SUBMISSION

Aging and Adult Safeguarding (Restrictive Practices) Amendment Bill 2021

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1. Introduction

Lived Experience Australia (hereafter LEA) is a national representative organisation for Australian mental health consumers and carers, formed in 2002 with a focus on the private sector. Our core business is to advocate for systemic change, empowerment of consumers in their own care, promoting engagement and inclusion of consumers and carers within system design, planning and evaluation and most importantly, advocating for consumer choice and family and carer inclusion.

2 Comments on the Amendment Bill 2021

Lived Experience Australia (LEA) welcomes this **Bill to amend the *Aging and Adult Safeguarding Act* 1995.** We commend the Hon John Darley MLC for his excellent capture of several key issues of concern to mental health consumers and their family carers, and no doubt to the wider community associated with this issue. His summation of the concerns raised by Dementia Australia in their submission to the Royal Commission on People with a Disability, in August 2020, resonate strongly with us as consumers and family carers of people who experience mental health challenges in the population, and more broadly.

They also resonate with our Executive Director, Prof Sharon Lawn who has the current privilege of supervising Emeritus Professor Eimear Muir-Cochrane, arguably Australia's leading expert on seclusion and restraint in mental health contexts, in her 2nd PhD on the topic at hand. The SafeWards model that Prof Muir-Cochrane has critiqued and proposed as useful for overcoming a range of concerns about the use of restrictive practices in mental health, may offer some useful considerations for the residential aged care setting. The SafeWards model places strong emphasis on the nature of the relationship between staff and residents/inpatients, whilst also acknowledging the complexity of factors at play that need to be considered and examined at the micro (person-staff engagement) level, the meso (physical environment, structure, routine, and activities) level and macro level (regulatory framework) level.

Whilst we fully understand and acknowledge the need for restrictive practices in some contexts, we welcome any measures that reduce the use of restrictive practices in all of its forms. We note that the Bill is inclusive of the overt forms but also, and equally important, the less obvious forms of restrictive practice that may have unintentionally become part of everyday practice routines for aged care facilities and their staff in how they use medications, how entry and exit to their facilities is managed, staffing routines, and so forth. These more subtle forms of restrictive practice can often go unchallenged as part of the practice culture of organisations and ignoring them can mean that the meaningful implementation of improvements is challenging, with little tangible improvement in human rights of this highly vulnerable population.

Our interest, and concern, is for all residents in aged care facilities, supported accommodation, or those supported in the community who may be subject to restrictive practices, but particularly for individuals who may also experience co-occurring mental health challenges. They are already a highly marginalised and potentially stigmatised group within the aged care sector where many staff do not have more specialised mental health understanding, expertise and training. They are also highly likely to have experienced significant marginalisation prior to entering aged care facilities, to have fewer social networks of support (and importantly, family and friends who can advocate for them and have 'eyes' on what is occurring in their care within the facilities.

We note the foundations underpinning the use of restrictive practices; that they are only to be used in limited circumstances, as a last resort, in the least restrictive way and for the shortest possible time. Restrictive practices are to be limited to circumstances where a person may be at risk of harm to

themselves or others. Restrictive practices must be consistent with a person's human rights and proportionate and balanced between the level of risk of harm and the negative consequences arising from the restrictive practices. Restrictive practices must be undertaken in a manner that maximises the opportunity for positive outcomes and aims to reduce or eliminate the need for their use. Restrictive practices must never be used as a punishment or for the convenience of others. Similarly, restrictive practices must not be used to address inadequate staffing levels or lack of adequate equipment or facilities. These foundational principles are heartening to see, though we have concern for their operationalisation into everyday practice in aged care facilities where we know that the level of skills and staff resources to ensure the intention of these principles is met is a challenge.

Like the Hon John Darley MLC, we find it highly disturbing to read that half of the residents in residential care are receiving antipsychotic medicine, seemingly to sedate them and restrict their movement and activity levels. As a national peak organisation representing mental health consumers and carers, we are acutely aware of the iatrogenic effects of anti-psychotic medications on people of all ages with mental health challenges and have even greater concern for their impact on frail elderly. We have concern that 37C (2)(c) of the Amendment Bill regarding the use of medication prescribed for a diagnosed mental disorder as falling outside of the restrictive practice definition in the aged care context. We know from experience, how readily a 'mental disorder' diagnosis can be given as a convenience in order to authorise the prescription of certain medications, particularly anti-psychotic medications. There is significant potential for conflation in practice with the use of PRN medications used within the guide of current agreed treatment.

These facilities are the residents' 'home' and every effort to maximise their quality of life and engagement in it should be promoted; otherwise, these individuals are likely to be viewed not as unique human individuals deserving of basic compassion and care, and the potential for abuse and neglect is heightened. We have learned from the Ann Smith case and from the Oakden example how easily human rights can be overlooked when people stop being seen as human beings. In the Oakden case, in addition to the more overt and horrific illustrations of poor care including, elder abuse, and the excessive use of seclusion and restraint without mandatory documentation, we also note what was documented in the nursing notes as 'floor time' (the practice of leaving disturbed patients on the floor with no nursing intervention by staff for long periods of time, in some cases). These inhumane practices, once openly known, were shocking and detailed the systemic failure of care for older people with mental health challenges and resulted in a renewed and sustained focus on the lack of adherence to least restrictive practices in mental health care as well as the need to report all incidences of seclusion and restraint.

We also have concern for resourcing and staffing and skill levels in these facilities. Until these issues are addressed, unauthorised restrictive practices are likely to continue in everyday practice, in spite of the Amendment Bill.

We note that the Bill establishes an authorisation process for positive behaviour management plans ensuring transparency and accountability. Again, we welcome this but have concern for its operationalisation within everyday practice, and the level of accountability to align practice with these plans. We note that, whilst the intention is to focus on supporting 'positive' behaviours, the overwhelming thrust of the criteria as written is about avoiding the negative and how to avoid restrictive practice. We also note in section 37R (2) that there is virtually no mention of the individual needs of the person or mention of understanding individualised concerns that may trigger distress and adverse behavioural responses. Surely understanding individualised histories and needs may in fact alleviate and potential forestall the very disturbing behaviours that can lead to staff resorting to use of restrictive practices. We also think that these positive behaviour management plans must have a stronger intention built in about continuous learning so that they evolve according to the needs of the person over time (37R (3)). With regard to 37R (4), we also believe that merely providing a copy

of the approved plan to a guardian or carer is a missed opportunity, particularly as their knowledge of the person is likely invaluable for deciding what goes into the plan, behavioural triggers, known history of trauma for the person and how they respond, and so forth.

We welcome the appointment of a Senior Practitioner with powers to monitor and ensure accountability across this sector. It is no doubt a daunting task and one that will require adequate resourcing for all the functions of the Senior Practitioner role to be fully realised and not merely add administrative burden without meaningful change and improvement in the lives of the elderly people concerned. Finally, we query whether the various penalties for breaches are sufficient to effect meaningful change in culture and behaviour at the service and individual level of practice.

Thank you for the opportunity to contribute to the Opposition's briefing on this matter.

Please feel free to contact the below with any queries or clarifications you may require.

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4. Contact

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