The Public Advocate
Influencing change to transform lives

11 March 2025

Department of Health and Aged Care
New Aged Care Act Consultation
GPO Box 9848
Canberra
ACT 2601

Via online submission

Re: Aged Care Rules – Release 3 Relating to Provider Obligations

Thank you for the opportunity to comment on the draft of the new *Aged Care Act Rules 2025* (the Rules).

As you may be aware, as the Public Advocate for Queensland, I undertake systemic advocacy to promote and protect the rights and interests of Queensland adults with impaired decision-making ability.[1] There are several conditions that may affect a person's decision-making ability, including intellectual disability, acquired brain injury, mental illness, neurological disorders (such as dementia) or alcohol and drug misuse.

My submission concerns the restrictive practices provisions contained in the new Rules, which I note have been taken from the current *Quality of Care Principles 2014*.

I have previously expressed strong reservations about the consent-based authorisation framework regarding restrictive practices in aged care, which I initially noted when the Quality of Care Principles were amended in 2022, with my concerns noted in a letter that I wrote to the Minister for Aged Care and Minister for Sport (attached).

I have also recently published a Discussion Paper in relation to this issue, the 'Proposal for the future regulation (and reduction in the use) of restrictive practices in Queensland' (attached).

Further to this, I have drafted a number of articles outlining my concerns, which are available on the Australian Ageing Agenda website (https://www.australianageingagenda.com.au/author/dr-john-chesterman/).

The solution to my concerns is to encourage each state and territory to develop their own authorising frameworks for restrictive practices in aged care (and other) settings, which should go some way toward reducing the complexity of the scheme and enable aged care service providers to concentrate on reducing and eliminating restrictive practice usage.

However, a further concern I have is that, on my reading of the new Rules, the existing framework could potentially extend beyond December 2026, as the Rules state that it is only 'intended' that the relevant provisions will be repealed, with no certainty that this will occur (see notes to this effect at Rules 6-15, 6-20(2) and 162-40).

It would be preferable, from my perspective, for a 'sunset' clause to be inserted into the Rules.

[1] *Guardianship and Administration Act 2000* (Qld) s 209.

Thank you again for the opportunity to comment on the draft *Aged Care Act Rules*.

Should you wish to discuss any of the matters I have raised in this submission further, please do not hesitate to contact my office via email public.advocate@justice.qld.gov.au or phone 07 3738 9513.

Yours sincerely

John Chesterman (Dr)
Public Advocate

Enc.

The Public Advocate
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5 September 2022

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

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

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

Dear Minister,

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

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

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

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

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

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

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

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

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

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

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

5. **Restrictive practices authority**.

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

6. **Nominee**.

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

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

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

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

8. **Medical treatment authority**.

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

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

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

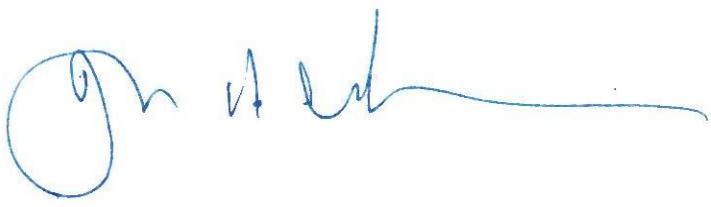
b. Second, as I have previously argued, this proposal would give such a person far more power than they have under existing state and territory law. The idea here is that the person who can play this role is 'an individual or body that, under the law of the State or Territory in which the care recipient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

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

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

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

Yours sincerely,



John Chesterman (Dr)
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Proposal for the future regulation (and reduction in the use) of restrictive practices in Queensland

Discussion Paper

March 2025

1. Introduction

This discussion paper provides an outline of how a state-based system could be established for the authorisation of restrictive practices across a range of settings. It draws on earlier work I have conducted as Public Advocate, including an Options Paper from 2021,[1] a series of articles on aged care restrictive practices that were published in *Australian Ageing Agenda*,[2] and a book chapter in which I called for the adoption of a uniform authorisation process.[3] The discussion paper identifies in greater detail the way in which a state-based authorisation mechanism could work.

The problems with the regulation of restrictive practices are well known.

We have sector specific and quite differing regulatory approaches in an array of fields, such as in disability services, authorised mental health services, and in aged care homes. Meanwhile there is very limited regulation in other areas, such as health services, out-of-home child protection and in educational settings.

The result is very piecemeal and inconsistent regulation, where it exists, that:

- makes compliance difficult;
- inevitably results in unauthorised usages of restrictive practices and an under-reporting of restrictive practice usage;
- makes all but impossible any cross-sector comparison of restrictive practice usage; and
- inhibits a broad expertise-led approach to minimising and eliminating the use of restrictive practices.

We can do better.

The proposal raised in this paper is that Queensland create the statutory role of Senior Practitioner, which would have authority to oversee the authorisation of restrictive practices in a range of fields.

Following a staged introduction, the proposal is that the Senior Practitioner's role would ultimately extend to the authorisation of restrictive practice usage by disability services, aged care services, health services, and potentially by other services, including those operating in educational and out-of-home child protection settings.

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[1] Queensland Public Advocate, 'Improving the regulation of restrictive practices in Queensland: a way forward', 5 October 2021, available at https://www.justice.qld.gov.au/__data/assets/pdf_file/0004/697729/20211005-opa-restrictive-practices-reform-options-paper.pdf.

[2] See John Chesterman 'Stopping the inappropriate use of restrictive practices', *Australian Ageing Agenda*, 17 May 2022; 'Proposed restrictive practice changes "deeply flawed"', *Australian Ageing Agenda*, 7 September 2022; 'Are we regulating or regularising aged care restrictive practices?', *Australian Ageing Agenda*, 14 December 2022; 'A way forward on restrictive practice regulation', *Australian Ageing Agenda*, 20 April 2023; 'What needs to happen to significantly reduce restrictive practice use in Australia's aged care homes?', *Australian Ageing Agenda* magazine, July-August 2023, p. 20; 'More work needed on aged care bill', *Australian Ageing Agenda*, 22 January 2024 (a briefer version was also published in the hard copy of *Australian Ageing Agenda* magazine, January-February 2024, p. 17).

[3] John Chesterman, 'Who approves the use of restrictive practices in Australia? The case for a uniform authorisation process', in Kay Wilson, Yvette Maker, Piers Gooding and Jamie Walvisch (eds), *The future of mental health, disability and criminal law: Essays in honour of Emeritus Professor Bernadette McSherry* (Routledge, 2024), pp. 73-87.

2. What are restrictive practices?

While different definitions exist of what constitutes a restrictive practice, there is increasing broad regulatory alignment at least on this topic, certainly so far as the disability and aged care sectors are concerned.

The NDIS and aged care legislation each defines a 'restrictive practice' to be 'any practice or intervention that has the effect of restricting the rights or freedom of movement of' the relevant person.[4]

The Commonwealth NDIS rules and the aged care 'Quality of Care Principles' each then define particular restrictive practices in the way depicted in the following table.

Restrictive practice	NDIS Rules definitions[5]	Quality of Care Principles (aged care) definitions[6]
Seclusion	'the sole confinement of a person with disability in a room or a physical space at any hour of the day or night where voluntary exit is prevented, or not facilitated, or it is implied that voluntary exit is not permitted'	'a practice or intervention that is, or that involves, the solitary confinement of a care recipient in a room or a physical space at any hour of the day or night where: (a) voluntary exit is prevented or not facilitated; or (b) it is implied that voluntary exit is not permitted; for the primary purpose of influencing the care recipient's behaviour'
Chemical restraint	'the use of medication or chemical substance for the primary purpose of influencing a person's behaviour. It does not include the use of medication prescribed by a medical practitioner for the treatment of, or to enable treatment of, a diagnosed mental disorder, a physical illness or a physical condition'	'a practice or intervention that is, or that involves, the use of medication or a chemical substance for the primary purpose of influencing a care recipient's behaviour, but does not include the use of medication prescribed for: (a) the treatment of, or to enable treatment of, the care recipient for: (i) a diagnosed mental disorder; or (ii) a physical illness; or (iii) a physical condition; or (b) end of life care for the care recipient'
Mechanical restraint	'the use of a device to prevent, restrict, or subdue a person's movement for the primary purpose of influencing a person's behaviour but does not include the use of devices for therapeutic or non-behavioural purposes'	'a practice or intervention that is, or that involves, the use of a device to prevent, restrict or subdue a care recipient's movement for the primary purpose of influencing the care recipient's behaviour, but does not include the use of a device for therapeutic or non-behavioural purposes in relation to the care recipient'
Physical restraint	'the use or action of physical force to prevent, restrict or subdue movement of a person's body, or part of their body, for the primary purpose	'a practice or intervention that: (a) is or involves the use of physical force to prevent, restrict or subdue movement of a care recipient's body, or part of a care recipient's body, for the primary

[4] *NDIS Act 2013* (Cth), section 9; *Aged Care Act 2024* (Cth), section 17.
[5] National Disability Insurance Scheme (Restrictive Practices and Behaviour Support) Rules 2018, Rule 6.
[6] Quality of Care Principles 2014, compilation 19, 1 October 2024, section 15E.

	of influencing their behaviour. Physical restraint does not include the use of a hands-on technique in a reflexive way to guide or redirect a person away from potential harm/injury, consistent with what could reasonably be considered the exercise of care towards a person'	purpose of influencing the care recipient's behaviour; but (b) does not include the use of a hands-on technique in a reflexive way to guide or redirect the care recipient away from potential harm or injury if it is consistent with what could reasonably be considered to be the exercise of care towards the care recipient'
Environmental restraint	restricts 'a person's free access to all parts of their environment, including items or activities'.	'a practice or intervention that restricts, or that involves restricting, a care recipient's free access to all parts of the care recipient's environment (including items and activities) for the primary purpose of influencing the care recipient's behaviour'.

While these broad definitions in federal regulations largely align, there remain ongoing practice challenges in identifying whether particular interventions satisfy the relevant legislative criterion. For instance, does the use of a locked keypad front door – a standard feature of residential aged care facilities – always constitute an environmental restraint? When does the use of a sedative constitute a chemical restraint?

The lack of uniform regulation of restrictive practices enables different sectors to develop their own answers to these questions. From the perspective of the person at the centre of all of this – the person subject to the limitation on their free movement – this does not make sense. Uniform regulation would almost certainly ensure that this changes.

3. Current data

Reliable data on restrictive practice usage is not readily available.

The disability sector has the most thorough statistics, though even here there are significant gaps, and much of the data comes essentially from the self-reports of those providers who have used restrictive practices. As the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability (Disability Royal Commission) noted: 'Data collection and reporting on the use of restrictive practices on people with disability in Australia are poor. This means the use of restrictive practices cannot be properly assessed, monitored over time or compared across settings or jurisdictions.'[7]

At a national level, the NDIS Quality and Safeguards Commission collates data reported monthly to it by disability service providers concerning their use of restrictive practices on NDIS participants.

As the Disability Royal Commission noted in its final report, the NDIS Quality and Safeguards Commission, in the year to June 2022, recorded '1.4 million unauthorised uses of restrictive practices against 8,830 NDIS participants' and '5.58 million uses of authorised restrictive practices against 8,685 NDIS participants.'[8]

More recently, we know that in the year to June 2024, there were 14,390 NDIS participants in relation to whom behaviour support plans had been lodged with the Commission. (We also know that the Commission has serious reservations about the quality of behaviour support plans.)[9]

Even in the disability sector, where the data is more extensive than elsewhere, the high rate of self-reported unauthorised restrictive practice usage gives considerable grounds for surmising that a very

[7] Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability (Disability Royal Commission), *Final Report*, 2023, Executive Summary, p. 82.
[8] Disability Royal Commission, *Final Report*, Executive Summary, p. 82.
[9] NDIS Quality and Safeguards Commission, *Annual Report 2023-2024*, available via https://www.ndiscommission.gov.au/about-us/corporate-reports#paragraph-id-9478, at pp. 78-79.

significant amount of restrictive practice usage is unreported, or under-reported. One imagines this underreporting to be particularly pronounced in those jurisdictions where no formal authorisation process exists; where knowledge of restrictive practice definitions and reporting responsibilities is likely to be even lower than elsewhere.

In compulsory settings, annual reports from the Queensland Chief Psychiatrist detail restrictive practice usage in mental health services,[10] while annual reports from the Queensland Director of Forensic Disability detail restrictive practice usage in relation to Forensic Disability Service clients.[11]

In other sectors, the limited data that we have comes from self-reports of those utilising restrictive practices, or from estimates.

Aged care is a signature example. We know that restrictive practice usage in aged care facilities is common. For instance, the Australian Institute for Health and Welfare, in compiling 'quality indicators' self-reporting from aged care providers, notes that in each quarter between mid-2021 and mid-2024, between 17 and 23 per cent of aged care residents were subject to the 'use of physical restraint'.[12]

Meanwhile Dementia Australia estimates that more than half of aged care residents are being prescribed 'antipsychotic medications'.[13] In the absence of meeting strict clinical criteria, the use of such medications will constitute a chemical restrictive practice.

But the use of restrictive practices by aged care providers does not need to be externally authorised or even reported to the main sector oversight body, the Aged Care Quality and Safety Commission, which notes that the authorised 'use of restrictive practices does not need to be reported to the Commission.'[14]

The poor level of publicly-available data on restrictive practices usage is – self-evidently – a key inhibitor to our ability to monitor, and reduce, its usage. When so much is out of sight, it is difficult to identify and prioritise the areas on which the regulatory torch needs to be shone.

4. Current regulatory requirements

In this section I will briefly explore current restrictive practice regulatory requirements, focussing on compulsory mental health, forensic disability, general disability and aged care settings; each of these settings has in place specific legislated authorisation requirements.

In other sectors, such as the health, education, and out-of-home child protection fields, sector specific requirements come more in the form of general laws, and occasionally departmental guidelines and directives.

To take health settings as one example, while there is no specific legislative authorisation framework in place concerning the use of restrictive practices in these settings, more than a dozen pieces of state and federal legislation have possible application when restrictive practices are in use.

For instance, Queensland's guardianship legislation provides that: 'A health provider and a person acting under the health provider's direction or supervision may use the minimum force necessary and reasonable to carry out health care authorised under this Act.'[15] Meanwhile the *Criminal Code* provides generally

[10] See Office of the Chief Psychiatrist (Qld), *Annual Report 2023-2024*, available at https://www.health.qld.gov.au/__data/assets/pdf_file/0032/1364954/Chief-Psychiatrist-Annual-Report-2023-2024.PDF, pp. 50-59.
[11] Director of Forensic Disability (Qld), *Annual Report 2023-2024*, available at https://www.parliament.qld.gov.au/Work-of-the-Assembly/Tabled-Papers/docs/5824T0224/5824t224.pdf, pp. 22-24.
[12] Australian Institute of Health and Welfare, Gen Aged Care Data. Residential Aged Care. Quality Indicators – April to June 2024. Technical Notes, 22 October 2024, available at https://www.gen-agedcaredata.gov.au/getmedia/7de80607-fb64-4321-9fe5-6d7746d17921/RACS-QI-report-April-to-June-2024-technical-notes_Q4, p. 10.
[13] Dementia Australia, Restrictive practices: A submission to the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, 2020, available at https://www.dementia.org.au/sites/default/files/2024-02/Dementia-Australia-Disability-Royal-Commission-restrictive-practices-submission.pdf, at p. 4.
[14] Aged Care Quality and Safety Commission, *Reportable incidents: Inappropriate use of restrictive practices*, fact sheet, available at https://www.agedcarequality.gov.au/sites/default/files/media/sirs-inappropriate-use-of-restrictive-practices-fact-sheet_0.pdf, at p. 4.
[15] *Guardianship and Administration Act 2000* (Qld), s. 75.

that: 'An assault is unlawful and constitutes an offence unless it is authorised or justified or excused by law.'[16]

Restrictive practice usage in health settings is far from unusual; this usage is not meaningfully constrained, monitored, or regulated through the existence of these broad legislative provisions.

In fields where restrictive practices are subject to legislative regulation, there are broadly two regulatory models in place. One involves external authorisation by a legislatively empowered office holder. The other involves authorisation by the person concerned through their consent to the practice, or far more typically via the consent to the practice by someone else on the person's behalf.

Compulsory mental health and forensic disability

In compulsory mental health settings, the Queensland *Mental Health Act* enables authorised doctors and/or the Chief Psychiatrist to authorise certain restrictive practices, including 'mechanical restraint' and seclusion; and this legislation also provides parameters for other restrictive practice usage, including 'physical restraint' and the use of sedative medication. The legislation further empowers the Chief Psychiatrist to give directions about certain restrictive practices.[17]

Meanwhile the *Forensic Disability Act* enables the authorisation by clinicians, or certain office holders, of the use of 'restraint', seclusion, and 'behaviour control medication' in forensic disability settings, which at present principally consists of the Forensic Disability Service in Wacol.[18]

Disability

Currently in Queensland the regulatory model in use concerning restrictive practices in the disability field consists of a mixture of a consent (or really substitute consent) model, together with a requirement in some cases for external authorisation. A 'guardian for a restrictive practice' can approve the use of restrictive practices on adults who receive 'disability services', with short-term approvals able to be provided by the relevant departmental head. The Queensland Civil and Administrative Tribunal (QCAT), meanwhile, is required to approve seclusion and containment, with the Public Guardian able to provide such authorisations for six months or less.[19]

There are some peculiarities with the Queensland requirements. For instance, the relevant legislation here uses the term 'containment' instead of 'environmental restraint', and the current legislation specifies that an adult 'is not contained' if they have 'a skills deficit' and their 'free exit from the premises is prevented by the locking of gates, doors or windows'.[20] Similarly 'mechanical restraint' is defined so as not to include 'using bed rails or guards to prevent injury while the adult is asleep'.[21]

A very important development in Queensland in 2024 was the introduction of legislation that would have established in Queensland what I am terming a 'Senior Practitioner authorisation model' for the authorisation of restrictive practices in disability services. The Disability Services (Restrictive Practices) and Other Legislation Amendment Bill 2024 was introduced to parliament in June 2024 and was reviewed by the Community Support and Services Committee, which recommended that the Bill's reach extend to regulated 'residential services', and that the Bill be passed.[22] The Bill, however, lapsed when parliament was prorogued in the lead-up to the 2024 State election.

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[16] *Criminal Code 1899* (Qld), section 246.
[17] *Mental Health Act 2016* (Qld), chapter 8, especially sections 249, 250, 257, 258, 267, 272, 273.
[18] *Forensic Disability Act 2011* (Qld), chapter 6, especially sections 50, 56, 62.
[19] *Guardianship and Administration Act 2000* (Qld), chapter 5B; *Disability Services Act 2006* (Qld), part 6.
[20] *Disability Services Act 2006* (Qld), section 146(2).
[21] *Disability Services Act 2006* (Qld), section 147(2).
[22] Community Support and Services Committee, Report on the Disability Services (Restrictive Practices) and Other Legislation Amendment Bill 2024, July 2024, available at https://www.parliament.qld.gov.au/Work-of-the-Assembly/Tabled-Papers/docs/5724t1161/5724t1161-e13f.pdf.

Other jurisdictions, such as Victoria, the ACT and Tasmania, have established variations on a Senior Practitioner authorisation model.

In Victoria the Senior Practitioner monitors the work of 'authorised program officers' who can approve restrictive practices, while some significant interventions, such as seclusion, require the approval of the Senior Practitioner.[23]

In the ACT the Senior Practitioner appoints panels which can approve proposed restrictive practices that are contained in behaviour support plans.[24]

In each case behaviour support plans, outlining the need for restrictive practice usage, must be prepared and lodged with the Senior Practitioner. Particular requirements accompany the use of restrictive practices in emergency situations.[25]

Tasmania legislated in 2024 to introduce a Senior Practitioner authorisation model in relation to restrictive practice use by disability service providers.[26]

A variation on this mechanism, involving 'authorised program officers' and a 'Senior Authorising Officer', exists in South Australia.[27]

New South Wales has recently released a consultation paper proposing that a 'Senior Practitioner would authorise or oversee authorisation of restrictive practices used in the provision of NDIS funded services by NDIS providers'. This would cover a range of NSW settings in which 'NDIS funded services are provided'.[28]

At the national level, requirements exist in relation to restrictive practice usage on NDIS participants that are additional to the requirement to meet state and territory authorisation requirements (where these exist). These include the requirement that providers of behaviour support services must be registered with the NDIS Quality and Safeguards Commission; and, as noted earlier, monthly usage of restrictive practices must be reported to the Commission.[29]

Aged Care

The origins of the current way in which restrictive practices are regulated in aged care settings began in 2019, with the establishment of a consent-based authorisation model.[30]

The Royal Commission into Aged Care Quality and Safety, in its final report, recommended that the Quality of Care principles be revised to specify that restrictive practices in aged care settings should only be permitted 'with the documented informed consent of the person receiving care or someone authorised by law to give consent on that person's behalf'.[31]

This resulted in a provision being added to the aged care legalisation requiring there to be informed consent to any restrictive practice usage, a requirement that has been continued in the new Aged Care Act that was enacted in 2024.[32]

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[23] *Disability Act 2006* (Vic), parts 6A and 7.
[24] *Senior Practitioner Act 2018* (ACT).
[25] *Disability Act 2006* (Vic), sections 137, 138, 145; *Senior Practitioner Act 2018* (ACT), part 3; see also Chesterman, 'Who approves the use of restrictive practices in Australia?', p. 75.
[26] *Disability Rights, Inclusion and Safeguarding Act 2024* (Tas), parts 6 and 7.
[27] *Disability Inclusion Act 2018* (SA), part 6A.
[28] New South Wales Department of Communities and Justice, *Consultation paper: A legislative framework to regulate restrictive practices*, December 2024, available at https://hdp-au-prod-app-nsw-haveyoursay-files.s3.ap-southeast-2.amazonaws.com/3117/3344/0342/Consultation_Paper.pdf, at pp. 10, 15.
[29] *National Disability Insurance Scheme Act 2013* (Cth), sections 73B, 181H; National Disability Insurance Scheme (Restrictive Practices and Behaviour Support) Rules 2018.
[30] See Chesterman, 'Who approves the use of restrictive practices in Australia?', pp. 79-80.
[31] Royal Commission into Aged Care Quality and Safety, *Final Report*, 2021, recommendation 17.
[32] *Aged Care Act 1997* (Cth), section 54.10(1)(f); see also Chesterman, 'Who approves the use of restrictive practices in Australia?', p. 80. See now *Aged Care Act 2024* (Cth), section 18(1)(f).

According to the current rendition of the Quality of Care Principles, the relevant parts of which have been extended until December 2026, restrictive practices can only be used in aged care settings where:

> 'informed consent to the use of the restrictive practice, and how it is to be used (including its duration, frequency and intended outcome), has been given by:
> (i) the care recipient; or
> (ii) if the care recipient lacks the capacity to give that consent — the restrictive practices substitute decision-maker for the restrictive practice'.[33]

The Quality of Care Principles recognise a person as a:

> 'restrictive practices substitute-decision maker … if the individual or body has been appointed, under the law of the State or Territory in which the care recipient is provided with aged care, as an individual or body that can give informed consent to the use of the restrictive practice in relation to the care recipient'.[34]

The Quality of Care Principles then set out a statutory hierarchy of people who can play the role of 'restrictive practices substitute-decision maker' in the event that:

> 'there is no such individual or body appointed for the restrictive practice in relation to the care recipient under the law of the State or Territory in which the care recipient is provided with aged care; and … either:
> (i) there is no clear mechanism for appointing such an individual or body under the law of the State or Territory; or
> (ii) an application has been made for an appointment under the law of the State or Territory in relation to the use of the restrictive practice in relation to the care recipient, but there is a significant delay in deciding the application.'

That statutory hierarchy includes a person appointed as a 'restrictive practices nominee' and also extends to others who have not been appointed to the role by the person themselves or a tribunal, including a person's partner, relative, or even 'friend'. [35]

I have previously described, and continue to describe, this extraordinarily complex regulatory situation as quite flawed.[36]

Demonstrating the complexity of this scheme, in order to apply it one must first know whether there is a 'clear mechanism' for the appointment of restrictive practices substitute decision makers in the state or territory in question.

The answer to this has taken some time to clarify. All states and territories allow for the appointment of guardians, but do those guardians have the power to authorise aged care restrictive practices?

In 2022 QCAT determined that a guardian appointed under section 12 of the *Guardianship and Administration Act* with power to make decisions in relation to 'personal matters' had power to authorise aged care restrictive practices. [37] This, it should be clarified, is different to the power of guardians in Queensland who are appointed as guardians for restrictive practices under Chapter 5B of the *Guardianship and Administration Act* (which relate to restrictive practices used by disability services).

A corollary to this determination is that a person appointed under an enduring power of attorney in Queensland, with power to make decisions about 'personal matters', would likely also have power to make aged care restrictive practices decisions.

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[33] Quality of Care Principles 2014, compilation 19, 1 October 2024, section 15FA(1)(f).
[34] Quality of Care Principles 2014, compilation 19, 1 October 2024, section 5B.
[35] Quality of Care Principles 2014, compilation 19, 1 October 2024, section 5B.
[36] John Chesterman: 'More work needed on aged care bill', *Australian Ageing Agenda*, 22 January 2024.
[37] *NJ* [2022] QCAT 283 par. 102.

It is worth noting that a different decision was reached in Victoria, where guardians were found not to be able to authorise aged care restrictive practices.[38] This resulted in new legislation being enacted to enable the identification of people in Victoria who could authorise aged care restrictive practices.[39]

Even in a jurisdiction like Queensland where, following the *NJ* decision, it could be seen that there was a 'clear mechanism' for the appointment of a restrictive practices substitute decision maker, the Quality of Care Principles are not easy to apply. As noted above, the statutory hierarchy set out in the Principles can still be used if there is a 'significant delay' in determining a guardianship application. How long is a significant delay?

In practice it is accepted in Queensland that a delay in hearing a guardianship application of more than three months probably constitutes a 'significant delay'. So the statutory hierarchy can be used in those circumstances. But this requires knowing in advance how long the delay is. And the statutory hierarchy can only be used once an application has been made. It cannot be used, in a jurisdiction like Queensland, in the absence of a guardianship application, something which is widely misunderstood.

I have previously argued that a state Senior Practitioner ought to have responsibility to oversee the authorisation of aged care restrictive practices, an argument incidentally that is supported by Queensland's Public Guardian.[40]

5. The case for uniform regulation

As can be seen, current regulatory arrangements for the use of restrictive practices in Queensland (and indeed elsewhere in Australia), where they exist, are very complex.

There are four reasons why more uniform regulation of restrictive practices is required.

First, some fields are insufficiently regulated, such as health, education and out-of-home care, where there is no specific legislative authorisation mechanism in place in Queensland. This means there is insufficient protection of the human rights of people who are subject to restrictive practices in these fields.

Second, the sector-specific and uneven nature of current regulatory requirements inevitably makes compliance more difficult than it would be were there a uniform process.

For instance, as I discussed in the previous section, there is currently a state-based authorisation scheme for restrictive practice use by disability services; this sees adult guardians authorised to consent to some restrictive practices, with QCAT authorised to approve containment and seclusion. In aged care, federal regulations enable individuals empowered at state level to approve the use of restrictive practices. Where such individuals do not exist, the regulations allow for nominees to provide consent, or, where other conditions are met, those highest placed on an automatic statutory hierarchy of approvers can provide authorisation for a restrictive practice to be used.

In addition to knowledge about sector-specific requirements taking time to acquire and retain, this also means that there is no cross-sector consistency in the way particular restrictive practices are classified. While there is increasing alignment on how restrictive practices generally are defined, particular questions endure, as indicated earlier, such as whether a locked door is always an environmental restraint, and whether particular medications constitute chemical restraints. The answers to these questions can currently be quite sector-specific – one might be viewed as a restrictive practice when used by a disability service but not when used in an aged care home – which would be less likely were regulation uniform.

The third reason justifying uniform regulation is that the current sector-specific nature of regulation makes all but impossible the comparison of restrictive practice usage across sectors, which significantly impedes broad monitoring and improvement activity.

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[38] *HYY (Guardianship)* [2022] VCAT 97, pars. 175, 206; *KGW (Guardianship)* [2024] VCAT 1091, esp par. 34.
[39] *Aged Care Restrictive Practices Substitute Decision-maker Act 2024* (Vic).
[40] Chesterman, 'Who approves the use of restrictive practices in Australia?', p. 84; Office of the Public Guardian, *Annual Report 2023-24*, p. 12.

Even more importantly, a fourth reason to support uniform regulation concerns the fact that sector-specific regulatory requirements, where they exist, inhibit the development of broad cross-sector expertise on how restrictive practices can be reduced and eliminated.

6. Senior Practitioner or consent authorisation model?

In promoting a harmonised approach to restrictive practice regulation, a decision needs to be made as to which of the two predominant models should be preferred: the Senior Practitioner authorisation model, which is increasingly common in state and territory disability sectors; or the consent model, which remains central to aged care restrictive practice regulation.

I have previously argued, including in the options paper mentioned above, that the consent model is sub-optimal for three key reasons.

First, any requirement for a person to consent to their own restrictive practice generates significant ethical and pragmatic concerns. Preventing a person from leaving a locked facility on the basis that they previously agreed to this, makes little sense (the fact that they are trying to leave indicates they no longer wish to be bound by any earlier undertaking).

It is worth noting that elsewhere our laws recognise that a person's consent is insufficient to authorise a harm being committed against them. For instance, Queensland's *Criminal Code* provides that 'The application of force by one person to the person of another may be unlawful, although it is done with the consent of that other person'.[41]

In reality it is not the person's own consent, but substitute consent that is typically sought – the consent given by another person on behalf of the person who is subject to the restriction.

Substitute decision-making laws are increasingly requiring such decision makers to make decisions that accord with what the person themselves would have wanted to happen. So we are back to the ethical and pragmatic difficulty of requiring substitute decision makers to consent to a restrictive practice only if they believe that the person themselves would likely have consented to it.

Or we are asking the substitute decision maker to override the person's will and preferences here in order to protect the person, or others, from serious harm.

That is the nub of the second problem, namely that asking a substitute decision maker to consent to a restrictive practice puts them in a very difficult position. Inevitably restrictive practice usage is implemented in a bid to restrain the person from harming themselves or others. The substitute decision maker will feel pressure to consent, since their refusal to do so could be depicted as them jeopardising the wellbeing of the person in question, or those who interact with them. Relatedly, the decision maker may also feel pressure to consent to the restrictive practice or risk jeopardising the person's current living arrangements.

Third, substitute decision makers will rarely have the clinical expertise to identify alternative behaviour management options to the use of restrictive practices. Theirs will tend to be a 'yes/no' answer, and without clinical expertise, people making substitute consent decisions will have little basis on which to resist the pressure on them to provide consent.

The Parliamentary Joint Committee on Human Rights, which I was invited to brief, shares these concerns. In a March 2023 report concerning proposed aged care reforms, the Committee noted 'that further consideration should … be given to whether the consent model to the use of restrictive practices is the best approach to protect the rights of aged care residents'.[42]

[41] *Criminal Code 1899* (Qld), section 246(2).
[42] Parliamentary Joint Committee on Human Rights, Report 3 of 2023, available at PJCHR Report 3 of 2023 - no signature.pdf, par. 1.35.

It is important to note that my critiques of the consent model do not for a moment mean that the views of the person who is subject to a restrictive practice are not relevant. Their views should always be sought, and the person worked with to identify alternative ways of minimising whatever dangers have led to the potential use of a restrictive practice.

In addition, when one considers the use of chemical restraints in their most common form – a pill – for this restrictive practice to be implemented the person must be willing to take the pill, and good medical practice will require the prescribing physician to explain to the person what it is they are being asked to take, and why.

Similarly with a locked cupboard, when such a drastic measure is considered to be essential to prevent an adult from harming themselves, the appropriate practice is to explain to the person the need for the measure and ensure that no less restrictive options are feasible. Ideally the person would accept the reason for the practice; but they may not.

The point is that there needs to be an extrinsic authorisation process – in addition to engagement with the person – since, for the reasons outlined above, the informed consent of the person, or someone on their behalf, is not a sufficient safeguard.

As I've described in this discussion paper, the Senior Practitioner authorisation model is increasingly popular among Australia's states and territories in the disability field. Foremost among its benefits are this model's prioritisation of clinical expertise in overseeing the authorisation of restrictive practices, and in monitoring both their usage and the quality of behaviour support plans that are lodged in relation to them.

The Disability Royal Commission made a number of recommendations in relation to restrictive practices, including these:

> 'States and territories should ensure appropriate legal frameworks are in place in disability, health, education and justice settings, which provide that a person with disability should not be subjected to restrictive practices, except in accordance with procedures for authorisation, review and oversight established by law …
>
> The legal frameworks should set out the powers and functions of a Senior Practitioner for restrictive practices in disability service provision (or equivalent authority). These powers and functions should include … considering applications to use restrictive practices in disability service settings and authorising their use …'[43]

The Independent Review into the NDIS also recognised, in its final report, that 'the Senior Practitioner model is recognised as the best practice approach for the authorisation of restrictive practices'.[44]

7. A uniform authorisation process

My key reform proposal is that Queensland should create the statutory office of Queensland Senior Practitioner, with the holder of that office having the authority to authorise restrictive practices in a broad range of fields, beginning with providers of state and federally-funded disability support, and extending to aged care, health, and potentially to education and out-of-home child protection settings.

In compulsory mental health and forensic disability settings, existing legislation provides authorisation processes that are comparable to the model being proposed here; inasmuch as there is generally a legislative requirement for a particular restrictive practice to be authorised either by a clinician or by a particular office holder. This is unlike the situation in health, education and other settings. And, as with the model being proposed in this discussion paper, authorisation of restrictive practices in compulsory mental health and forensic disability settings does not centre around the informed consent of the person concerned or the substitute consent of someone on the person's behalf.

[43] Disability Royal Commission, *Final Report*, Recommendation 6.35.
[44] Independent Review into the National Disability Insurance Scheme, *Working together to deliver the NDIS*, Final Report, 2023, p. 221.

While there are reasons why a Senior Practitioner's expertise should be available to people working and residing in these clinical settings, I do not believe that a new Senior Practitioner should have authority to authorise restrictive practices in compulsory mental health and forensic disability settings. Such a reform runs the risk of simply creating an even more complex and diversified regulatory situation than currently exists in these already highly regulated settings. The risk, if this were to happen, is that the Senior Practitioner would have oversight of only one aspect of compulsory settings that are largely regulated elsewhere; this may in the end not benefit patients or forensic disability clients.

Having said that, it is very important also to note that significant concerns have been raised about the use of restrictive practices in these compulsory mental health and forensic disability settings,[45] which warrant separate reform attention.

The proposed authorisation model

The proposed transformation to a new authorisation model for the regulation of restrictive practices would require clear guiding principles.

As the Disability Royal Commission noted, each state and territory should have a legislative framework in place that provides:

'that restrictive practices only be authorised and used:

- as a last resort and in response to the risk of harm to the person with disability or others, and only after other strategies … have been explored and applied
- as the least restrictive response possible to ensure the safety of the person with disability or others
- to reduce the risk of harm and be proportionate to the potential negative consequence or risk of harm
- for the shortest time possible.'[46]

In its application to disability service providers, aged care services, health services, and potentially to education and out-of-home child protection services, the proposed scheme would utilise local authorisers – authorised program officers – who would be registered with the Senior Practitioner, who would need to satisfy certain eligibility criteria, and who would have reporting obligations.

In establishing the roles of local authorisers in health settings, there will likely need to be a bespoke approach to ensure that these local authorisers are appropriately integrated within health service clinical governance mechanisms.

The proposal is that all non-emergency usage of restrictive practices would need to be authorised by these local authorisers or by the Senior Practitioner. Any usage beyond one-off or very short term usage (which the office of the Senior Practitioner would be responsible for defining) would need to be accompanied by a Behaviour Support Plan, which would need to be lodged with the Senior Practitioner.

There would be specific requirements for the use of restrictive practices in emergency scenarios (which would still need to be reported to the Senior Practitioner).

The legislation introduced into Queensland Parliament in 2024 to regulate restrictive practices in disability settings did not provide for local authorisers. It instead placed responsibility for authorising all restrictive practices with the Senior Practitioner. This is unlike the situation in Victoria, South Australia and the ACT, where a Senior Practitioner authorisation model (or something like it, in the case of South Australia) is in operation.

[45] See, for instance, Mental Health Lived Experience Peak Queensland, *Shining a light. Eliminating coercive practices in Queensland mental health services*, 2023, available at https://mhlepq.org.au/wp-content/uploads/2023/12/MHLEPQ-CP-report_Shining-a-light-FINAL.pdf; Queensland Ombudsman, *Forensic Disability Service – Second report*, 2024.
[46] Disability Royal Commission, *Final Report*, Executive Summary, p. 83.

My own view is that relying only on the Senior Practitioner to authorise all restrictive practices risks overwhelming the office. In addition, the case for utilising local authorisers becomes stronger as the various service 'markets' become more stabilised.

The Senior Practitioner's roles, I propose, would be to:

- develop the authorisation framework;
- register and monitor the activities of authorised program officers;
- collate data, and publicly report on restrictive practice usage;
- identity when behaviour support plans are required;
- monitor the quality of behaviour support plans; and
- provide practical guidance on when an intervention constitutes a restrictive practice.

As suggested above, the empowerment of a Senior Practitioner to oversee the authorisation of restrictive practices would extend to a range of settings. The priority areas should be disability and aged care services, noting that the relevant elements of the current aged care Quality of Care Principles are due to cease in December 2026. Implementation in other sectors, including health and potentially education and out-of-home child protection, could follow in a staged process after that.

If we are serious about reducing and eliminating restrictive practice usage, we need to have a line of sight on how often restrictive practices are used. And we need to develop an authorising and monitoring regulatory system that has two key elements: it places at its centre the observance of the human rights of the people whose actions and movements are at risk of being curtailed; and it draws on cross-sector behavioural and clinical expertise to ensure that restrictive practices are only ever used briefly and in the most necessitous of circumstances.

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