public safe, consistent with their value set as well.

Mr PERRETT: This one I might throw to Ms Coad. Particularly for your members, the instrument provides a very broad definition of 'restraint' including 'any practice, device or action that restricts a consumer's free movement'. In your opinion, is this likely to create any practical issues with the provision of care to aged-care residents?

Ms Coad: Look, it certainly could if you've got a facility that is understaffed. For example, someone might be dealing with someone in one room and hear someone else yelling out from another room. They might pop the

rails up on that bed so that that person can't get out and race into the other room to deal with the person who is yelling out. So, technically, that might be considered a restraint, but that person—

Mr PERRETT: But you've made a practical call to keep somebody safe—

Ms Reeves: Yes, or two people safe.

Mr PERRETT: So could that be a defence to what you have done?

Ms Coad: It definitely could cause complications.

Mr PERRETT: Okay. Besides that one thing, are there any other—

Ms Coad: I think there may be other examples. That is the first one that popped into my mind, but there may be other examples I can't think of off the top of my head.

Mr PERRETT: Would the nurses like to comment as well?

Mr Shepherd: I think it might be a defence in an emergency because there might be the need in an emergency to prevent imminent harm to someone or someone else, so you might need to restrain them. I think that the regulation needs to clarify how it defines 'restraint'. In my mind there are two different types of restraint. We heard earlier about environmental restraint, but there are also the mechanical types of restraint that restrict someone's movement from whatever position they are in as well as confining someone to a particular area of the facility. They are very different things.

Mr PERRETT: My mother was a nurse, so my understanding is, from the way practice was in a small country hospital, that you would be going from emergency to emergency, basically. No-one yells out and says, 'Don't come; we don't need you.' It just seems that you to move from room to room. So is an aged-care facility similar to that, where you're moving from crisis to crisis and, especially in terms of night ratios, you might be down to one person looking after an incredible number of people?

Mr Shepherd: Yes, a couple of years ago I assisted a registered nurse on night shift who was the only RN looking after 166 residents.

Mr PERRETT: One hundred and sixty-six?

Mr Shepherd: One hundred and sixty-six residents with six assistants in nursing or carers on duty as well. We had issues around the particular S8, or schedule 8, medications that were required for a patient, and she was seeking just an additional enrolled nurse on night shift to assist her with those medications. The employer was refusing and was stonewalling our assistance to that nurse, but the nurse stuck to her guns and said, 'If that's the case, then you leave me no alternative but to call the ambulance to come and assist me with that process,' and the employer employed an enrolled nurse on night shift.

Mr PERRETT: But, with 160-odd people in your care, you're just crossing your fingers hoping nothing kicks off, I assume.

Ms Reeves: That's right. We recently did a survey of our members, where 2,775 staff responded. I thought a relevant quote here was where the staff member, the nurse, says: 'We have six staff on duty at night for 120 residents, including an RN. We cannot always effectively manage challenging behaviour issues for dementia residents whilst at the same time care for others who have very complex health issues, and receive little or no support from management when things don't go as planned.'

Dr WEBSTER: Ms Reeves, several submissions to this inquiry have raised concerns about the divided loyalty of nursing and medical practitioners working within residential aged-care facilities. Is this an issue in your experience?

Ms Reeves: Thank you for that question. Ideally, nurses and doctors work well together, and it's important for a multidisciplinary team that we do work well together. In many facilities doctors are relying on nurses for that feedback, and nurses are relying on doctors to keep residents safe and keep them in a working environment. Sometimes it can be challenging when there is no access. I've heard doctors say that they walk into a residential facility and they can't find a nurse or a staff member to talk to. I've heard the same from registered nurses and enrolled nurses and carers, saying that they can't access GPs.

Dr WEBSTER: I declare that my husband is a GP and does quite a lot of work in aged-care facilities, so I understand. Ms Coad, does this instrument make the job of aged-care workers easier or does it just make things more complicated?

Ms Coad: I think it potentially makes things more complicated. I refer back to the example that I just spoke about briefly before. I think the other issue is that the direct care staff in residential aged-care facilities do not always have a full understanding of these types of regulations. They're not always trained in what the regulations

are and how things work, so they are not always going to have a thorough understanding of what it means, particularly where there are some areas that might be slightly opaque, where they're not particularly clear, where things are not defined: What is an emergency? What is restraint? These are people that are not trained at a tertiary level and will not necessarily be able to really work out the minutiae of those sorts of regulations, so it could potentially make the work a little more complicated for people. And they're at the front line, so they're at the receiving end of these types of regulations.

Dr WEBSTER: Thank you.

CHAIR: Are there any further questions?

Ms HAMMOND: Could I just pick up on the point made by Ms Coad. I completely understand—anybody needs to be educated and trained, and a lot of work has to be done there, but isn't regulating the practice better than not regulating the practice at all?

Ms Reeves: Regulating it is definitely better than not regulating it, yes, absolutely.

Ms HAMMOND: Thank you.

Senator CHANDLER: That was going to be my first question, so thank you for asking that, Ms Hammond. I did want to ask something, given that we have representatives of the nursing profession here today. Stripping everything back, let's say that the regulations that we are talking about today aren't in place. What are the considerations that your members would have to go through, from a quality-of-care perspective, when they're determining whether or not they are going to use restraints? What is the checklist in their mind of the elements that have to be satisfied before they're going to use restraints?

Mr Shepherd: As I've said before, one of the indications would have to be an imminent risk of serious harm. There should be, and I would expect there would be, a clinical case conference around that resident. We're not talking about an emergency situation; we're talking about someone's repetitive behaviour that is creating challenges.

Senator CHANDLER: Could you explain in layman's terms what a clinical case conference is for me, for us?

Mr Shepherd: Okay. All the relevant clinicians—the nurses, the GP and all the clinicians involved with the care of that patient—get together and have a discussion on the best way forward to manage it. It should also include a discussion about what has already been tried with that patient. We talk about 'diversion, distraction, de-escalation'. All those sorts of things should have been tried before there's even a discussion around restraining someone, but the problem is they don't get the time to do that. They're too busy going from one resident to the next, to the next, to the next. With the example I gave of one RN for 166 patients, you're looking at four minutes per patient per shift. That's why we are really pushing that the best way to minimise restraint is to have the surveillance. If you've got the surveillance by qualified people—and that goes to the assistants in nursing as well. The certificate III and the certificate IV in individual support and in aged care are really critical, but, further to that, there needs to be a lot of training in dementia care—that is, the behavioural and psychological symptoms of dementia and how to divert and distract those symptoms so that you don't get to the point where someone has to be restrained.

Senator CHANDLER: Thank you.

Senator McKIM: Thank you all for your submissions today. Just briefly, I want to ask all of you whether, given that you represent people who work at the coalface in this area, there is any reason why a regulatory regime around physical restraints should be different to a regulatory regime around chemical restraints? That's what this instrument does; it creates two very different regimes. I've asked most witnesses but have not got a sensible answer out of most. I'm just wondering if you can shed some light on it.

Mr Shepherd: To me, if you're going to regulate restraint, you need to regulate every form of restraint and you need to report on every form of restraint. At present, the quality indicators that commenced on 1 July only require the reporting of physical restraint, and even then it's only going to be reported quarterly—once every four months. I think that's just grossly insufficient.

Ms Reeves: I would agree and I think the ANMF would agree that there shouldn't be an inconsistency; there should be consistency between the two restraints. I just wanted to go to the point of the importance of regulation. The ANMF are very supportive of regulation because we know that changes practice, and we need to change practice. So to answer your question: I would say that they should be consistent.

Ms Coad: I would say the same. There's no reason why they shouldn't be consistent.

Senator McKIM: Thanks. I think it was you, Mr Shepherd, in response to a question Senator Chandler asked around what goes through the minds of your members—I'm happy to throw this out to all three witnesses—who

said words to the effect of 'restraint should be used as a last resort'. Firstly, could you to comment on the fact that there is no such requirement proposed in this instrument for the use of chemical restraints? That's the first question, on chemical restraints. Secondly, do you think, as is allowable under this instrument, that people should be able to be administered psychotropic meds that might kill them without giving informed consent?

Mr Shepherd: With regard to the first question, our opening statement talked about how the chief psychiatrist has developed policies and practice guidelines for the use of restraint. I think the instrument that you're inquiring about today should go a little bit further, to stipulate that practice guidelines should be developed by the department and that they should be followed. This is so that you've got some really good clinical practice guidelines about how to, as a last resort, safely engage restraint. It should also include the reporting of it, who should be authorising the restraint and who is required to consent to the restraint. It should cover all those issues, and the documents I provided today will explain that further.

With regard to psychotropic medication, our members would say that psychotropic medication should not be prescribed unless there's a clinical need for it—that is, the presence of a mental illness or a mental disorder, and that includes neurocognitive disorders that we used to call 'dementia'. There has to be proven, demonstrable clinical need to prescribe that psychotropic medication.

Senator McKIM: In other words, you're saying it should not be prescribed solely for the purpose of restraint?

Mr Shepherd: That's what I'm saying, yes. A better way to manage that is having actual staff there to care for the person, and to ensure that all of those—in the chief psychiatrist guidelines, when someone's restrained, they have to have one-to-one care for the entire time that they're restrained. That never happens in aged care.

CHAIR interjecting—

Senator McKIM: Chair, I just want to give the other two witnesses the opportunity, if they wish, to respond.

Ms Reeves: I would just add to Jamie's discussion about informed consent: I think that the regulations could be enhanced with regard to informed consent.

Ms Coad: I would agree with both of my colleagues' comments.

Senator McKIM: Thank you. Thanks, Chair.

CHAIR: I would just note that the documents provided are publicly available, so we'll treat them as information for the committee rather than as tabled documents. I take this opportunity to thank you for appearing before the committee, and for the giving of your time this afternoon. Thank you.

EGGERT, Dr Marlene, Senior Policy Officer, Leading Aged Services Australia

HICKS, Mr Tim, General Manager, Policy and Advocacy, Leading Aged Services Australia

[14:03]

CHAIR: I now welcome representatives from Leading Aged Services Australia. I understand that information on parliamentary privilege and the protection of witnesses and evidence has been provided to you. Is that correct?

Mr Hicks: That is correct.

CHAIR: I now invite you to make a brief opening statement, and at the conclusion of your remarks I'll invite members of the committee to ask questions. Alternatively, to maximise the time available for the committee to ask questions, and in lieu of reading an opening statement, you may wish to instead provide a hard copy of your opening statement to the committee. Do you wish to make an opening statement?

Mr Hicks: Yes.

CHAIR: Please proceed, Mr Hicks.

Mr Hicks: Thank you, and thank you for the opportunity to participate in this hearing. I'll make some very brief remarks. I'll talk to some of the more general issues facing the industry, and Marlene, my colleague, who is a registered nurse with a mental health background, will speak to some of the specific issues in clinical practice use of restraints. LASA fundamentally believes that it's the responsibility of aged-care providers and their staff [inaudible] medical practitioners and allied health professionals to minimise the use of restraints in a residential aged-care setting and to aspire to a restraint-free environment. LASA stresses that any use of physical and chemical restraint must be part of a broader approach to care and behaviour management, and this could include the family and friends of residents [inaudible]. A key focus in any [inaudible] to reduce use of restraints should be research and education on—

CHAIR: We're having difficulty hearing you. Are you on speakerphone?

Mr Hicks: We are, yes. As there are two of us, we're on speakerphone. Is this any better?

CHAIR: Slightly better, I think.

Mr Hicks: Let me know. I'll try to speak up a little bit. I'm right next to the phone.

CHAIR: That's better.

Mr Hicks: Let me know if there are any other problems with the audio. Just to reiterate that very briefly, we believe that it's the responsibility of providers and their staff to minimise restraints and to aspire to a restraint-free environment. We stress that any use of physical or chemical restraint must be part of a broader approach to care and behaviour management and should include families and friends, as appropriate. A key focus on any use of restraints should be actually on an effort to put in place alternative measures, including research and education. I briefly note that, in Australia, the use of restraints is regulated in a range of ways, including through the professional standards for nurses and other medical practitioners, and these special standards are themselves built through the Human Rights Foundation. The use of restraints is also regulated through the aged-care standards themselves. The guidance in the standards mentions the minimisation of restraints in a number of different places. The Charter Of Aged Care Rights also goes to the importance of individuals maintaining their [inaudible] care. We acknowledge that these principles are not always being followed and we wouldn't make any excuses for that. However, we would say that improving or minimising the use of restraints needs to focus on providing better evidence and better education and better resources [inaudible] that, to put in place alternative measures. Notwithstanding that, we also note that, if we look at the comparison on the use of psychotropic drugs across the OECD, Australia actually ranks very close to the bottom in that comparison, along with [inaudible] Scandinavian countries [inaudible]. Roughly 33.7 cases per 1,000 people over the age of 65 [inaudible] 2016 compared to the OECD average of 47.8 [inaudible] doesn't detract at all from the many cases that we've seen where restraints probably could have been avoided and it doesn't detract from the need [inaudible] endeavour, but it does give us a starting point for our conversation [inaudible]. Thank you.

CHAIR: Ms Eggert, do you wish to make some statements?

Dr Eggert: No, I'm happy to respond to questions.

CHAIR: Dr Webster, do you have any questions?

Dr WEBSTER: In a submission to this inquiry, the Aged Care Industry Association argued that some medical treatment may fall under the definition of 'restraint', as set out in the instrument, and that it is inappropriate for a person claiming to represent a resident to give or withhold consent to medical treatment. Do you agree with the ACIA's concerns?

Dr Eggert: I'm unclear—what is the issue about representing the person?

Dr WEBSTER: I think it has to do with consent, with people actually claiming to represent a resident giving or withholding consent. Is it inappropriate for someone else to do that?

Dr Eggert: Actually, the state based laws will come in here when somebody needs to have legal authority to make decisions for the person if the person is unable to make that decision. In New South Wales it would be an enduring guardian. In some states you would have to specify whether the representative can make decisions about restraint. So it would be a state-by-state scenario, but providers would have to make sure that, if they have a substitute decision-maker, this decision-maker has the legal authority.

Senator CHANDLER: I don't have pinpoint references for paragraphs, but in LASA's submission under the heading 'Educational approaches important to changing practices', you have referenced the report *Decision-making tool: supporting a restraint free environment in residential care*. I note that you have footnoted a reference to that, so by all means don't reel off exactly what the website says. At a high level could you perhaps walk us through how that decision-making tool works and what principles underpin it?

Dr Eggert: I think the principle that underpins it is that any one person with cognitive decline is different from the next, so it's very important to take a personalised approach and build on a thorough assessment and a continuing assessment. It's also very important to have the life story of people because this can help explain some behaviours. For example, if somebody worked a lot of night-time work then that might inform people as to why this person does not sleep at night-time, and really the best approach to manage that may be to give that person activities to do. The next important factor is the comfort factor, basic things like: Is that person well hydrated? May they be hungry? May they be in pain? May they be constipated? Could there be an infection that is causing them discomfort? It's basically trying to read a person when the person is unable to tell you what discomfort is unsettling them.

Senator CHANDLER: You continue in that paragraph to say:

The Decision-Making Tool also comments that the application of restraint, for any reason, is an imposition on an individual's rights and dignity and, in some cases, may subject the person to an increased risk of physical and/or psychological harm.

Do your employees in your member organisations understand this and do they understand that physical or chemical restraints are a means of last resort?

Dr Eggert: Well, that is part of the legislation, and, of course, the guidelines that were issued by the Department of Health, which you just referred to, were issued in 2012, so they have now been around for quite a long time. I think that is well acknowledged, but how every provider judges 'last resort' I suppose can vary from situation to situation. Of course, the issue is that the person with the cognitive decline lives in a community with other people, so there is the need to weigh up the rights of the other people in the community to live free from violence or fear or disturbance. There is the worker's right to work in a safe working environment, and that is balanced against the rights of the person to live free from restraint as far as possible.

Senator CHANDLER: Thank you, Dr Eggert. That wasn't a trick question. You answered it just as I hoped that you would.

Ms HAMMOND: My call went very dodgy at the beginning, and both of you might have addressed this, but what is your position on the regulation as it stands? Is it helpful? Is it not helpful? If it's not helpful, could it be resuscitated, if you like, or changed to make it helpful?

Dr Eggert: I was closely involved in the consultation process, and I can speak for LASA. We were really disappointed that the consultation process was cut so short. There was not even an exposure draft for people to look at. This is a really important issue. As I pointed out in my previous answer, it affects many people and cuts across many different rights and jurisdictions. I think a good, deep reflection, with all stakeholders involved, would have been terrific. There is an additional problem with the legislation—that it does not address PRN chemical restraint drugs. Again, it would have been terrific to get it clarified for providers how that situation works. At the moment, the legislation as it stands is silent on that.

Mr Hicks: If I could just add to that, I think what the regulation has done is that it has provided an opportunity for providers and their staff to focus their attention on this issue. I think it largely sets out what—

CHAIR: It's not clear. Could you speak into the phone?

Mr Hicks: Sorry; let me try again. I'd just add to Marlene's comments that the legislation has focused the attention of the industry on this issue. It's articulated, for instance, what was previously, I think, broadly accepted and agreed, but it has provided a bit more of a framework both to providers and to regulators. I think that that is a positive.

CHAIR: Are there any further questions? There being none, I thank you very much for appearing before the committee today and for giving your time today.

Mr Hicks: Thank you.

Dr Eggert: Thank you.

MITCHELL, Mr William (Bill), Member, National Association of Community Legal Centres

ROWE, Mr Geoff, Chief Executive Officer, Aged and Disability Advocacy Australia

Evidence from Mr Mitchell was taken via teleconference—

[14:20]

CHAIR: Welcome. I understand that information on parliamentary privilege and the protection of witnesses and evidence has been provided to you.

Mr Rowe: It has.

CHAIR: Is there anything you would like to add to the capacity in which you appear today?

Mr Mitchell: I'm the principal solicitor of Townsville Community Legal Service, but I appear today on behalf the National Association of Community Legal Centres.

CHAIR: I now invite you both to make brief opening statements, and at the conclusion of your remarks I will invite members of the committee to ask questions. Alternatively, to maximise the time available for the committee to ask questions and in lieu of reading an opening statement, you may choose to instead provide a hard copy of your opening statement to the committee. We will begin with you, Mr Rowe. Do you wish to make an opening statement?

Mr Rowe: Yes I do, thank you. Thank you, committee, for the opportunity to meet with you today. ADA Australia has submitted a submission to the committee dated 6 August, and I'll take it as read rather than repeating what's in that. Essentially, the message I want to give to the committee today is that it is our belief that the new principles breach Australia's human rights obligations and allow abuse of our most vulnerable older people in our community, and, as such, it should be withdrawn and government should develop a rights based approach to restrictive practices.

In my opening address I want to bring three different perspectives. One is the perspective of an advocate. In our world, the role of an advocate is to bring the voice of the consumer to the aged-care provider, to government and to the system. As a Churchill Fellow, I have recently returned from a six-week Churchill Fellowship study tour, travelling across the world and looking at elder abuse in aged care and the community, although I have not reflected any of that in the submission. Also, I am a former manager, having worked in disability services during the introduction of the restrictive practices legislation in Queensland.

As an advocate, we are continually hearing from families and from the older people that we support that they are very concerned regarding the use of restrictive practices, particularly chemical restraint, within aged care. They are not informed about the use of chemical restraint, they are not consulted, and the impact of the use of chemical restraint is deeply troubling. That's been outlined in the submission. I probably should, as I did when I appeared before the royal commission less than two weeks ago, make a very clear statement that often in these forums we portray aged care as being 'mad' and 'bad'. As advocates, we see probably less than one per cent of aged-care users in Queensland. Does that mean 99 per cent are happy? No. We only see one per cent because those are the resources that we have. We do know that many aged-care users have very good experiences and very positive experiences, but we hear the experiences of people whose experiences don't fall into that positive category.

We've also this year partnered with Human Rights Watch. In particular, their New York research is looking at the use of chemical restraint within Australia and looking at the consumer experience, and we're hopeful that that report might be available in October of this year. As a Churchill Fellow, my simple observation is that, when I look at aged care in Australia, I see an absence of human rights. I often talk about older people being required to check in their rights when they check into aged care. And that is not right.

As a former worker in disability land, when I started in 2010 in probably one of the country's largest disability providers, we identified 750-plus clients who were subject to restrictive practices. To the credit of the organisation I was working for, their role or their aim was to remove the use of restrictive practices rather than complying with the legislation. By the time I left after five years, that number was down to 104 people who were subject to restrictive practices. It was about people having their medications reviewed, it was about having staff trained to deal with challenging behaviour and it was about restrictive practices being the last resort and not the first resort. It can be done. It should be done.

I would implore you as a committee to look at the legislation that we have before us and to see it for what it is—a bold attempt to very quickly protect older people. What it has done, in my view, is to leave it really wide open so it is far easier for service providers, and particularly service providers who are under pressure, to opt for restrictive practices as a first resort rather than as a last resort.

CHAIR: Mr Mitchell, do you wish to make an opening statement?

Mr Mitchell: Just a very brief one, Chair. The national association has serious concerns about the use of restrictive practices or restraints in aged-care settings. We see it as a nationally important human rights issue and, in our view, the principles are not compatible with our obligations at international law. We have set out why we believe that to be the case in our written submission. We think that the existing framework has both an inadequate and unenforceable accountability mechanism where there are problems with the use of the principle. We think that older persons themselves have very limited rights, remedies and redress where there are breaches of their rights or breaches of the principles. We think that the principles themselves and the accountability mechanisms that come behind them, including the Aged Care Act, the charter and the quality standards, are poorly framed and do not provide an adequate benchmark. They do not comply with normative standards at international law that have been expected of us for at least the last decade.

We also think that these principles are inconsistent with each other, are ambiguous in parts and lack specificity on a number of keenly important areas, including those areas that might give rise to the use of broad discretion within the sector. So in some ways we see that the principles not only fail the basic test of complying with our international law obligations but may well make the situation worse and may legitimise the longstanding poor use of restraint. They may legitimise rolling use of restraints in individual circumstances without any proper accountability.

Mr PERRETT: Further to your answer, Mr Mitchell, your submission argues that the Aged Care Act and the instrument are founded on the consumer protection model and that this is a fundamentally flawed method of protecting older Australians from serious human rights breaches. Could you tell us a bit more about this?

Mr Mitchell: It's a longstanding submission that we have made that the Aged Care Act and all of its associated provisions, including those that seek to provide protections to older persons, are framed within a consumer protection framework. That is inherent in its language and in the way its mechanisms are framed and drafted within legislation. We say that a human rights approach is the only appropriate approach, particularly given the examples we have seen in the media, in the royal commission and in almost daily commentary. We suggest that a human rights framework would give you an approach that deals best with the sorts of issues that these restraints seek to address. It's simply the case that older people who are subject to restraints in aged care are not buying motor vehicles. They're not engaging in a consumer process that needs laws to level the playing field. They are being treated in such a way that they need serious human rights protections. The consequences of these restraints can be various harms, and in fact they can lead to death. When you put all of that into perspective, we say a consumer protection framework is simply inadequate to protect older people.

Dr WEBSTER: So what you're saying is that older people in residential care are not, effectively, buying a service?

Mr Mitchell: No. What I'm saying is that they are not effectively protected by the rights framework. They are of course engaging in a market mechanism; this is what has led to the use of the consumer protection framework, because of that engagement in market mechanisms to so-called buy, purchase care or purchase arrangements. However, the rights issues they face within care simply don't align properly with a consumer protection framework. They align perfectly with human rights issues that we have signed obligations on, including things such as the use of cruel and inhumane treatments and protecting people from violence and abuse. The range of human rights obligations we have not just under the Convention on the Rights of Persons with Disabilities but under a range of those [inaudible] are far better aligned with the sorts of protections older people need. Again, I don't want to make it sound like every older person will have a need of every one of these protections; they won't. But those that face serious issues in terms of neglect and breach of their care are facing critically serious issues, and all of the examples that have surfaced through the media, commentary and the commission have shown us that we need a very serious framework to deal with those issues.

Mr PERRETT: Especially in the context of earlier evidence we had that about one in four people in these facilities would have some diminished capacity because of medication, and two in five of them would have no outside influence in their life in terms of people being there to advocate about their consumer choices, if we go back to the model you're comparing it with. So I see your point. My question is actually to Mr Rowe, going back to the reason for this inquiry: do you think this reg will actually facilitate people not complying, being able to do more shonky behaviour?

Mr Rowe: It legitimises behaviour that occurs currently. I guess one of my fears is that it says to the broader community that this issue is sorted, and this issue is not sorted. Let's look at the recent activities at Earle Haven on the Gold Coast. That was the facility where the managers walked out. Evidence at the royal commission two weeks ago was that the department, in their audit two weeks before that closure, identified that 71 per cent of the

residents of that facility were subject to chemical restraint at that time, and 50 per cent to physical restraint. We've heard other figures bandied around which are much lower, but I think that's probably the reality of the use—and it's certainly the feedback we get—because it's the first option. Think about it logically. I'll use my mother as an example. My dad is 91. He's a primary carer for my mother, who is 88, and she has dementia. If dad falls over tomorrow and mum's required to go into aged care, she's going to be distraught. Her partner of 70 years is suddenly not there. She's a person with dementia. She's in a new environment, and it's all strange. I can see that what would happen to mum is that immediately they would go for the drug cabinet, rather than saying, 'What support do you need to make that adjustment?'

Several major life traumas have happened all at once: you've moved out of your home of many years, you've lost your partner of many years, you've moved into a strange environment. They're all major life changes.

Mr PERRETT: All stressful.

Mr Rowe: What we do know about people moving into aged care in Australia is that generally it happens at a time of crisis. We don't plan for our aged care. At a conference a couple of years back I heard the statement, 'We all want to have a long life, but none of us want to get old,' and I think that really says it. We don't plan for our old age. We don't plan for that transition to aged care. So there is going to be some adjustment required, and people need to be supported through that adjustment process, not medicated to manage that. You've spent the day here and I haven't, but the bits I've heard—you've heard about the staffing issues. We've seen stuff in the royal commission. This is not a silver bullet; this is a very troubling bullet, and I think we need to get it right.

Absolutely: there will always be a place for restrictive practices, but we need to get it right. I think we can look to the disability model as an area that's been operating for eight to 10-plus years and has worked well. Picking up Bill's point before, disability legislation is written from a rights basis. The Commonwealth Disability Services Act 1986 established that people with a disability have a human right. The Australian Aged Care Act 1997 does not talk about rights, and we still don't talk about rights.

Mr PERRETT: My final question is to Mr Mitchell. Mr Mitchell, with your Queensland hat and your national hat on, what is your understanding of the requirements for consent before chemical restraints are prescribed under the regulations?

Mr Mitchell: I think one of the real problems we have with this legislation, these principles, is that the first thing they do is presume that every restraint has a medical or a clinical basis. That's the first thing we'd say. Just because you include this in someone's clinical care plan does not necessarily make it a treatment which is medical or clinical.

Mr PERRETT: Could you lean into the mic again, please.

Mr Mitchell: Sorry, I'm saying that just because we say that care is clinical care or medical care doesn't make it so, and many of the practices that are used, including chemical restraints, are used for reasons other than medical treatment. So, for me, the issue of informed consent to medical treatment is actually a bit of a red herring because it presumes that all the things that are happening to people are actually medical treatment, when in fact they're not. That's the first problem.

The second problem is that the requirement for consent is inconsistent as between the two tests. We are also especially concerned about the problems that people face by allowing a third party to provide consent for another. I think it's questionable whether families or anyone else other than statutory power holders should be able to give consent to these sorts of things, and in the absence, as far as we can tell, of any real controls in that regard. It seems to supplant a decision-making process that has far less rigour than we have at state or federal disability level. It seems to ignore all of the good principles of moving from substitution to supported decision-making and it seems to ignore a bunch of other obligations. So, for us, the test for consent is just one part of a far bigger problem. In fact these things don't all fall neatly within medical treatment, and nor does the test really have the desired effect. For us, so many parts of these principles lack clarity and specificity that we think there's a very wide discretion given here to make a basic attempt at getting consent and then using whatever consent you got from a third party forevermore—and that concerns us—with no obligation for systemic review. The provider wouldn't have even known if that decision-maker had stopped being the representative. So we say there are so many problems with that particular process that it's flawed from the outset.

Senator CHANDLER: I only have one question today and it is drawing upon some of the things, Mr Rowe, that you raised in your submission just then as they relate to previous submissions we have heard today from professional bodies for medical practitioners and nurses. I just want to understand what your perspective on this actually is. We heard from these professional bodies that they understand that use of restraints is intended to be a last resort. I must say I am not a medical expert but I understand there are a lot of standards or industry better

practice guides, not to mention the various regulatory functions, that these professional bodies have to ensure that doctors, nurses and medical practitioners maintain a certain standard of care and understand the principles that we are talking about. So, when you referenced a worker in an aged-care facility immediately going for the drug cabinet, were you saying that was not because they didn't understand how aged care should operate holistically but more out of necessity—a lack of resources, a lack of training, that sort of thing?

Mr Rowe: I think it is a good question. It is multiple. I think it certainly is lack of training. I think it is a cultural issue that we are seeing. Associated with a lack of training is a lack of other options in your toolbox. Certainly one of the things that we found in disability when we transitioned in was that we had to come up with a whole range of other skill sets for our staff so that they knew how to manage people with challenging behaviour.

I would like to make a comment. One of the hats I wear is I am on a couple of the committees of the Medical Board of Australia that look at complaints about doctors, so I probably have a perverted view of aged care and a perverted view of doctors courtesy of that. While we all like to think that the medical profession, and I will extend it out beyond doctors, is going to do the right thing by consumers, we do see time and time again that it doesn't.

Again, if I can reference my mother, when I took her to see her geriatrician recently, about 10 minutes into the consultation, he asked what I did, I suppose because of the comments I was making. He spent the next 20 to 25 minutes downloading at the poor behaviour that he saw from GPs. He quoted that, in one facility that he visits and spends the day, he watched a GP come in, spend an hour there, not see anyone, bill Medicare for 47 patient consultations and leave. He talked about spending a day in the facility coming up with care plans to manage people's behaviours, and they were ignored by staff and they were ignored by the GPs. So I think we absolutely need legislation. We need strong legislation that is going to protect older people and is also going to make it really clear about when it is appropriate to use restrictive practices. In respect of the geriatrician discussion, I was encouraging him to put a submission into the royal commission and I believe he has.

It is complex. I feel for the staff on the shop floor. I think there are a lot of people out there doing absolutely their best, but we also see a lot of agency staff. The feedback that we get from older people time and time again is that the relationships that used to happen within aged care don't happen anymore; it is a new person each time they are getting to know. We are going to come up with a plan to deal with Geoff's behaviour because he is a grumpy old bugger. When you have got a new person in each time, they've got no hope of controlling me. But if you have got some consistency, absolutely there is—so, yes, more tools in the toolbox.

Senator CHANDLER: The reason I asked the question is that we were talking a lot today about where the consideration of the human rights of a person living in aged-care facility comes into play. Is it right at the end of the process, when we are talking about the principles that we are discussing today and whether or not restraint is meant to be used?

We've had some submissions saying that it's not appropriately considered at that point, but I'm trying to determine what checkpoints there are along the way for that consideration to be made. Subsidiary to that query is, if we accept that the human rights of a person in an aged-care facility are considered holistically throughout the care process, is it being appropriately resourced at point A so that we don't have to get to point X, Y or Z, where we might be using restraints? Thank you for your insight there.

Mr Rowe: Thank you. A statement I've heard recently made is that we've commodified people. I think Earle Haven was a perfect example of this. It was like staff walking out of a nursery, thinking they're not people. I think it's problematic.

Dr WEBSTER: Mr Rowe, in your submission you expressed concern about the divided loyalty that exists for medical and nurse practitioners working in residential aged-care facilities, and that many residents do not trust their GPs, which I think you've just addressed. Could you explain it further, however, and how it could be taken into account through regulation?

Mr Rowe: I don't know that I know the answer to your question, but I'll try to explain. When people move into residential aged care—and some of it's about the pressure on aged care—they often have to move from their community, particularly when we are talking about people who live in rural and remote communities that don't have aged-care facilities. The relationships they have with their GP—they've had to leave them behind or they've moved to other suburbs. As you've heard from other witnesses today, often a residential aged-care facility will have one GP, or a number of GPs, that is that person's GP. My concern is that they don't get to know the older person. The visits are often short. I've just given a very extreme example of a doctor's visit that was non-engaging, but a lot of them are under the pump. They don't get to know and they will take the advice of staff regarding what the issues are for the person. And there is also that disconnect with the family. Again, who is the person that

knows the older person the most? It's potentially someone who does a shift in their wing a couple of times a week or several times a week. The disconnect continues to happen.

Dr WEBSTER: How can this regulation address that?

Mr Rowe: What I believe we need to do when looking at regulation is go back to the drawing board. I'm harking back to disability, but I know that at times it has been the same issue, particularly where people with a disability have been supported in residential aged care. The same medical issues have happened. I was at a meeting in Canberra last week with a senior member of the Department of Health who was looking at trying to encourage the use of GPs with a specialisation in geriatrics. Maybe it's about looking at what type of GPs we start getting working in the facility, so that an older person with complex needs is not one in a case load of 50 and the practitioner is far more comfortable, I suppose, with the issues that are confronting the older person.

Dr WEBSTER: Thank you.

Senator McKIM: Mr Rowe, you said that you think the instrument should be withdrawn. If it's not withdrawn, and proceeded with in its current form, do you think that parliament should allow it or disallow it?

Mr Rowe: I'm not a lawyer, but—

Senator McKIM: It will either go through parliament or it won't. Would you like to see it go through parliament in its current form or not?

Mr Rowe: Probably not. I said in the submission that I think it should be withdrawn, and that's based on the advice of some of my team.

Senator McKIM: Thanks. Mr Mitchell, you've been quite scathing—and fair enough, too, in my view—in your conclusion, but I put the same question to you: do you think parliament should allow or disallow this instrument in its current form?

Mr Mitchell: It's our view it should be disallowed.

Senator McKIM: Thank you. Mr Rowe, I wanted to ask you, because you've got significant experience in—I think 'disability land' was the way you described it. Sorry, I can see you wincing there; I'm probably sharing your wince, but I've said it now as well. Let's say working in the disability care sector. Given that experience, can you see any reason why the regulation of physical restraint should be different to that for chemical restraint, particularly in the context of this instrument, where the tests around the use of chemical restraint are much lower than the bar that's set around physical restraint?

Mr Rowe: I think the use of any type of restrictive practice should be treated the same.

Senator McKIM: Would that include requiring that consent be given prior to the use of chemical restraint?

Mr Rowe: Yes, I would say prior to the use of chemical restraint—that would be my view. Of course, there is the issue of urgent and critical, but, again, I struggle with that. I think there is little reason why a matter is so urgent that someone requires us to go in through the back door.

Senator McKIM: Mr Mitchell, you've submitted at length around the need to apply a rights based approach, as opposed to a consumer based approach, to regulation in this area. What would be some of the dangers or risks, in your opinion, of continuing down the path of a consumer based approach as opposed to a rights based approach?

Mr Mitchell: I think the principal problem we have with the system as it stands now is that if there were a breach of principle there would not be any properly enforceable right of complaint by an older person. There would be a right to make a complaint under the Quality of Care Principles or the aged care charter, but this is essentially a dispute resolution process. There are, of course, some abilities to make systemic sanctions at times, but we've seen time and time again that these things come far too late. The Earle Haven example typifies that, but it's not the only one. We saw the same thing at Oakden. In our view, the principal issue we face is that the model built to manage our obligations in international law is not fit for purpose, and so we do need to start from scratch and ask what human rights we are expected to protect in these institutions and how we can best protect them, rather than using an approach that's based on a market model if the market can't adequately protect human rights. It may do well in protecting consumer rights, but, if you look at consumer rights, people don't even have access to consumer rights as we know them under the Australian Consumer Law. It's the second-best model.

CHAIR: I thank you both for appearing before the committee and for giving your time today.

GEAR, Mr Craig, Chief Executive Officer, Older Persons Advocacy Network

HOLLYWOOD, Ms Romola, Director, Policy and Advocacy, People with Disability Australia

STOKES, Dr Kaele, Executive Director, Advocacy and Research, Dementia Australia

Evidence from Mr Gear and Dr Stokes was taken via teleconference—

[14:58]

CHAIR: Welcome. I understand that information on parliamentary privilege and the protection of witnesses and evidence has been provided to you. Is that correct?

Ms Hollywood: Yes.

Mr Gear: Yes.

Dr Stokes: Yes.

CHAIR: I now invite each of you to make a brief opening statement. At the conclusion of your remarks I invite members of the committee to ask questions. Alternatively, to maximise the time available for the committee to ask questions and in lieu of reading an opening statement, you may choose to instead provide a hard copy of your opening statement to the committee.

Ms Hollywood: I will just make a short opening statement if that's okay. First of all I acknowledge that we're meeting on the land of the Gadigal people of the Eora nation and pay my respects to elders past and present and to any Aboriginal and Torres Strait Islander people who are here today. I thank members of the committee for the invitation for us to give evidence here. People with Disability Australia is a leading disability rights and advocacy representative organisation of and for all people with disability. We are the only national cross-disability organisation. We represent the interests of people with all kinds of disabilities. We are a New South Wales and national peak organisation and also a founding member of Disabled People's Organisations (DPO) Australia, Women With Disabilities Australia, First Peoples Disability Network and National Ethnic Disability Alliance. Disabled people's organisations are organisations led and constituted for and by people with disability. Our purpose is to promote, protect and advance the human rights and freedoms of people with disability in Australia.

I'm representing People with Disability Australia here today because we hold grave concerns about the Quality of Care Amendment (Minimising the Use of Restraints) Principles 2019. We do not believe that the approach contained within the amendment protects the rights of people using aged-care services. In fact we concur with and support the analysis that has been put forward by other submitters that these provisions represent and will lead to continuing and ongoing breaches of human rights in the aged-care sector. In making this submission as a disabled-people's organisation and as a disability representative organisation I draw the committee's attention to the fact that nearly half of older Australians identify as having a disability. Further, the Australian Bureau of Statistics in 2015 identified that nearly all people living in aged care or using aged-care services have some form of disability. When we are talking about this issue we are talking about a clear majority of people that have disability.

We are concerned the amendment to minimise the use of restraints has not given sufficient regard to Australia's human rights obligations under a range of covenants and conventions, in particular the Convention on the Rights of Persons with Disabilities. From an overarching perspective we are deeply concerned that this amendment does not seek to eliminate the use of restraints and in fact allows substitute decision-making rather than providing supportive decision-making processes that will seek the consent of the person who may be subject to the restraint. In the recently released *Australian civil society shadow report to the United Nations Committee on the Rights of Persons with Disabilities: UN CRPD review 2019* disabled-people's organisations, disability representative organisations and disability advocacy organisations have called for Australia to, amongst other things:

- establish a nationally, consistent framework for the protection of people with disability from behaviour modification and the elimination of restrictive practices across a broad range of settings;

I submit to members that this would include aged care. We believe that this wider approach needs to be implemented as a matter of urgency. e also note for the committee's consideration that this instrument does not align well with the approaches that are being developed within the NDIS through the Quality and Safeguards Commission, which, whilst not perfect, is aiming and moving towards strengthening practice that will reduce and eventually eliminate the use of restraints and restrictive practices.

As has been identified by other organisations, we believe that there are insufficient safeguards and protections for people who may be the subject of restraints, both physical and chemical, and we are recommending that the amendment needs to be urgently and thoroughly reviewed so that we do not see the human rights of older

Australians systemically breached. And we note that the majority of people living in aged care have disability and so must be afforded the full protections under the Convention on the Rights of Persons with Disabilities. Thank you.

CHAIR: Mr Gear, do you have an opening statement?

Mr Gear: OPAN, through its nine members, implements the National Aged Care Advocacy Program. Last year we saw 13½ thousand people and provided individual support to help people exercise and uphold their rights. The charter of rights talks about high-quality and safe care and people being able to live free of abuse and neglect. While the amendment does provide a definition of 'restraint', we don't think it goes far enough to actually minimise restraints and, as it stands, it will breach human rights obligations. Restrictive practices without informed consent and appropriate independent authorisation should really be prohibited. Where it does need to be used, it needs independent authorisation and tight controls to be in place. Unlike aged care, the disability sector and the mental health sector have much tighter controls than those outlined in the current amendment and are subject to much greater regulation and monitoring.

Some of our concerns and suggestions include that there needs to be a high authorisation threshold and that threshold needs to be external to the prescriber or the service provider. There is currently a lack of compulsion in the amendment to adhere to consistent policies and procedures and, while the explanatory memorandum does mention frameworks for the reduction of restrictive practices, there's no compulsion to follow those. Of great concern is that there's no concordance between the two forms of restraints that are mentioned—chemical and physical restraints—in relation to consent. We believe that, while there might be considerations of the prescriber's responsibility versus the administrator's responsibility, confirmation of consent is absolutely vital and it should be a prerequisite before implementation of any restrictive practices. There continues to be a lack of controls around time frames surrounding chemical restraints, and it really should be mandatory for this to be reported as part of the clinical indicators. Really, the use of chemical restraint or physical restraint in an emergency should be the absolute exception. OPAN would uphold that that should be considered a critical incident and should be reported through the Serious Incident Response Scheme, which is currently under development by the Australian Commission on Safety and Quality in Health Care and the Department of Health.

The amendment as it stands says that chemical restraint can be used indefinitely and does not compel authorisation to be given to use this restrictive practice for a time-limited period. The allowance for administration of chemical restraint in an emergency without consent and notification if practical is of great concern. Notification should not be about informing; it should be mandatory before use. There's a lack of emphasis in the amendment on compelling the use of alternative practices of restraint prior to use of or authorisation of or seeking to have authorisation of these restrictive practices. It should be that skilled behavioural assessment and documentation prior to authorisation is a prerequisite and must be checked before a restrictive practice is authorised.

Finally, we see that there is a need to increase individual advocacy and support to older people who are particularly in a vulnerable place when they are being implemented physical or chemical restraints. We need greater access to advocacy for individual support to allow that to happen. Finally, we would like to see the amendment reviewed—and, alongside our colleagues, we think this needs to occur urgently—and the consideration of independent authorisation processes, as occurs in mental health and disability.

CHAIR: Dr Stokes?

Dr Stokes: I will probably echo some of the points that my colleagues have already made. Dementia Australia, to set some context, is the peak advocacy organisation for people with dementia here in Australia, and we represent people of all ages, with all forms of dementia, as well as their families and carers. We work with a wide range of individuals and their families and also with members of the community to ensure that the voices of people living with dementia and of their families and carers are elevated in all levels of policy and operation. We also run a range of early direct services, including the National Dementia Helpline, and a range of early intervention programs, and we work quite extensively with the sector through our Centre for Dementia Learning, which is the education arm of the organisation. Finally, as I mentioned, we are the peak body for dementia, so we do have a range of advocates—that is, people who have a lived experience of dementia and who are interested in elevating their voices and sharing their experiences—across the country.

With that, we do have some fairly significant concerns around the implications of the quality of care amendment, although we didn't have the opportunity to make a formal submission prior to this hearing. That is mainly because, at the current time, there are an estimated 447,000 people living with dementia in Australia, and we know that, without a significant medical breakthrough, there will be over one million people living with dementia by 2056. In that, around half of people living in residential aged care will have a diagnosis of dementia,

so the issue of chemical and physical restraint is particularly important for the people that we represent. We do have multiple stories, from multiple sources, around the significant impacts of the use of physical and chemical restraints in residential care. We don't feel that the legislation as it's worded sufficiently challenges or prevents the sorts of stories that we hear about from people living with dementia and from their families and carers all the time.

To echo some of the points that my colleagues have already made: the legislation in no way really combats the overuse of antipsychotics as a form of chemical restraint, and the lack of informed consent in relation to chemical restraint is of significant concern to us. It also doesn't combat confusion over the roles and responsibilities of providers and prescribers, consumers, family members and formal advocates in determining whether a form of restraint is in fact a last resort. I think there's no real mechanism in the legislation that enforces that last resort approach.

There's also a lack of tangible links to quality and compliance mechanisms, including mandatory reporting schemes such as that which my colleague from OPAN has just referenced. It certainly doesn't seem to draw on other forms of legislation or comparable legislation with more rigorous safeguards. So those would be the key points that we would like to draw attention to at this stage.

CHAIR: I will now move on to questions, starting with the deputy chair.

Mr PERRETT: My first question is to you, Dr Stokes. I will continue on those horrible statistics you gave. I think we had earlier evidence today that dementia was not actually in the DSM-5 or whatever number the DSM is up to. Is that right?

Dr Stokes: It's referred to as minor and major neurocognitive disorder. I think that is the latest terminology for it.

Mr PERRETT: Okay. To further unpack dementia: obviously there is not one type of dementia. What else can you tell us about the ranges of dementia and therefore the ranges of responses in terms of, in particular, chemical restraints? I'm not as worried about the physical restraints.

Dr Stokes: Dementia really refers to a disease process. There are a number of different diseases. I think that, at the last count, there were over 100 different types of dementia. There are diseases that cause a gradual cognitive decline, and that is referred to collectively as dementia. So there are a number of diseases. The most common form of dementia is still Alzheimer's disease, but there a range of other diseases, including frontotemporal dementia and primary progressive aphasia. A lot of people tend to assume that dementia is a memory disorder where people lose their memory, but it actually can impair a whole range of different cognitive functions, including physiospatial skills and their ability to interpret particular behaviours. It might lead to disinhibitions. There are a range of different impacts that aren't just related to memory.

I'm sure you've already heard from Professor Breen earlier today about the overuse of chemical restraints. Effectively, as to the range of antipsychotics, benzodiazepines and antidepressants that are used in people living with a cognitive impairment, there's only a very small proportion of those people on whom it will have a positive impact; I think it's about 20 per cent of those on antipsychotics who actually seem to respond to them. For the remaining people who are living with dementia and are on antipsychotics, there are increased risk factors—falls, stroke et cetera. And the impact, effectively, on somebody with a cognitive impairment is as a sedative. That is the primary purpose of prescribing those particular classes of medication.

Mr PERRETT: So reaching immediately for one pill that's going to fit all is not the approach at all, if you've got 100 different types of dementia. Also, we heard in evidence earlier a clear statement that there was overprescribing and that, as to the efficacy of such prescriptions, only 20 per cent or so had any usefulness—

Dr Stokes: That's right.

Mr PERRETT: and that there are other strategies that should be used first. So the suggestion was that medication should be a last resort rather than a first resort. Would you like to further comment?

Dr Stokes: I think there's an underpinning issue which is really the ability of the workforce and the people working within the aged-care sector to understand and support people with dementia in an appropriate way and to apply a whole range of different interventions. We know that the majority of people working in residential care, for example, are part of the unregulated workforce, so they might have a certificate III. We know that mandatory qualifications or education or training in dementia is lacking in the majority of them, so knowledge and understanding about what dementia is, how it can impact a person and how other strategies can be employed with somebody who might be showing signs of agitation or changed behaviours is lacking in general in the workforce. Workforce training and the shift in culture and leadership within the sector is absolutely vital, because if you don't know how else to manage somebody's changed behaviours then somebody behaving in an aggressive fashion

might automatically lead to them being sedated because the staff don't actually know of a better way of dealing with things.

Mr PERRETT: And we don't have to reinvent the wheel here. I assume we've done this in the disability sector; we've done it in the mental health sector. There would be learnings from both of those, surely?

Dr Stokes: Absolutely, and in the aged-care sector as well. There are providers who are doing it well. It's not that we have no examples of those things being done well. We do know of aged-care providers who are investing in education and training for their staff, are specialising in dementia and have a good understanding of the whole range of different interventions that you can apply to somebody living with a cognitive impairment to ensure that they have a positive quality of life.

Mr Gear: In these other sectors, disability and mental health, they see the removal of that difficulty by physical or chemical restraint as being such a serious decision that they need independent authorisation, and there is a process and a documentation to show that this is a treatment or restriction of last resort and is clearly done by an independent authorisation. Guardians or representatives, or even care providers, need to step to a higher bar to be able to use this as a strategy because of all the risks and concerns that go with it.

Mr PERRETT: Because you're removing a person's freedom, you're very much saying that it should be done as a last resort and is something that, at best, might be restored. But certainly, in the evidence we've heard as to those who are medicated, we're getting data that 95 per cent of them are not coming off that medication and are not being reviewed after eight weeks or 12 weeks, or sometimes not being reviewed at all, and maybe suffering from falls, from pneumonia—all sorts of things—or dying.

Dr Stokes: Yes.

Mr PERRETT: Okay. Thank you.

Dr Stokes: I think it comes back to the point I made earlier, that the roles and responsibilities of providers versus prescribers versus family members and advocates are still very unclear and are certainly not helped by the wording in the legislation. In fact, the removal of informed consent from chemical restraint makes the management of prescription even more challenging.

Dr WEBSTER: I've got a question, and I don't mind who answers it: how should the instrument, as it sits right now, be amended to provide safeguards for the use of chemical restraints, and what safeguards would you recommend?

Mr Gear: I believe that a requirement, as a first tranche, would be to put a requirement on chemical restraints to have informed consent and for whoever is administering that—that's why I suppose it sits within the Aged Care Act; the service provider has the responsibility, normally, for the administration of medication—to have a moral, ethical and professional responsibility to confirm that that consent has been obtained and that it is informed. Secondly, we at OPAN would like to see that this has an independent authorisation process that provides documentation of the processes that have been gone through to explore alternatives. That would need to be independent but could piggyback off similar systems that are there for mental health and disabilities vulnerable people.

Ms Hollywood: We've talked about the mental health system and the disability sector as having stronger and better processes than what's before us today. I think that that's true, but I also think it's important for the committee to be aware that, even within those systems, we still need to move to a process of elimination of restrictive practices. I would note that, at the New South Wales level, there is a review at the moment around the authorisations processes in the disability sector. Different states and territories have different authorisation processes. That's talking about authorising the practice as opposed to reducing or eliminating it. So I do think it's important for us to be aware that, whilst there are probably better approaches being used in other areas, we do need a broader framework.

In terms of amending this instrument, I'm not sure that it's simply changing some words or expanding some definitions. I think that we need to have a much broader look at—and others have identified this around the independence of the authorisation processes—the safeguards for oversight and look at what the practice actually is so that people can make complaints and that those complaints can be made by the individuals but also by family members. I just think that this instrument does not actually get us there, and changing a few phrases won't fix the extent of the issues here.

Mr Gear: I would agree with that. This allows for emergency use, but there is no definition of emergency. Again, you would need this to be reported as a serious incident to the Aged Care Quality and Safety Commission. The fact that you've taken away their consent ability at all and administered the medication without consent is a

breach of rights and is a serious incident that needs to be reported. It would be difficult to see how you would build some of these things into an adjustment of the amendment. It needs further work.

Senator McKIM: Ms Hollywood, thanks for coming in. I want to ask you, because of your representation of people with disabilities, whether you know of any reason why the regulatory regime proposed in this instrument should be different to—and, in my view, weaker than—the NDIS rules around use of restraints. Firstly, would you agree with the proposition that it is weaker?

Ms Hollywood: I agree with the proposition that the two approaches are very different. I am not sure why. If we think about Australia's obligations, as I said earlier, Australia is a signatory to the Convention on the Rights of Persons with Disabilities. If we just work from the assumption that many people who are using aged-care services or living in aged-care residences may have disability, then we should be taking an approach that is consistent.

The other point I was thinking about is that, from a staffing point of view and from a regulatory point of view, it makes much more sense for us to have a consistent approach. People might move between working in the sector. Even for families and people themselves—you may move from one facility to another, so you would think the laws and your protections and the approaches actually carry across rather than it being the case that suddenly you turn 65 and you've got a different set of standards being applied. I think that's really problematic.

Senator McKIM: Thank you. I will put this to Dr Stokes and Mr Gear as well. Committee members will have heard me ask this question repeatedly already today. Can anyone give me a good reason why regulation around chemical restraints should be lighter touch and different to regulation around physical restraints? Dr Stokes, perhaps I'll offer you the first opportunity there.

Dr Stokes: I think it's a pretty short answer, which is: no, there is no reason why that should be lighter touch. The issue of informed consent is the same across all forms of regulation, or should be the same across all forms of regulation, on restraint.

Mr Gear: I would agree.

Senator McKIM: I was just going to say that you address this in your submission, but please carry on.

Mr Gear: We would say no, there should be no difference as well. I understand that the rationale for not having it here in the amendment was because of prescribing rights of the prescriber. However, this is meant to be an amendment to minimise restraint and it does nothing for that and has a false equivalency, and it should be clear that there is no difference.

Senator McKIM: Ms Hollywood, would you care to offer any observations?

Ms Hollywood: I was going to simply say that, in a way, I don't think this approach around minimising the use of restraints achieves the goal or the objective of the title of the instrument. It seems like it might actually entrench practices that are in fact a breach of human rights.

Dr Stokes: Just to add to that, when you look at the guidelines on the use of restraint in aged care produced by the then Department of Health and Ageing back in 2012, they state that there should be informed consent across forms of both physical and chemical restraint, and that there should be a focus on minimising or eliminating the use of restraints. So there's something missing in terms of what's happening in practice to make sure those principles are being enforced.

Mr PERRETT: Further to that, Dr Stokes, do you think these regulations might increase the use of chemical restraints used in dementia patients?

Dr Stokes: It's possible. As my colleagues have already suggested, it certainly doesn't go anywhere near minimising the use of restraints; it actually creates an authorising environment in which chemical restraints can be used. Whether that will then play out into them being used more frequently than they are currently is hard to say. But we already know that rates of prescriptions in antipsychotics and benzodiazepines and antidepressants are very high in people living with dementia, so it's basically making a bad situation worse if it does do that.

Mr PERRETT: Dare I suggest that—and we had the evergreen example given by Geoff Rowe—with the poor providers, there will be more facility for the rogues to carry out poor practice. That would be my suggestion. Would you like to comment on that, Dr Stokes?

Dr Stokes: I don't think the wording of the legislation makes it easy for providers to implement quality practices and it certainly doesn't provide a level of clarity and distinction on how to do that.

CHAIR: Are there any further questions? There being none, I thank you for appearing before the committee and for giving your time today.

CROUCHER, Professor Rosalind, President, Australian Human Rights Commission

[15:30]

CHAIR: I now welcome the President of the Australian Human Rights Commission. I understand that information on parliamentary privilege and the protection of witnesses and evidence has been provided to you.

Prof. Croucher: It has indeed, thank you.

CHAIR: I now invite you to make a brief opening statement. At the conclusion of your remarks, I will invite members of the committee to ask questions. Alternatively, to maximise the time available to the committee to ask questions and in lieu of reading an opening statement, you may choose instead to provide a hard copy of your opening statement to the committee. Do you wish to make an opening statement?

Prof. Croucher: I will just say something briefly. I don't have a prepared statement. The commission has made available to this committee the submission it made to the royal commission in relation to aged care. I am speaking both with reference to that and also with my experience in leading the Australian Law Reform Commission report on elder abuse. A quick snapshot of observations is that I think the principles capture some very good things that are definitely missing without them, but there are more things that need to be done, particularly in the context of safeguarding, and I would be very happy to explore that in questions. But there were two other things that occurred to me when I was doing my homework with respect to the legislative instrument and the one to which it is an amendment. There were two phrases or words that I would like to draw to the attention of the committee that may otherwise be missed. I haven't heard the other comments that have been made, but one was the use of 'consumer'. It jarred with me a great deal, particularly where the original form of the principles talked in terms of a 'care recipient'. To talk about the minimising of restraints and restrictive practices in the context of 'consumers' really jarred with me, so I found that difficult in its particular context and particularly since the major legislative instrument uses the concept of 'care recipient'.

The second observation is one when I was cross-checking all of the definitions. The use of the word 'representative' is a good one. That certainly is consonant with some recommendations about language that I made when leading the disability inquiry at the Law Reform Commission. But when you look into the definition of 'representative' and the various people that can be in that envelope of people who are involved in supporting or assisting in the decision of the medical practitioners, the phrase that jumps out at me is someone who holds an enduring power of attorney. The difficulty with that is that the concept is not the same in all jurisdictions in Australia. If you're in Canberra, the notion of an enduring power of attorney can cover things like health and medical decisions—those personal decisions—but an enduring power of attorney in New South Wales means someone can make decisions about your property. In the context that I'm very familiar with from the elder abuse environment, you don't necessarily want someone who can make property decisions involved in decisions about medications. I just want to note that for the record—that I consider that the use of that expression needs to be defined very carefully, because otherwise it can compound the confusion about the nature of the authority that a donee under power actually has. That was something that certainly became apparent to me in leading the elder abuse inquiry. Those are just a couple of bonus bits of results of my homework, but, with respect to the major issues that you wanted to explore, I'm very happy to be led by your questions, Chair.

CHAIR: Excellent. We will start with questions, starting with the deputy chair.

Mr PERRETT: Thank you, President Croucher. I understand *Hansard* doesn't show irony or the like, so this is said very much as a devil's advocate: do older Australians have the same human rights as middle-aged and young Australians?

Prof. Croucher: In principle, yes, as in human rights are that all people should be 'free and equal in dignity and rights'. That is how the first article in the universal declaration starts. But in practice there are some real barriers. Ageism is pernicious, which was revealed through the work that we did in the Law Reform Commission elder abuse inquiry—I carry the tome with me. Kay Patterson, as the Age Discrimination Commissioner, has become the champion of leading initiatives to try and address ageism. The difficulty with ageism and stereotyping is that, when a person is not seen as an individual person imbued with dignity, that can stand in the way of an equal enjoyment of rights.

Mr PERRETT: Much of our discussion today and evidence has been to do with chemical restraints. I have phrased it as basically taking away someone's freedom to be themselves, in a way, because of the evidence we've had of what transpires when people are heavily medicated. It just seems to be a decision that is made regularly and lightly. We've had evidence about aged-care facilities where 70-plus per cent of the residents were so medicated. We've heard that, on average, one in four people in aged-care facilities are medicated, with dubious

claims about the clinical reasons for so doing. Could you make comment on that in terms of your past investigations or the work that is detailed in the report in front of you?

Prof. Croucher: I'll make it general. I can't speak to the statistics. Clearly you'd have to rely on the proper evidence of that. But, as an observation, it would not be surprising to find an increase of medication in an aged-care facility. As people age, their medical needs increase. So, as a fact, that's not the issue. The issue is when it does diminish the autonomy and the dignity of the person. That's where we get into the human rights issues. Hence the importance of assessing the purpose, the real need and also the safeguarding, which is one of the elements that I think is absent in the principles as they appear. The recommendation for additional safeguards was certainly part of the package of recommendations that the Law Reform Commission made and that have been captured by the submission of the Human Rights Commission in relation to the royal commission. If I may continue along that line, an aspect of that is the need to have independent oversight of the regime that is adopted, based on the model that was implemented in Victoria, which involved an independent practitioner—the independent senior practitioner model. It's included in the Human Rights Commission's submission to the royal commission, which was provided to you—at paragraph 151, to give you a pinpoint. It was framed in terms of further safeguards in relation to the use of restrictive practices in residential aged care and spoke of:

… establishing an independent Senior Practitioner for aged care, to provide expert leadership on and oversight of the use of restrictive practices …

and there were some other aspects to that as well. The idea of that is that you have the assessment done by medical professionals—which is good—in consultation with key people, like someone who might have an enduring guardianship, a healthcare decision-maker. That's a good thing. But if that's all an internally referenced thing—and, given the experience I had with the elder abuse work, if anybody in that is invested in hastening the departure of one's relative; I'm sorry to put it in such dark terms, but inheritance impatience was something that was a very stark and dark side of elder abuse—then it's good to have an independent practitioner whose job it is to have full oversight of the use of restrictive practices and the reporting and the consideration of decelerating the use, so that you're looking at it being really effectively consensual, as in the care recipient, not 'consumer', being actively involved in that process. For many people in an aged-care facility, they are fully able to participate in such decisions and shouldn't be presumed not to be able to participate in the decisions. That's a long answer to your question. So I think that's the missing bit—to get the counterweight to the internal referencing of these decisions. Some of those decisions are made just because they're always made that way—and you don't want that to happen. You need that oversight from outside, I would suggest.

Mr PERRETT: It's funny; in another profession I worked in state law as a lawyer, and I'd completely forgotten that people are often motivated by less than altruistic reasons when making decisions about the care of people!

Prof. Croucher: I should also add, if I may be allowed, that there are many carers in Australia—I think there were 2.7 million at the end of 2015. Many of those carers are actually people in their 50s and 60s who are assisting their elderly parents. I include myself—not as a parent, but as the child. We recognise that there is an element where people aren't necessarily doing a job that is fully in the interests of the care recipient, but there are many, many out there who are the good angels, not the bad eggs.

Dr WEBSTER: I'm very interested in what you have to say. Thank you very much for coming. When you talk about 'care recipient', it feels much kinder, for a start, than 'consumer', and I understand what you're saying there. I wonder, however, whether there's a possibility of both, in the sense that 'consumer' implies a sense of autonomy, a sense of self-determination. 'Care recipient', by its very wording, implies I am the—'victim' is too strong—recipient. When you talk about autonomy and dignity, it is possible, even though one's autonomy is reduced, to still maintain dignity, which is what we're really talking about here, it seems to me. We want our older folk to maintain their dignity, though they may be losing their autonomy. That is what this legislation is all about: how do we do that? I want to talk about those words, because I think they're really important.

Prof. Croucher: Thank you. I think that's most appropriate. I think you can see why it jarred with me, someone who was a 'consumer' of a restrictive practice. It was more a question. I'm not saying it should be excised completely, but it didn't quite work for me, particularly given the emphasis on the work I have done previously, which was on ensuring that the person—the older person in our particular equation—is supported in their decision-making and helped to make those difficult decisions. My reference earlier to the deputy chair, about the fact that there is a lot of medication in an aged-care facility, was because that is about the preservation of dignity in circumstances where medication provides assistance. In some cases, with patients who are suffering severe dementia, it is possibly the avenue towards preserving their dignity, provided that it is negotiated to a point

where it's not just assumed 'this person's demented, therefore X'. It's a nuanced, individualised, dignified road towards making those choices—and, I would add, regulated independently.

Dr WEBSTER: Given your previous history and experience: does the use of restrictive practices in aged-care facilities amount to elder abuse? Do you think the way this instrument has regulated restrictive practices is sufficient to protect the rights of residents?

Prof. Croucher: I'll give the lawyer's answer: it depends. That's the answer to the first part: it can. An individualised, proper care assessment, with the involvement of the person or the relevantly close people—not necessarily the people who make property decisions, but the ones who are entrusted by the person themselves in advance to make those sorts of decisions—is not abusive, because that is respectful of autonomy. It's respectful of the person's dignity. It takes into account appropriate considerations. In the absence of those things, because it would not be respectful of a human rights approach to making those decisions, that could be considered elder abuse.

I will add one extra rider, and it goes to the notion of restraint. It picks up, Dr Webster, your comment about dignity. It can actually be assisting in their dignity. I remember one discussion in the course of consultations for the elder abuse report where a resident had said, 'I want to have bed rails,' but the aged-care facility was nervous about the fact that they were physical restraints and that they would get in trouble if they gave them bed rails. But in fact this particular resident had said, 'I want bed rails because I'm worried about falling out of bed.' There can be some restraints that are actually an exercise of autonomous choice and assist in the preservation of dignity—and, in a case like that, their own physical safety, by virtue of having the bed rails.

Dr WEBSTER: Thank you.

Senator McKIM: Good afternoon, Professor Croucher. I hope you're well. Thanks for coming in today. I want to take you to the issue of consent and the fact that this instrument treats consent differently when it proposes regulating physical restraint as opposed to chemical restraint. Do you believe that the administration of chemical restraint—which can often take the form of the administration of psychotropic drugs without consent—raises human rights problems for you?

Prof. Croucher: First, it's not a matter of belief, Senator. I certainly consider that you should treat these issues the same, because, as to both physical and chemical—even use of the word 'restraint' suggests that they are an intervention in relation to the person. So any intervention of any kind, physical or medical—and the chemical ones are medical interventions, or pharmaceutical interventions—ought to be considered in the same way, because they can have the same impact. The issue is that it starts with the point of: 'Is there genuinely informed consent in relation to this kind of intervention?' That can involve taking time to assist the person in understanding why this proposal is being made. It may be that they have limited ability to participate, notwithstanding all of the support that you can try to give them to understand. That's where the network of others becomes relevant to assisting. But not to use the language of 'best interests' either, because that is redolent of making decisions in some kind of objective way—decisions that aren't really translated through the lens of that particular person. Informed consent is what you want for whatever intervention. The approach should be the same, because, as an intervention, it is the same.

Senator McKIM: That similar approach, I assume from your answer, in your view, should encapsulate the gaining of informed consent for both physical constraint and chemical restraint?

Prof. Croucher: Yes. The model is, 'Don't do it,' but it's in the 'unless' space for both physical and chemical restraints—'They shouldn't be used unless'—and 'unless' is where they have to go through asking you as a person: 'Do you understand the nature of the condition?' There'd be a medical history that can assist. It's a properly—

Senator McKIM: The risks associated with chemical restraints, for example.

Prof. Croucher: Yes, exactly. And the lack of using them as well.

Senator McKIM: Professor, does the instrument, as it currently stands, engage any of Australia's international human rights obligations?

Prof. Croucher: Yes.

Senator McKIM: Could you run through a list, if there is a list?

Prof. Croucher: Perhaps I could defer. I know you like to quiz me and set exams for me, Senator! But the human rights perspective in the aged-care submission that the commission made to the aged-care royal commission does navigate through that quite well. The key ones are: liberty, humane treatment—that is, not to be subjected to torture—

Senator McKIM: So that's torture basically.

Prof. Croucher: And inhumane treatment. The ratification of OPCAT is relevant as part of it. I'm deviating from the specific answers to your question—

Senator McKIM: That's okay.

Prof. Croucher: but the Optional Protocol to the Convention against Torture, which Australia ratified in December 2017, enables a preventive approach. I was talking about the independent regulatory oversight. That recommendation in the ALRC report was made before we ratified OPCAT. The two mechanisms work together. One is the independent regulatory oversight of things in advance and after the fact, together with the inspection mechanisms, the national preventive mechanisms—it's a bit of an awkward title—currently being led through the Commonwealth Ombudsman's office. They may provide a balance. It's mainly about torture because that embraces inhumane treatment, and liberty comes up, particularly in closed wards, where you need keypads to get in and out—that sort of thing—particularly in dementia wings where wandering can be an issue of safety for both the resident and others.

Senator McKIM: Have you turned your mind to whether it engages Australia's obligations under the Convention on the Rights of Persons with Disabilities?

Prof. Croucher: Certainly, because there are clearly parallel issues. The emphasis in the disability committees is that they are very averse to restrictive practices. You can line up the various comments of the Committee on the Rights of Persons with Disabilities, plus the committee reporting processes and the general comments. While they're very averse, the word that is in there is actually 'unregulated'. It has 'properly regulated', 'monitored' and 'progressively reduced, where that is the right option', but it's the absence of regulation that I think joins up the various applications of the treaties.

Senator McKIM: Thank you. Our obligations with regard to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment—they're absolute, right? They can't be limited at all under any circumstances; is that right?

Prof. Croucher: Torture? Yes.

Senator McKIM: And you've said that you think this does engage our obligations?

Prof. Croucher: Because of the potential for overuse, to be inhuman—or inhumane—then, yes, there is a potential there. It's a long bow to say that it all is, because the emphasis is on has it been done properly? But I see the OPCAT approach and, using the New Zealand example, which is—this has probably already been drawn to your attention, but it's a really useful and instructive document. Have you seen this one?

Senator McKIM: I can't read it from here, sorry.

Prof. Croucher: Okay. It's called *A pathway forward*. It's from 2016. It's by the New Zealand Human Rights Commission—the counterpart commission of the Australian commission. It looks at the scope and the role of the optional protocol to the convention against torture in relation to aged care and disability residents in facilities. It's a really good document; I'm sure it has come across your radar already. The emphasis or the takeaway from that is that aged-care facilities are covered by OPCAT, and a good practice interpretation of OPCAT will include aged-care facilities. What that would enable is inspections of aged-care residential facilities to be embraced by the national preventative mechanism, which I think's a good way forward to ensure that it doesn't trespass unduly into that domain of the convention.

Senator McKIM: Thank you. Given this instrument is currently before parliament, have you got any thoughts you'd like to share on whether parliament should allow it or disallow it?

Prof. Croucher: It's a good step forward. It's not bad; it doesn't go far enough.

Senator McKIM: Sorry, just to be clear: an instrument that allows for the administration of chemical restraints without consent is, you think, 'not bad'?

Prof. Croucher: That's a good question. I didn't exactly say that. The regulatory structure of it is better than an absence of one. So it's a step down the road towards ensuring that any restraints, if they are used, are in the 'unless' zone. The starting point is: 'must not use'. It's a very strong containment. I'd rather there be a containment expressly than none. So the framing of it as 'must not use', physical or chemical—it's the same chapeau in both of those provisions. The 'unless' bit is really where the action actually happens. To deny all possibility is not realistic—

Senator McKIM: Sorry, I didn't quite understand that. 'To deny all possibility' of what?

Prof. Croucher: To deny the possibility of any chemical intervention.

Senator McKIM: Well, I don't think anyone's suggesting that.

Prof. Croucher: Well, in a way you were—

Senator McKIM: No, I'm asking specifically—

Prof. Croucher: I've misunderstood your question.

Senator McKIM: Perhaps you have and perhaps you haven't, but my question—I've asked this of many of the witnesses today. It's been pretty unanimous that parliament should disallow it. It's no good; it's bad and should be disallowed. Now you've given a contrary view, which is fine.

Prof. Croucher: Well, it depends. It depends on the extra bits. It's incomplete. It's like, if I've got this as a draft—

Senator McKIM: Yes, but that's not what parliament has got.

Prof. Croucher: All right, and it's your role, and I defer to your role here. It's not good enough—sorry, I didn't mean that. I didn't mean to say that.

Unidentified speaker: It's all right; it's late in the day.

Prof. Croucher: I have to say, I am not humorous naturally; it always happens by accident. It's got some good bits but it's not good enough without that independent oversight. So if it is a choice of it or nothing, nothing might be better than it as it is, but recognising that it actually has some good bits in it. You don't want to lose all of it for the sake of that.

Senator CHANDLER: Professor, thank you for making the time to come along today. We heard a lot evidence earlier in the day from medical professionals or representative bodies of medical professionals. Obviously, their member groups are at the coalface every day in these aged-care facilities and are in positions where they are holistically caring for elderly people, not necessarily always restraining them. We heard a lot about the different steps that might occur before we come to the extreme point where a restraint might be used. We as legislators, I suppose, in regulating any process, have to balance up the knowledge and expertise of those people at the coalface and give them the flexibility to do what they need to do while at the same time protecting vulnerable people—in this case, those in aged-care facilities—to make sure that their rights are not impinged upon. I am interested in your perspective more broadly, and perhaps you addressed it in your submission to the royal commission on aged care. What role do you see the government taking in regulating this quite contentious area?

Prof. Croucher: I see it as putting it on a proper foundation with good safeguards. You would have heard, as I have in previous work, evidence of overuse or potential overuse. That can arise for all manner of reasons.

Senator CHANDLER: We have heard some of those reasons today.

Prof. Croucher: I observed this myself in one facility where my late in-laws were, where the doctor visited regularly but kind of just walked past the door and said, 'Are you all right, Phil?' So there can be inadequate attention and there can be some excellent attention. There is great variety. But because of that variety and the need to ensure the dignity of everyone in every aged-care facility, which sits under Commonwealth legislative remit—you have the best opportunity for everyone to be treated in that dignified way and to preserve their autonomy. That is where you need an additional safeguard, which was my concern before.

Senator CHANDLER: More broadly, there are industry codes of practice standards that stipulate that doctors, nurses and aged-care workers are not allowed to treat their patients terribly.

Prof. Croucher: Yes, there are, and they're all part of a good regulatory structure. We have an ageing population. We will all be a lot older; some of us sooner than others. The necessity of ensuring that, across the whole—that is where having that independent additional check is important. The health professionals do have codes but many of them may be under great pressure in some instances. I had very powerful submissions in the elder abuse work from the nurses and midwives association in terms of the appropriate staffing ratios. There can be all sorts of pressures that happen in the day-to-day management of sometimes very difficult residents. Getting that calibration right in the health codes, no doubt; the professional codes; and the professional diligence that people embrace will be important, but without that additional independent ability, both with the national preventative mechanism to inspect on an ongoing basis—but the independent monitoring has worked very well in Victoria. I would see it as a good model that could easily be deployed at the Commonwealth level as well.

Senator CHANDLER: But I think we need to understand where professional diligence ends and where regulation should kick in, and determine, through the lens of what we're talking about today, whether professional diligence doesn't cover off on all manner of human rights but implies that the rights of someone in an aged-care facility will be considered throughout right up until and including the point that restraints might be utilised.

Prof. Croucher: The professional codes are part of that regulatory framework, but it's the extra check of having someone outside the immediate environment that can in a way assist the particular facility to maintain the standards that are needed across the whole. So having the eyes across the wider landscape is the advantage of that extra level.

Mr PERRETT: Further to Senator Chandler's question, the medical practitioners will be making decisions about everyone in the facility, not the individual. Turning to that, the instrument provides that physical restraint can be approved when a person poses a 'risk of harm to themselves and any other person', whereas the ALRC inquiry into elder abuse recommended it only be used to prevent serious physical harm—so a different standard. Is this difference a concern to you?

Prof. Croucher: I haven't given that thought. The 'risk of physical harm' is perhaps an umbrella term that could encompass both—just in quick answer to your question.

Mr PERRETT: We had evidence earlier today of someone caring for 166 people. In terms of being able to make decisions based on a risk of harm to themselves and any other person: obviously if there are four people in a room you might have to restrain a person who's a problem for the others while you go to the next room or something like that, whereas if the standard was to prevent serious physical harm it would be a different standard and a different level of decision-making perhaps, which was how the lawyers approached it, whereas—well, I'm not sure who crafted this document.

Prof. Croucher: That might be a harder piece of homework to interrogate.

Mr PERRETT: I hate to give you homework on a Tuesday afternoon.

Prof. Croucher: That's absolutely fine.

CHAIR: As there are no further questions, I thank you for your appearance before the committee here today and for your time.

Prof. Croucher: Could I just make a footnote?

CHAIR: Yes.

Prof. Croucher: It's just been prompted by your question, Deputy Chair. The idea of the care plan for each individual resident has a lot of work to do in this area. You get away from the emergency or the 'unless' factor if you've really done a serious individualised consideration medically and socially—and all sorts of reasons—and that ought to anticipate some of the issues. So you get away from the 'unless' or the emergency situation if that's developed properly.

Dr WEBSTER: So, really, you're talking about a proactive approach rather than a reactive one.

Prof. Croucher: Yes. I think with Senator McKim's questions it was taking into account the 'unless' and the emergency and the whole needs of the person. There are some conditions where you know it's degenerative, but that can be anticipated. This is well understood by professionals, and that can be calibrated into the thinking. So it's that individualised planning that I think is a good feature. Sorry, Chair, for adding a little bit more.

CHAIR: That's okay. Thank you very much for your time.

Prof. Croucher: My pleasure always.

LAFFAN, Ms Amy, Assistant Secretary, Aged Care Quality Regulatory Design and Implementation, Department of Health

LEONARD, Ms Ingrid, Director, Aged Care Quality Regulatory Design and Implementation, Department of Health

TOWLER, Dr Bernie, Principal Medical Adviser, Ageing and Aged Care, Department of Health

[16:10]

CHAIR: I now welcome representatives from the Department of Health. I understand that information on parliamentary privilege and the protection of witnesses and evidence has been provided to you. I remind senators and members that the Senate has resolved that an officer of a department of the Commonwealth or of a state shall not be asked to give opinions on matters of policy and shall be given reasonable opportunity to refer questions asked of the officer to superior officers or to a minister. This resolution prohibits only questions asking for opinions on matters of policy and does not preclude questions asking for explanations of policies or factual questions about when and how policies were adopted. Officers of a department are also reminded that any claim that it would be contrary to the public interest to answer a question must be made by a minister and should be accompanied by a statement setting out the basis for the claim.

I now invite you to make a brief opening statement. At the conclusion of your remarks I may invite members of the committee to ask questions. Alternatively, to maximise the time available for the committee to ask questions and in lieu of reading an opening statement, you may choose to instead provide a hard copy of your opening statement to the committee.

Ms Laffan: I have a short opening statement. The Department of Health appreciates the opportunity to present to this committee. Any restraint should only ever be used as a last resort. Use of physical and chemical restraint has been identified as a widespread problem in residential aged care. Minimising the use of restraint is a complex issue that requires a multifaceted approach. I note that today's inquiry relates to the Quality of Care Amendment (Minimising the Use of Restraints) Principles 2019, the introduction of which imposes specific regulatory requirements on approved providers of residential care in relation to restraints and mandates compliance with specific processes, conditions, documentation and review requirements. However, regulating the use of restraint is only part of the solution. Non-regulatory measures such as cultural change and effective clinical governance are also needed to drive reform.

The 2019 principles complement other approaches and reforms which are currently in place, soon to be introduced or under development. Reforms commencing from 1 July 2019 include mandatory participation in the National Aged Care Mandatory Quality Indicator Program for residential aged-care providers. The quality indicator program includes an indicator on the use of physical restraint. A new charter of aged-care rights across all aged-care programs covers 14 fundamental protections, including rights to safe and quality care, to be treated with dignity and respect, to live without abuse and neglect and to have control over and make choices about care. The new Aged Care Quality Standards strengthen the requirements regarding clinical care, including medication management. Clinical care must be best practice and supported by a clinical governance framework that minimises the use of restraint, including physical and chemical restraint.

In January 2019, Minister Wyatt requested that the Australian government Chief Medical Officer chair an aged-care clinical advisory committee to consider options to reduce the inappropriate use of chemical restraint in residential aged care. The committee explored a range of measures across the themes of education, workforce best practice, prescribing behaviours, alternative approaches such as diversional therapies, and clinical governance. The committee was also consulted on the regulatory response. The committee developed options which were supported by the minister for further investigation and scoping. These included educative activities and revamped materials for aged-care providers, consumers and their families, as well as prescribing clinicians, about the appropriate use of antipsychotic medications in residential aged care; letters from the Chief Medical Officer to those identified as high prescribers; pilots to test workforce initiatives such as nurse champions, train-the-trainer programs and embedded pharmacists in residential aged-care facilities; and changes to the Pharmaceutical Benefits Scheme to introduce a streamlined authority code for repeat prescriptions of risperidone and improve PBS data capture of medicines dispensed to consumers in residential aged care.

The department is now working to further scope for implementation all of the committee's recommendations. This includes reconvening the Chief Medical Officer's aged-care clinical advisory committee for the implementation phase. The 2019-20 budget included $7.7 million to reduce the misuse of medicines in residential aged care by establishing a new clinical unit within the Aged Care Quality and Safety Commission to work directly with residential aged-care providers around the best-practice use of medicines and expanding the National

Aged Care Mandatory Quality Indicator Program to include two new quality indicators: falls and fractures and medication management. The government is also supporting an ACT trial to embed a part-time pharmacist in all residential facilities to ensure the quality use of medicines. To ensure the use of chemical and physical restraint in residential care is appropriate, the Department of Health has also developed resources to support providers.

With these remarks as background, my colleagues and I will be happy to answer your questions.

Mr PERRETT: I note the *Decision-making tool: supporting a restraint free environment in residential aged care*, which is the decision-making tool you referred to, isn't it?

Ms Laffan: Correct.

Mr PERRETT: I just want to contrast the disability sector and the mental health sector, where they seem to have made a national commitment to reduce and eliminate the use of restrictive practices, with the aged-care sector. Is that really what we're trying to get to—to the extent of totally eliminating?

Ms Laffan: That's not government policy. The policy is to minimise the use of restraint, and that restraint can be used only once certain conditions are met.

Mr PERRETT: As a last resort?

Ms Laffan: Absolutely as a last resort.

Mr PERRETT: You certainly spoke about those other processes. I think you mentioned staff education and quite a few others. Would it be true to say that they haven't been utilised as much as they could be?

Ms Laffan: For example, if you look at education, we've recently done a stocktake, and there are actually a lot of documents out there for all of those groups—for prescribers, for aged-care services, for consumers and their families. Part of the challenge we have is asking, 'What is it about those materials that perhaps isn't getting through or isn't working?' and looking at those documents and creating some better educational materials.

Mr PERRETT: Why is there no express requirement that restraints be used only as a last resort and be in proportion to the potential negative consequences of risk or harm? I'm not sure if you heard the earlier evidence where they were talking about falls, pneumonia, death—the other risks associated with these things. So why not make it an express requirement?

Ms Laffan: The principles do, in effect, require that restraint be used only as a last resort. That's mentioned a number of times in the explanatory statement and all of our communications.

Mr PERRETT: But not in the document itself.

Ms Laffan: We haven't used that phrase in the principles themselves, but I would suggest—

Mr PERRETT: Are you scared of it? It seems strange. It's normally a good idea to have the intent of the regulation up-front, isn't it?

Ms Laffan: I would suggest that the conditions we require be met altogether bundle to equal as 'last resort'. I think there could be issues with saying 'as a matter of last resort' in itself in a legislative instrument. The question would then be, 'What is meant by "last resort"?' and I believe that the—

Mr PERRETT: Well, it means that it's not first—

Senator McKIM: That you try everything else first—or consider everything else first.

Ms Laffan: provisions of the instrument certainly say that explicitly.

Mr PERRETT: The NDIA expressly say that this is a last resort. My understanding is that the world hasn't stopped spinning in terms of dealing with people in the disability sector. It just seems a strange approach.

Dr Towler: That is absolutely the intention of the legislation. As my colleague says, the list of arrangements that need to be in place before you consider using physical or chemical restraint I think make it very clear that you don't consider that first up; you need to meet a range of requirements to be compliant with this legislation before you go to physical or chemical restraint. I think that's implicitly there, and it's certainly stated in the explanatory statement.

Mr PERRETT: I don't mean that it is not implicit; I mean explicit in terms of making a statement.

Dr Towler: Sure. So that was the intention—that it is a last resort.

Mr PERRETT: It was intended to be explicit?

Dr Towler: No, the intention was that there are a whole range of other ways of managing these behaviours of people in residential aged care that are far preferable prior to going to physical or chemical restraint and that you really need to have exhausted all of those other methods. In fact in some cases you may introduce physical or chemical restraint in addition to those other measures if you still have a person who is suffering in that way.

Mr PERRETT: I understand the opening comments about policy but I just keep coming back to the NDIS or mental health, where there are clearly expressed explicit words up-front making it clear this is what providers need to consider. It just seems a stark contrast.

Ms HAMMOND: Could I make a comment here?

CHAIR: Certainly.

Ms HAMMOND: I would like to make three points. Comments in the explanatory memorandum to the regulations can be used in interpreting this. I think what the department is saying here is that the NDIS legislation is fantastic but the use of the phrase 'as a last resort' is not a very precise legal term and to put it into any legislation or regulation will open up another can of worms. I also note that the regulations that we have in front of us do, as has just been pointed out by Dr Bernie, refer to alternatives having been tried first. So when you look at those phrases for both physical restraints and chemical restraints, with the explanatory memorandum, I understand the argument of the department that is getting there without using that explicit phrase.

Mr PERRETT: For physical not chemical?

Dr Towler: No, for both.

Ms HAMMOND: In chemical as well.

Dr Towler: Absolutely, for both.

Ms HAMMOND: If you look at 1.12(b), the alternatives to restraint that have been used.

Mr PERRETT: Okay.

Dr WEBSTER: Thank you for coming in. I just want a bit of clarification. I think you said in your opening statement that there was a streamlining of continuous provision for risperidone. Is that you said?

Dr Towler: Yes. At the moment that is the only antipsychotic medication on the Pharmaceutical Benefits Scheme and available as a streamline authority prescription for the behavioural and psychological symptoms of dementia. They are the behaviours we are treating here and that in lay parlance is referred to as chemical restraint. There is a streamline authority for risperidone. I think my colleague may have referred to some work we have underway to actually address that even further. There is an item at the moment in which you need to meet a range of requirements. It needs to be a particular type of dementia, Alzheimer's type dementia. You are supposed to prescribe that for a 12-week period. It also looked at other nonpharmacological measures et cetera. We are in fact going to the pharmaceutical benefits advisory committee on Friday this week for its consideration of a further streamline item for prescription beyond 12 weeks, which would enable us to put a lot of other restrictions there around you really need to review why your residents, your patient in residential aged care, needs to be on this medication for longer than a 12-week period. I should add that the 12 weeks is around the limits of the trials and the data and accompanied the application to have these medications listed on the PBS in the first place. Nevertheless, we know that these are medications that have a range of side effects, and there are international and Australian guidelines that say that you really need to review somebody on that medication after that period of time or even within that period of time. The second authority item allows people to start to deprescribe and taper off the medication and potentially cease it.

I should add here that there is a very small proportion of people out there who do actually need to be on these medications. They have severe behaviours and those behaviours actually get worse if the medications are ceased or they aren't on these medications. In the second item, we're suggesting that you do need to undertake that trial, but, if someone has a recurrence of their hallucinations or delusions or their very aggressive or distressed behaviour and they were doing well on the medication, they need to be on it. So there is a really small proportion of people who do benefit, and that's still called chemical restraint.

Dr WEBSTER: What we're looking at obviously is deprescribing, but there are obviously, as you say, some who really do need to be on it.

Dr Towler: Yes, but we would say that is a small proportion of people.

Dr WEBSTER: Why are there differing and fewer safeguards for the use of chemical restraints compared to physical restraints?

Ms Laffan: I wouldn't say there are fewer safeguards. I would say that there are fewer safeguards within this piece of regulation. In fact, there are a number of pieces of regulation in general law which require, particularly for chemical restraint, informed consent, and other things are given.

Dr WEBSTER: So should it be part of this regulation?

Ms Laffan: The decision was that this regulation is really about approved providers. The Aged Care Act is focused on the actions of providers, and that's where this kind of regulation is focused. It talks about what the responsibilities are of an approved provider. There are other things that capture the responsibilities of prescribers, such as state and territory legislation and general law.

Dr Towler: You probably heard evidence from other people today when we were in transit and weren't able to hear, but there are extensive arrangements available, nationally and in the states and territories, for regulating the practice of health practitioners who may prescribe these medications. They need to be registered in the first place and then for ongoing practice, and be governed by their medical boards, and that includes medication management. Doctors and nurse practitioners, if it's within their scope of practice to prescribe these kinds of medications, are expected to adhere to appropriate behaviour. They're accountable for that behaviour; they can be sued for that behaviour; they can be struck off by their medical boards. So there is a whole range of regulations and processes in place at national and state and territory levels to manage that behaviour.

Dr WEBSTER: You would say oversight of the practitioners is an independent objective, if you like, of prescribing behaviours?

Dr Towler: Yes. It's independent accountability on the part of the practitioners—yes—at multiple levels.

Dr WEBSTER: These antipsychotic drugs that are the concern are all S4 and S8 authority scripts?

Dr Towler: No, they're not, and I couldn't tell you which ones were or were not, I'm sorry, but I could find out.

Ms Laffan: We could take that on notice for you.

Dr WEBSTER: I wonder, if they're authority scripts, whether that's another requirement that may cause pause.

Dr Towler: We have done some work looking at the data here. Certainly, the most prescribed ones—risperidone, olanzapine and quetiapine are authority scripts. When you're talking about benzodiazepines, though, they're not authority scripts. There are the antipsychotics and the ones that are most commonly prescribed. The most commonly prescribed one is risperidone.

Senator McKIM: Following on from the questions you've just answered around the difference in the way this instrument treats physical versus chemical restraint, have I understood your response correctly—for example, the failure of this instrument to contain a requirement that, before the use of chemical restraint, consent must be given? The reason for that is that you think that's dealt with in state and territory legislation and therefore it's not needed here. Is that right?

Ms Laffan: This legislation focuses on the approved provider, and, with respect to chemical restraint, it is not their responsibility to seek informed consent; that is the clear responsibility of the prescriber.

Dr Towler: So it simply doesn't sit under this legislation, which is about the approved providers. But there are extensive requirements on the part of the prescribers to get informed consent, and, as you heard earlier, that's quite a detailed process.

Senator McKIM: That's for prescription. Does that include administration?

Dr Towler: To get informed consent? The informed consent would be for—

Senator McKIM: I am asking for the difference between prescribing the medication and administering it to a patient.

Dr Towler: Yes, I understand. You would normally get informed consent for prescribing it, and the authority is then passed on to whoever is actually providing it to the resident.

Senator McKIM: Administering.

Dr Towler: Administering it, yes, but the informed consent sits with the prescriber.

Senator McKIM: Understood. Wouldn't it be good practice to require consent to be given by the person who is administering the medication.

Dr Towler: That's not how informed consent works for any medications that I know about.

Senator McKIM: Even when the person who prescribed it may not be present when it is being administered?

Dr Towler: Because the person who has prescribed it is supposed to have gone through a quite detailed, explicit process around informed consent. This is part of practise training for doctors and nurses. It is well understood. It is not a matter of just telling somebody about a medication; it's taking them through the side

effects, alternatives to the medication and exactly why it has been prescribed and for how long. There's also a judgement in there on somebody's capacity to consent.

Senator McKIM: So why is there a difference in the test which has to be met between physical restraint and chemical restraint in that physical restraint requires that a person be assessed as posing a risk of harm to themselves and others, whereas chemical restraint just requires an assessment that the person requires the restraint? Why is that a different test?

Dr Towler: I think that this again comes back to that there are different persons who are seeking the consent. Firstly, consent is required for both.

Senator McKIM: Not under this instrument.

Dr Towler: No, not under this instrument—correct. So there are different people who are enacting the consent process to give you the authority with the person that you are going to enact the physical or chemical restraint with for each of those. I'm not sure if I've answered your questions.

Senator McKIM: The question wasn't about who gives the consent; it was about the test that's needed to be met and the test difference between physical and chemical. So the test for physical is that a person has to be assessed as posing a risk of harm to themselves or others. I will put the question differently: why haven't you applied that test to chemical restraints?

Dr Towler: The decision to prescribe a medication or a chemical substance that is called chemical restraint is a decision of the health practitioner who is going to prescribe that medication for that person. It is part of the assessment of why they would do that, and that goes to all of those other regulatory mechanisms that I talked about before that sit at a national and a state and territory level and between doctors and nurses and their boards. There are other accountabilities here. To include that in the legislation would, I think, be a step too far in terms of the different purposes for—

Ms Laffan: We would be describing all of the factors that a prescriber takes into account with assessing and prescribing clinical restraint, and I don't think that could easily be—

Senator McKIM: But why would it not—

Dr Towler: Because it's their responsibility and they are accountable in a whole range of other ways—not under this legislation—for those decisions and that clinical judgement in multiple ways, These professions are highly regulated in Australia. Doctors and nurse practitioners, people who are doing the prescribing, are highly accountable and held to account as well.

Mr PERRETT: Further to that: if the prescribing doctor is assumed to have already obtained the consent, why does that include the consumer or consumer's rep being informed about the use of the chemical restraint if it is practicable to do so?

Ms Laffan: That provision was put there as a bit of a flag or stopgap. We are aware of situations where informed consent may not have been provided. What we were doing there was looking at the role of the approved provider and what we could reasonably ask them to do. And we think something we can reasonably ask a provider to do is to flag with the consumer or family that they are about to start taking one of these drugs—

Mr PERRETT: Or they took them last night.

Dr Towler: Yes, where it wasn't practical to do it earlier. Perhaps at that point you call up the daughter and say, 'Hey, do you know that your mum has been prescribed X, Y and Z?' And the daughter says, 'Yes, I know that; I was at the doctor's appointment yesterday.' Or they say no. That's where we've got a bit of a stopgap there, and the approved provider could suggest to that family member, that representative or consumer, that they should be talking to the doctor about the prescription decision.

Senator McKIM: Why wouldn't you discuss that with the patient in the first instance rather than another person?

Ms Laffan: The consumer or the representative—whoever is the most appropriate person in that situation. It could be the consumer.

Mr PERRETT: Going back to the trust that reposes in the prescriber: much of the responsibility rests on that decision. We had evidence put to us today that, where a prescriber is an employee of the very facility that makes decisions about managing patients, there could be the possibility of a conflict of interest between their duty as a servant, shall we say, versus their responsibility to their patient. Is that something you've considered in this? We have talked about alternatives to restraint. They must be identified in the care and services plan and documented. But they are not expressly required to be used as an alternative; they are not actually stated as expressly being required to be used. I am framing it in light of a suggestion that this will facilitate more chemical restraints.

Ms Laffan: On the legislative front, the approved provider needs to consider and use alternatives to restraint.

Mr PERRETT: And document that?

Ms Laffan: Yes.

Mr PERRETT: So there is some sort of audit process through the Department of Health?

Ms Laffan: Through the Aged Care Quality and Safety Commission, yes.

Dr Towler: Through their assessments and their site visits, which are unannounced, we are able to detect this and see that approved providers are compliant with this legislation around chemical and physical restraint.

Mr PERRETT: Is that in their guidelines that are going to be on their website soon?

Dr Towler: Yes. It has been communicated to the sector as well. We have a range of mechanisms in place, actually.

Mr PERRETT: I go back to that possible conflict of interest if they are an employee. And even if they are not an employee—we have heard that there are practices that set up specifically to cater for aged-care homes and services, and their business model is to regularly go back to the facility. I am not sure if you know the bicycle courier case in terms of control.

Dr Towler: Yes, sure. Doctors are the majority of prescribers here, and this goes to the heart of what it is to be a professional. It is about your duty to your patient, in this case, and your professionalism in that you aren't able to be manipulated by a third party with respect to the doctor-patient relationship—and that's what you enact when you are prescribing something for somebody. It's probably best to ask professionals working in the sector about that, but that would be my view.

Mr PERRETT: I've seen professionals put under pressure where their duty to feed their kids sometimes trumps their duty to the person in front of them.

Dr Towler: Again, there are all those accountabilities that I referred to that regulate the profession to behave appropriately.

Mr PERRETT: Can we go to that then. The whole intent of this instrument is to reduce the use of all restraints.

Dr Towler: Correct.

Ms Laffan: To minimise and limit.

Mr PERRETT: Reduce.

Ms Laffan: Limit.

Mr PERRETT: Limit. Okay. I don't want to get into—I was an English teacher in another life. We are hoping that there will be fewer occasions when restraints are used?

Ms Laffan: Correct.

Mr PERRETT: We can agree on that language?

Ms Laffan: Yes.

Mr PERRETT: How do you expect to achieve that outcome? What evidence did you use to come to agree that that's the outcome we're trying to achieve? What evidence will you be using?

Ms Laffan: In terms of implementing the policy, this is the policy of government that we are implementing.

Mr PERRETT: The policy of government—

Ms Laffan: Government.

Mr PERRETT: but relying on the frank and fearless advice of you wonderful people to achieve this goal, which is, as we've said, to have fewer occasions when restraints are used.

Ms Laffan: Correct. We consulted, we developed the legislative principles and we will track through the results of these principles and how this works in terms of compliance with the principles. We'll be working closely with the Australian Aged Care Quality and Safety Commission, looking at non-compliance rates of meeting the standards and those sorts of things to track whether restraint is reduced.

Mr PERRETT: Would per capita use of restraints in aged-care homes be a simple—

Dr Towler: We will be monitoring, as my colleague says, because this is brand-new legislation—

Mr PERRETT: Is that what that means?

Ms Laffan: It is, yes.

Dr Towler: But we also have other mechanisms here. We introduced a new quality indicator from 1 July around physical restraint. Residential aged-care providers are required, quarterly, to provide us with data on their use of physical restraint. I won't go into the details, but there are a couple of different measures. That is a new measure as well where we will be getting that data—

Mr PERRETT: Public data?

Dr Towler: Yes, it will be.

Ms Laffan: The government has committed to making that data publicly available.

Dr Towler: It is a measure for the providers to be able to improve over time. Once you start to—

Mr PERRETT: But not chemical, only physical?

Dr Towler: That's physical at this point.

Mr PERRETT: Certainly the evidence we heard today was that, on a day-to-day basis—and this is on the record—a treating physician does not see physical restraints. It was only one person giving evidence.

Ms Laffan: I note, with respect to quality indicators, that government has committed to introducing a quality indicator on medication management by July 2021.

Senator CHANDLER: We've already touched on this, I think, in answering Dr Webster's questions about prescribing the use of certain drugs, whether used for chemical restraint or otherwise. You mentioned that it's not just these principles that we have in front of us today that govern, regulate and stipulate how that process works, that there is actually quite a complex interaction between federal legislation, various state based legislation, the industry guidance and principles which governs how doctors, nurses and aged-care facility workers go about their work. That's also the case for what we might consider the pattern of behaviour that could lead to physical restraint as well. Is that correct? It's not just the use of chemical restraints that we're concerned about here; holistically, the whole sphere of aged care is this quite complex interaction of where state legislation ends and federal legislation or regulation principles kick in?

Ms Laffan: That's correct. And also non-regulatory measures, which are the sorts of things I was trying to get at the start: embedding pharmacists in aged care, the education materials and those sorts of things which fit around the regulatory framework.

Senator CHANDLER: Is there any way that you can provide to the committee simple guidance on what those instruments might be and how they interact?

Ms Laffan: The regulatory instruments or just the broad framework?

Senator CHANDLER: The broad framework.

Ms Laffan: We'd be able to provide that on notice.

Senator CHANDLER: That would be wonderful.

Senator McKIM: Could I seek clarity on what you've asked for. Is that, for example, things that a medical practitioner must do before they prescribe interventions around chemical restraints? Would that be covered in what you've agreed to provide? Sorry, I'm still hung up on it, as you can probably tell.

Dr Towler: There are a whole range of different medications that can be used for chemical restraint. That's the first thing.

Senator McKIM: I understand that.

Dr Towler: There's one that has specific requirements on the PBS, so you need to meet all of those before you prescribe it. But I don't think that goes to your issue, which is what's the thinking of a medical practitioner before they actually prescribe this medication.

Senator CHANDLER: Yes, I'd be more interested in, I guess, the guiding principles that might determine what that decision process looks like rather than the step by step of exactly what a practitioner might have to go through, because otherwise we might be here a very long time reading through all of that information.

Dr Towler: For a medical practitioner, I would say that that goes to their professional training and their ongoing professional development, which we all have to do in order to maintain our registration. It's hard to get a thumbnail on that—

Ms Laffan: We'd be able to provide some details as to registration requirements and those sorts of things.

Senator CHANDLER: I think that information will be useful for the committee.

Ms HAMMOND: I have a question that picks up from Senator Chandler's point there. There are drugs at the moment that would act as a chemical restraint which would not need a script from a doctor—is that correct?

Dr Towler: Possibly.

Ms Laffan: There could be.

Dr Towler: I'd have to think hard about that. The big offenders here are the antipsychotics and the benzodiazepines, which—

Ms Laffan: Under the terms of this legislation, a chemical restraint has a very specific definition, but physical restraint is everything other than chemical restraint. I think, potentially, something that has not been prescribed, while it might be a chemical, would actually be covered under physical restraint under the terms of this legislation.

Ms HAMMOND: The point I'm coming from is that the provisions on chemical restraints have come under the most criticism throughout the course of the day. As I've understood your explanations this afternoon, which have been very, very helpful, the regulation of chemical restraints is only partially dealt with in here; it's also partially dealt with in professional rules and all other sorts of regulatory environments. In fact the regulation you've got in here is effectively saying an approved provider cannot give anything that could be deemed a chemical restraint without a doctor's sign-off, whereas it is possible at the moment without this regulation that they could do something which was chemical restraint without a doctor being involved.

Dr Towler: No. I would say that we have put into legislation what should be happening out there at the moment, so I would disagree with what you're saying.

Ms HAMMOND: Okay.

Ms Laffan: Really, it's about the prescription of those drugs. Someone would be taking those drugs because they been prescribed, and that was the case prior to this amendment.

Senator McKIM: This goes back to chemical restraints. As an introduction to this question, I've put to you some of my concerns, and you've said they're not in the instrument, because they're dealt with elsewhere. I'm happy for you to take this on notice: what steps does a medical professional have to go through to satisfy him or herself that it's okay for them to prescribe a chemical restraint for the purposes of restraint? Not for the purposes of a therapeutic intervention—I'm not asking about someone prescribing to address a medical problem; I'm asking about someone prescribing for the purpose of chemical restraint. What do they have to do to satisfy themselves that they're able to issue that prescription? Do they need informed consent from the patient before they do that?

Dr Towler: Absolutely they do.

Senator McKIM: They do? Okay. What else do they need to satisfy themselves of?

Dr Towler: They need to satisfy themselves that other non-pharmacological methods have been tried to the fullest extent possible and haven't worked and that the person is still suffering in a way that is likely to be alleviated by these kinds of medications that we're calling chemical restraint. Then they would make a clinical judgement—for example, there are some behavioural symptoms of dementia that don't respond to these kinds of medications, so you wouldn't prescribe them for that appropriately. But for things like aggressive and psychotic behaviours, people who are hallucinating, have delusions and who are very distressed by these symptoms can benefit from them. These symptoms are common in people with dementia. You would have heard data on the number of people who have dementia in residential aged care. Of those, a high proportion develop these symptoms over time, so there are people who definitely benefit. They need to satisfy themselves that somebody is sufficiently suffering and that other methods haven't worked. And then you trial it for specific behaviours; you don't put somebody on it and leave them on it forever. You trial it for specific behaviours and then you monitor people to see if there is an impact happening. If people are getting worse, obviously you stop. But if they are getting better and the symptoms go away then you might take people off it completely and see if the symptoms return. There is a whole bunch of ways that you should be managing these medications that are appropriate.

Senator McKIM: Is it possible under these regulations for an approved provider to administer a drug for the purposes of restraint that has been prescribed only for therapeutic intervention?

Dr Towler: I don't understand the question, sorry.

Senator McKIM: I will take you through an example. The doctor assesses someone and says that they require psychotropic drugs for the purposes of therapeutic intervention—nothing to do with restraint but just for treating a medical situation.

Mr PERRETT: They might be shaking.

Dr Towler: Yes, sure. Somebody who has a mental illness, for example, might need a psychotropic.

Senator McKIM: What is there in these regulations to stop the approved provider from administering that drug for the purpose of restraint when it was prescribed for that purpose? I will step you through it again. Someone has prescribed a psychotropic drug for the purpose of therapeutic intervention. In my reading of these regulations, an approved provider can use chemical restraint as long as a medical practitioner has assessed the consumer as requiring the treatment. I am asking if there is a gap there.

Dr Towler: I don't think so. Essentially, if we are talking about antipsychotics, they are used for mental illness. There is a small number of people who need them for mental illness in residential aged care. Then in another big group of people they are used for the behavioural and psychological symptoms of dementia. The prescriber needs to be prescribing these medications for specific indications. So if you are on this medication for your schizophrenia, that is appropriate and you would probably stay on that medication, and that is not chemical restraint.

Senator McKIM: No, it is not.

Ms Laffan: And then the aged-care providers, as part of the standards, as part of their medication management requirements, are required to look at what that medication was provided for and at the time frames—is it to be every six hours et cetera—and administer in accordance with that prescription. So that is part of their requirements under the standards.

Senator McKIM: Thank you, that's helpful. To distil my concerns down, I will put this to you: you have said that you haven't felt the need, around chemical constraints, to put a lot of stuff in this instrument because it is dealt with elsewhere. But that dealing with it elsewhere has resulted in innumerable horror stories through the aged-care network in this country of people being unreasonably restrained. So, if it's all working so well—

Ms Laffan: Yes, sure.

Senator McKIM: Is it all working so well? And if it's not working so well, why are you relying on the existing framework in order to minimise the use of restraints?

Ms Laffan: I wanted to say when I provided this opening statement that this is but one piece of work that we are doing to minimise the use of physical and chemical restraints in aged care. There is a vast amount of work being undertaken as part of the Chief Medical Officer's clinical advisory committee. We talked about the risperidone codes, we talked about education and we talked about workforce things. So it really is about: this plays one part, an important part, in terms of aged-care providers, but there are other things that we need to do that we are working on.

Senator McKIM: I understand that.

Dr Towler: Can I add that there is a whole suite of projects that we have underway. You are absolutely right; we have a problem out there and we are the first to say that. It has been a problem in the face of lots of literature for a long period of time now. There is some suggestion that it is getting better, but it is still a serious problem. There is a suite of work, a whole program of work, that is really focused on chemical restraint. I think that's the main point I want to make here.

Senator McKIM: That's okay. I don't want to get into an argument with you guys, because you don't set policy, but the minister could have put in this regulation a much more stringent group of requirements under 'chemical restraint' than he has. The only response we've got is, 'They're being dealt with elsewhere, so we don't need them here,' but 'dealt with elsewhere' has actually been part of the problem and it's one of the reasons we are facing this crisis around the use of restraints in residential care.

Dr Towler: Can I suggest that's a misunderstanding of the Aged Care Act?

Senator McKIM: I didn't mention the act. I'm talking about the real world, out there in residential care facilities.

Dr Towler: Sure; I get it. I'm saying that we haven't put it under the Aged Care Act in this legislative instrument, because this instrument regulates providers. We're not for one minute saying that there isn't a problem, but it needs to be addressed in a different way. We have a suite of projects and work underway to address the chemical restraint problem in a different way. We can't do that under this particular instrument, because this instrument is under the Aged Care Act, which regulates providers, not the prescribers, not the doctors, not the nurse practitioners.

Senator McKIM: With regard to physical restraint, an approved health practitioner who has stated a knowledge of the resident needs to assess the person as posing a risk of harm to themselves or others?

Ms Laffan: This is framed as a responsibility for approved providers. That would be staff of the approved provider.

Senator McKIM: The approved health practitioner?

Ms Laffan: That's correct.

Senator McKIM: And there are no cases where the approved health practitioner, who is staff of a provider, would prescribe chemical restraint?

Ms Laffan: They would, potentially, and in that case they would be covered under the use of chemical restraint provisions.

Senator McKIM: With a lower, softer test to be met.

Ms Laffan: I disagree that it's a lower, softer test.

Senator McKIM: Well, it is. In the context of this instrument, you'd have to agree it's a lower bar—

Ms Laffan: It's not in this instrument—I would agree with that.

Senator McKIM: Do you see the point I'm making? For physical restraint, you require that an approved health practitioner—which you say in this context would be an employee of the approved provider—who has day-to-day knowledge of the resident has assessed the person as posing a risk of harm to themselves or others. That's a requirement you've put in this regulation. Why is that same requirement not in the chemical constraint section when it is in the physical—

Ms Laffan: That's ultimately a requirement of the approved provider. Chemical restraint, all of those things—the assessment, the consent—is the responsibility—

Senator McKIM: Chemical?

Ms Laffan: For chemical restraint—that's the responsibility of the prescriber.

Senator McKIM: Sorry, but you've just—

Dr Towler: And that sits outside this legislation.

Senator McKIM: I understand that. Haven't you just said in evidence that there are situations where an approved health practitioner who is working for the approved provider can prescribe psychotropic medication for the purposes of chemical restraint?

Ms Laffan: But they would be doing so in their role as a prescriber. They would be governed by their responsibilities and accountabilities as a prescriber.

Dr Towler: It still comes back to that not being what this legislation is about and that the prescribers are regulated in a different way, not under this legislation.

Senator McKIM: Yes, and they have been regulated in a different way for many years and we're in a crisis situation.

Dr Towler: Which is why we're doing a whole suite of work around education and changing the PBS. We're also implementing a behavioural project with the prescribers so we're able to identify who the prescribers are. We'll be writing to them, and we can identify the ones who are the high prescribers. I could go into more and more detail, but there are lots of projects that we have underway to try to address exactly the issue of inappropriate prescribing of these types of medications.

Senator McKIM: This is my last question on this. I think this regulation requires that alternatives to chemical restraint need to be documented, but the reg also says 'if any'. Doesn't that suggest that no alternatives need to be recorded if they haven't been tried? In other words, it's not clear that it's a last resort.

Dr Towler: No. It's saying that alternatives may have been considered but haven't been used by the practitioner who has prescribed the medication, so we needed to say 'if any' because there may not have been any. There may have been a very thorough assessment, but that wasn't going to work for this person at this point in time, so there may not be any.

Senator McKIM: I want to ask a couple of questions around consultation. Firstly, did any human rights organisations get consulted, given that, in your explanatory statement, you've accepted that this engages a number of Australia's human rights obligations? If you want to take that on notice, that's fine, by the way. Perhaps I could ask you to respond by way of providing a list of the organisations that were consulted.

Dr Towler: Yes, we could do that.

Senator McKIM: Could you also, if you are able, provide a synopsis of the consultation process? We've heard evidence that some people who were involved didn't get to see a draft of this, for example. Just what is the actual consultation—

Ms Laffan: We can provide that, yes.

Senator McKIM: Lastly, on human rights—because this is the Human Rights Committee—the explanatory statement accepts that it engages some of Australia's international human rights obligations. They include the International Covenant on Civil and Political Rights, protections for people with disabilities and also for economic and cultural rights. But it doesn't include the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, and we've had evidence today that this clearly engages that instrument. Do you have a view on that that you'd like—

Ms Laffan: I'd have to take that on notice.

Senator McKIM: You'll take that on notice. Basically, the question I'd like you to take on notice is: in the department's view, does it engage Australia's obligations under the convention against torture? That's a shorthand version of a longer protocol which includes prohibitions against inhuman treatment. The evidence that we've received today is that, in the view of some submitters, it does engage them. If the department thinks it doesn't, could you explain why you think it doesn't? And if the department thinks it does, could you explain why it doesn't say it in the explanatory memorandum? Thank you.

Mr PERRETT: I have one final one, Chair.

CHAIR: Yes—one final question.

Mr PERRETT: It's going back to the safeguards—because that's what I'm particularly concerned about—and to the suggestion that we bring in this regulation, which should reflect current best practice. But, in terms of actually changing it, it comes back to the question I asked earlier: why not use the NDIS model? It's got the conditions there to make sure you're making it a last-possible choice in terms of decisions that are perhaps going to take away a person's freedoms at the end of their life and put them in harm's way.

Ms Laffan: Broadly, it's just that the aged-care requirements sit within a different legislative framework than do the NDIS requirements. But our view is that we substantially replicate the NDIS requirements as part of our principles, and certainly we had discussions with the NDIS. NDIS were part of our consultation group.

Mr PERRETT: All right. Thank you.

Senator McKIM: I will ask a follow-up, if you don't mind, Ms Laffan. I think you said you essentially do reflect the NDIS rules, but they require that interventions be, for example, the least restrictive response possible in the circumstances, that they reduce the risk of harm, that they be in proportion to the potential negative consequences and that they be used for the shortest possible time. Now, none of those are reflected in this instrument.

Ms Laffan: I would disagree; most of them are.

Dr Towler: Most of those are in this instrument.

Senator McKIM: Could you point me to the place where this instrument requires that chemical restraints be used for the shortest possible time?

Dr Towler: Physical restraint—

Senator McKIM: No, chemical restraint.

Dr Towler: That, again, goes to the clinical judgement of the prescribing practitioner—doctor or nurse practitioner.

Senator McKIM: I understand that, and that's the consistent response you've given.

Dr Towler: So it sits outside this legislation.

Senator McKIM: I understand that. Does your department administer NDIS?

Dr Towler: No, we don't.

Ms Laffan: No, it doesn't.

Senator McKIM: It doesn't? I'll just draw to your attention that a different Commonwealth department has taken a very different approach to this. In the NDIS rules, these things are explicit. So we don't get, 'They're dealt with elsewhere'; we get, 'They are explicitly in the NDIS rules.' I'm not comforted, because they are not explicit in this instrument. I guess it's just a different approach from different departments, which is interesting. So two groups of presumably highly competent people—and I make no assertion to the contrary—have come to different views about how to regulate it. The NDIS explicitly requires, for example, that certain interventions be used for the shortest possible time. And they didn't rely on those matters being captured elsewhere, which is the argument that you guys are giving us for the fact that this instrument does not explicitly require that.

Dr Towler: That is explicitly there for physical restraint.

Senator McKIM: But not for chemical.

Dr Towler: I think we've made the arguments for why it isn't there for chemical, and I would suggest that it would be inappropriate to be here, in this instrument, for chemical, which is why we didn't do that. We did consider those sorts of issues, yes.

CHAIR: As there are no further questions, I thank representatives from the Department of Health for appearing before the committee, and for giving your time today. This concludes today's proceedings into the committee's inquiry into the Quality of Care Amendment (Minimising the Use of Restraints) Principles 2019. The committee has resolved that, where any questions have been taken on notice by witnesses today, the date of return of answers to these questions on notice will be 9 September 2019. I thank all the witnesses who have given evidence to the committee today. Thank you also to Hansard, Broadcasting and the secretariat.

Committee adjourned at 17:06