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**INQUIRY INTO ELDER ABUSE - SUPPLEMENTARY QUESTIONS TO CARMELLE
PEISAH**

QUESTION 1. Are you aware of any examples of government assessing the impact of chemical restraint? a. If so, what are they?

The focus of much of the Government enquiry into chemical restraint has been on the nature and extent of restraint in Australia. This has emanated from the Commonwealth. For example, in 2013 the **Senate Community Affairs References Committee** conducted an enquiry into the **Care and management of younger and older Australians living with dementia and behavioural and psychiatric symptoms of dementia (BPSD)**, published in March 2014. In this enquiry, submissions regarding chemical restraint noted the overuse of such and the need to replace chemical restraint with non-pharmacological approaches. Within that report (a copy of which is enclosed by email), Recommendation 16 noted:

“The committee recommends that the Commonwealth undertake an information program for doctors and residential aged care facilities regarding the guidelines Responding to Issues of Restraint in Aged Care in Residential Care.

Further, the Committee view (within Recommendation 16) stated:

6.59 The evidence provided by the Department of Health and Ageing seems to confirm that there is significant overuse of psychotic medication in aged care to control BPSD. This overuse must not be allowed to continue. The existence of several providers who manage BPSD without reliance on chemical or physical restraints highlights what can be achieved with the current resources available.

In the same vein, the ALRC released **Equality, Capacity and Disability in Commonwealth Laws (ALRC Report 124)** on 24 November 2014. Section 8 specifically referred to the use of restrictive practices in Australia and is enclosed in Appendix 1. In this report, it was noted:

The Office of the Senior Practitioner found chemical restraint to be the most commonly used form of restraint. Chemical restraint is reportedly widely used on people with dementia. The Department of Health and Ageing told the Senate Inquiry into dementia that the use of drugs in dementia is higher than would be expected on clinical grounds alone:

In February 2013 [the drug utilisation subcommittee] found that there is a high and inappropriate utilisation of antipsychotics in the elderly, especially in the case of two drugs: quetiapine and olanzapine, which are prescribed at a rate inconsistent with the age-specific prevalence of bipolar disease

It is important to note that much of this work has focused on the nature and extent of chemical restraint in nursing homes. A recent study by Simpkins et al, has highlighted similar issues within hospitals.

Specifically in regards to the **impact** of chemical restraint, the scientific literature is unanimous in regards to acknowledging the side effects of chemical restraint which include, but are not limited to:

- sedation;
- falls;
- fractures;
- risk of thromboembolic and cerebrovascular event (clots and stroke)
- arrhythmia & QT prolongation (ECG abnormalities)
- neuroleptic hypersensitivity associated with Dementia with Lewy bodies
- aspirational pneumonia
- decreased seizure threshold (increased chance of seizures)
- Neuroleptic Malignant Syndrome and Serotonin Syndrome
- cognitive worsening (i.e. more confusion)
- extrapyramidal side effects (Parkinson's –like syndrome brought on by drugs)
- akathisia (restlessness and agitation)

- tardive dyskinesia (abnormal involuntary movements of the tongue, face, head, limbs or body)

Most importantly, there have been a raft of studies reporting an association between the use of chemical restraint and an increase in mortality. These studies include:

- Rossom, et al, (2010) Are All Commonly Prescribed Antipsychotics Associated with Greater Mortality in Elderly Male Veterans with Dementia? *Journal American Geriatric Society* 58:1027–1034.
- Huybrechts et al (2012) Differential risk of death in older residents in nursing homes prescribed specific antipsychotic drugs: population based cohort study; *British Medical Journal*; 344:e977.
- Kales et al (2012) Risk of Mortality Among Individual Antipsychotics in Patients With Dementia *American Journal Psychiatry*. 169:71 –79.

QUESTION 2. In your view, what constitutes ‘well-being’ for older people?

Wellbeing for older people is a holistic concept that includes physical, psychological, social and spiritual domains. Given the association between physical illness, frailty and ageing, particularly amongst the very old, well-being needs to be, and can be, achieved despite these changes.

Research on well-being places strong emphasis on adaptation and resilience, a sense of control and the ability to cope. Social connections and their quality are important, as are basic needs and comfort (including being pain-free) and sensory enrichment.

There have been a number of publications focusing on well-being for older people. The NSW Elderly Suicide Prevention Network (ESPN) and NSW Ministry of Health Mental Health and Drug & Alcohol Office (Older People’s Mental Health Policy Unit) developed *Promoting Positive Mental Health and Wellbeing in Older People*. This is a practical guide with information, programs and resources for enhancing the mental health and wellbeing of older people in NSW (enclosed via email). Similarly, Beyond Blue has published an evidence review of the efficacy of strategies to promote well-being (also enclosed): Wells, Y., Bhar, S., Kinsella, G., Kowalski, C., Merkes, M., Patchett, A., Salzmann, B., Teshuva, K., & van Holsteyn, J. (2014). *What works to promote emotional wellbeing in older people: A guide for aged care staff working in community or residential care settings*. Melbourne: beyondblue.

One of my concerns is that many definitions of well-being describe a state of Nirvana, absence of ill-health and aspire towards goals more relevant to younger people. Well-being is often equated with mental and/or physical health. An often referred to definition in discussions of well-being (even in those publications that focus on older people) is the World Health Organization statement: *'Mental health is a state of wellbeing in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community.'*

So does this mean that well-being is not achievable when we can no longer work productively or make a contribution? Older people who enter aged care facilities are equally entitled to the promotion of their well-being. To not to do so would constitute neglect and abuse. In 2011, a very useful resource was produced by the Victorian Government, which particularly focuses on people in residential care: "Well for Life. Improving Emotional Well-being for Older People In Residential Aged Care" (enclosed via email). It is aimed at staff and managers for the practical application of identifying the barriers and challenges to people's emotional wellbeing in such settings (e.g. environment, resources and staffing, ageism, staff burden) and to identify actions to overcome them. It provides education modules and help sheets, as well as facilitator's guides.

Widespread dissemination and consistent use of well-being promotion in aged care facilities is clearly an antidote to accusations of neglect, abuse and the overuse of chemical restraint.

I hope that these comments are of assistance to the Inquiry and that they sufficiently address the questions posed. As stated in my previous correspondence and submissions, I make myself available to elaborate on or address any further questions posed by members of the Committee.

Carmelle Peisah

APPENDIX 1

<https://www.alrc.gov.au/publications/use-restrictive-practices-australia>

8. Restrictive Practices

The use of restrictive practices in Australia

8.5 Restrictive practices involve the use of interventions by carers and service providers that have the effect of limiting the rights or freedom of movement of a person with disability, with the primary purpose of protecting the person or others from harm. These include restraint (chemical, mechanical, social or physical) and seclusion.^[5]

8.6 Persons with disability who display ‘challenging behaviour’ or ‘behaviours of concern’ may be subjected to restrictive practices or medical intervention in a variety of contexts, including: supported accommodation and group homes; residential aged care facilities; rehabilitation centres; mental health facilities; hospitals; prisons; and schools.^[6]

8.7 The limited available data from the Victorian Office of the Senior Practitioner accords with the international research that an estimated 10–15% of persons with disability will show ‘behaviours of concern’ and between 44–80% of them will be administered a form of chemical restraint in response to the behaviour.^[7]

8.8 The Office of the Senior Practitioner found chemical restraint to be the most commonly used form of restraint.^[8] Chemical restraint is reportedly widely used on people with dementia. The Department of Health and Ageing told the Senate Inquiry into dementia that the use of drugs in dementia is higher than would be expected on clinical grounds alone:

In February 2013 [the drug utilisation subcommittee] found that there is a high and inappropriate utilisation of antipsychotics in the elderly, especially in the case of two drugs: quetiapine and olanzapine, which are prescribed at a rate inconsistent with the age-specific prevalence of bipolar disease.^[9]

8.9 Between 50–60% of people presenting challenging behavior in the United Kingdom are subjected to physical restraint;^[10] those with multiple impairments and complex support needs may experience much higher levels of restrictive practices.

8.10 Surveillance may, in some circumstances, amount to a restrictive practice. The Office of the Public Advocate (Qld) reported that, in a census survey of 861 disability accommodation sites in 2013, 13% of them used some form of electronic monitoring of their residents. The majority of the residents subject to audio or visual surveillance had an intellectual disability and the reasons for surveillance included monitoring of the residents’ health, the desire to safeguard residents from accidental harm, and the residents’ challenging behaviours and self-harming behaviours.^[11]

Improper use of restrictive practices

8.11 While restrictive practices are used in circumstances to protect from harm the person with disability or others around them, there are concerns that such practices can also be imposed as a ‘means of coercion, discipline, convenience, or retaliation by staff, family members or others providing support’.^[12]

8.12 Many stakeholders raised systemic issues across various sectors which result in inappropriate or overuse of restrictive practices.^[13] A key explanation for the use of restrictive practices may be the lack of resources for positive behaviour management and multi-disciplinary interventions to ‘challenging behaviours’. Such behaviours may be better understood as a ‘legitimate response to difficult environments and situations’ or ‘adaptive behaviours to maladaptive environments’.^[14]

8.13 As the Chief Executive Officer (CEO) of Alzheimer’s Australia explained to the Senate Inquiry into dementia,^[15] it is important to look beyond behaviours to understand the reasons for them:

I think the secret to dementia care is actually very simple, and that is to look at the cause of a person’s symptoms and not to respond to the symptoms themselves. If somebody is violent, they are not being violent because they are a nasty person. They are being violent because they are frustrated. They feel no purpose in life ... They do not know where they are. They feel disoriented. They may feel very depressed. They may be suffering psychosis. They may be losing their words. They may not be able to communicate. You put all those things together and think of how you would react and then you can start to translate it into your own behaviours.^[16]

8.14 There is also evidence that what constitutes a restrictive practice is contested, which may result in inadvertent and misguided use of restrictive practices. A representative of the Royal Australian College of General Practitioners told the Senate Inquiry into dementia: Many facilities have a locked dementia unit so people cannot actually get out, where there might be a busy road or something like that. For the night people may be put in a low bed that is a little bit difficult to get out of so that they cannot wander easily. It is not actually a restraint as such but it does provide a physical barrier to wandering. So there are some things like that that do not feel anything like being tied up but that do minimise behaviour that might cause that resident some harm.^[17]

8.15 In contrast, Caxton Legal Centre described a similar scenario in a dementia unit as a clear instance of restrictive practices, submitting a case involving ‘Mrs H’, a woman in her mid-70s and of a culturally and linguistically diverse background, who called the centre to complain that she had been misdiagnosed with Alzheimer’s disease and had spent 10 months in ‘prison’.^[18]

8.16 High level definitions in the National Framework have set out the agreed understanding of restrictive practices and clarify that a restraint need not be physical, mechanical or chemical, but can also be psychosocial and involve the use of ‘power-control’ strategies.^[19] A case study submitted by Justice Connect illustrated this point:

An older man was frustrated with a rehabilitation facility that would not allow him to return home in circumstances where his children did not support his desire to do so. The man’s capacity was not impaired, but the facility was concerned about their duty of care. The man was told that if he attempted to leave the facility, the police would be called.^[20]

Australia’s international obligations

8.17 Australia, as a State Party, has obligations under the *United Nations Convention on the Rights of Persons with Disabilities*^[21] (CRPD) and the *United Nations Convention against Torture*.^[22]

8.18 The Australian Civil Society Response, as part of Australia’s appearance before the United Nations Committee on the Rights of Persons with Disabilities (UNCRPD) in 2013, expressed concern that persons with disabilities, especially cognitive impairment and psychosocial disability, are ‘routinely subjected to unregulated and under-regulated behaviour modification or restrictive practices such as chemical, mechanical and physical restraint and seclusion’.^[23]

8.19 Following this report, the UNCRPD recommended that Australia take immediate steps to end such practices, including by establishing an independent national preventive mechanism to monitor places of detention—such as mental health facilities, special schools, hospitals, disability justice centres and prisons—in order to ensure that persons with

disabilities, including psychosocial disabilities, are not subjected to intrusive medical interventions.^[24]

8.20 Article 12 of the CRPD protects the right of persons with disabilities to have equal recognition before the law. Articles 14, 15 and 16 provide their right to liberty and security of person, freedom from torture or cruel, inhuman or degrading treatment or punishment and freedom from exploitation, violence and abuse.

8.21 Stakeholders suggested that some forms of restrictive practices could even amount to torture.^[25] Australia is a party to the United Nations Convention against Torture^[26] and also a signatory to the Optional Protocol on the Convention against Torture (OPCAT).^[27] However, Australia has not yet ratified the OPCAT which requires States to establish a national system of inspections of all places of detention to ensure compliance with the Convention against Torture.^[28]

8.22 A national approach to restrictive practices that includes monitoring of detention and other deprivations of liberty could assist in meeting Australia's obligations under OPCAT, if it were to ratify the agreement.

8.23 The Offices of the Public Advocate (South Australia and Victoria) (OPA (SA and Vic)) noted the omission of detention as a restrictive practice from the National Framework.^[29] Stakeholders emphasised that disability accommodation with locked doors—where people cannot leave unless they are escorted—should be considered places of detention.^[30] Arguably, detention constitutes a criminal offence or otherwise fits within the high level definition of 'seclusion' in the National Framework as the sole confinement of a person with disability in a room or physical space at any hour of the day or night where voluntary exit is prevented, implied, or not facilitated.^[31]

8.24 The ALRC considers that a national approach should clarify the circumstances under which detention would be a crime or restrictive practice. The ALRC commends the existing Victorian^[32] and South Australian^[33] models, which prevent restrictions on people's liberty or freedom of movement, as useful in informing a national approach to restrictive practices that explicitly addresses detention in schools, residential treatment facilities and correctional institutions.

8.25 The People with Disability Australia and Disability Rights Research Collaboration proposed that 'a national dialogue' with people with disability and their representatives be held to consider all issues relating to the 'use of and protection from restrictive practices'.^[34] Such a dialogue would include examination of the relationship between restrictive practices and torture, Australian's international obligations under OPCAT and the utilisation of evidence of restrictive practices administered on children with disability that may be produced in the Royal Commission into Institutional Responses to Child Sexual Abuse.^[35] Noting the dearth of empirical studies of the views of people with disability and family carers, the joint submission contended that a nationally consistent framework on restrictive practices must be shaped by their lived experiences.^[36]

A patchwork of existing laws and policies

8.26 Stakeholders expressed significant concerns about the unregulated use of restrictive practices^[37] and were supportive of the ALRC's proposal for national reform.^[38]

8.27 Regulation of restrictive practices occurs at a state and territory level under disability services and mental health legislation, and under a range of policy directives, statements and guidance materials. There is substantial discrepancy in the regulation of restrictive practices

across jurisdictions, and the numerous frameworks ‘conspire to make the legal framework in this area exceedingly complex’.^[39]

8.28 Robust regulation that applies specifically to restrictive practices occurs in Victoria, Queensland and Tasmania through disability services legislation.^[40] The approach in other jurisdictions includes policy-based frameworks, voluntary codes of practice, and regulation as an aspect of guardianship.^[41]

8.29 In the context of the mental health system, Victoria and Queensland have detailed provisions relating to restrictive practices, combined with minimum standard guidelines^[42] and a policy statement.^[43] Legislative provisions are less prescriptive in other jurisdictions.^[44] In NSW, the use of restrictive practices is regulated by a lengthy policy directive.^[45] Mental health legislation is an area of ongoing review and reform, with implications for the regulation of restrictive practices.^[46]

8.30 Since March 2014, there is also a national agenda for consistency and standardisation in the regulation of restrictive practices in the form of the National Framework. The National Framework represents a united commitment ‘to the high-level guiding principles and implementation of the core strategies to reduce the use of restrictive practices in the disability service sector’.^[47]

8.31 The National Framework is intended to work within existing legislative arrangements to establish minimum standards in relation to the regulation of restrictive practices. It embodies the agreement by all jurisdictions that, by 2018, all disability service providers with NDIS funding will implement six core strategies to reduce the use of restrictive practices.^[48] The COAG Disability Reform Council indicated that these core strategies will guide governments in the development of national quality and safeguards system for the NDIS.^[49] Until such a system is developed, state and territory quality assurance and safeguards frameworks will apply.^[50]

8.32 The NDIS system will be underpinned by the revised National Standards for Disability Services.^[51] It is expected that, from 2018, this national system will govern the use of restrictive practices affecting NDIS participants to ensure their access to disability services is in accordance with human rights principles.


8.33 There are also relevant guidelines at a national level including those issued by the Royal Australian and New Zealand College of Psychiatrists,^[52] the Australian Psychological Association,^[53] Alzheimer’s Australia^[54] and the Australian Government Department of Health with respect to aged care.^[55]

8.34 The complex web of state, territory and national laws, policies, codes and guidelines has been much criticised. The OPA (SA and Vic) described the existing regulatory efforts as being ‘piecemeal’ across the country and insufficient ‘to protect and promote the rights of people who are subject to restrictive interventions’.^[56]

8.35 However, recent initiatives at a national level—the National Framework; the development of a national quality and safeguards system for the NDIS; the National Seclusion and Restraint Project^[57] and an Australian Research Council Linkage Project^[58]—provide a timely opportunity to inform and ground a uniform approach to regulating restrictive practices that applies in a broader range of settings than just the disability sector.

^[5] See, eg, definitions in: Australian Government, *National Framework for Reducing and Eliminating the Use of Restrictive Practices in the Disability Service Sector* (2014) 4; *Disability Act 2006* (Vic) s 3(1). For comment, see also: Philip French, Julie Dardel and Sonya Price-Kelly, ‘Rights Denied: Towards a National Policy Agenda about Abuse, Neglect and Exploitation of Persons with Cognitive Impairment’ (People with Disability Australia, 2009) [2.48]–[2.51]. See

also submissions in relation to proposed changes to the definitions under the Proposed National Framework: NMHCCF and MHCA, *Submission 81*; NSW Council for Intellectual Disability, *Submission 33*; Physical Disability Council of NSW, *Submission 32*.

^[16] See, eg, Justice Connect and Seniors Rights Victoria, *Submission 120*; PWDA and Disability Rights Research Collaboration, *Submission 111*; National Association of Community Legal Centres and Others, *Submission 78*; Children with Disability Australia, *Submission 68*; Central Australian Legal Aid Service, *Submission 48*; Public Interest Advocacy Centre, *Submission 41*; Office of the Public Advocate (Vic), *Submission 06*; Office of the Public Advocate (Qld), *Submission 05*. See also Victorian Law Reform Commission, *Guardianship*, Final Report No 24 (2012) 318  24 (2012) 318.

^[17] Eric Emerson, *Challenging Behaviour: Analysis and Intervention in People with Severe Intellectual Disabilities* (Cambridge University Press, 2001); Kathy Lowe et al, 'The Management and Treatment of Challenging Behaviours' (2005) 10 *Tizard Learning Disability Review* 34, cited in 'Chemical Restraint: What Every Disability Support Worker Needs to Know' (Office of the Senior Practitioner, Victoria, August 2008) 1. Victorian figures on behaviour support plans cited in Paul Ramcharan et al, 'Experiences of Restrictive Practices: A View from People with Disabilities and Family Carers' (Research Report, Office of the Senior Practitioner, 2009) 12.

^[18] 'Chemical Restraint: What Every Disability Support Worker Needs to Know', above n 7.

^[19] Commonwealth, *Committee Hansard*, Senate, 17 July 2013, 40–41 (Ms Adriana Platona).

^[10] Eric Emerson, 'The Prevalence of Use of Reactive Management Strategies in Community-Based Services in the UK' in David Allen (ed), *Ethical Approaches to Physical Interventions: Responding to Challenging Behaviour in People with Intellectual Disabilities* (BILD, 2003).

^[11] Office of the Public Advocate (Qld), *Submission 110*. See, attachment to the submission, 'Inquiry into the Use of Electronic Monitoring at Disability Accommodation Sites in Queensland' May 2014.

^[12] Disability Rights Now, *Civil Society Report to the United Nations on the Rights of Persons with Disabilities* (2012) [241].

^[13] See, eg, NMHCCF and MHCA, *Submission 81*; Australian Psychological Society, *Submission 60*; Disability Discrimination Legal Service, *Submission 55*; Central Australian Legal Aid Service, *Submission 48*; Physical Disability Council of NSW, *Submission 32*. See also National Mental Health Commission, 'A Contributing Life, the 2013 National Report Card on Mental Health and Suicide Prevention' (2013).

^[14] Paul Ramcharan et al, 'Experiences of Restrictive Practices: A View from People with Disabilities and Family Carers' (Research Report, Office of the Senior Practitioner, 2009) 2. See also Physical Disability Council of NSW, *Submission 32*.

^[15] Senate Committee on Community Affairs, Parliament of Australia, *Care and Management of Younger and Older Australians Living with Dementia and Behavioural and Psychiatric Symptoms of Dementia* (2014).

^[16] Commonwealth, *Committee Hansard*, Senate, 17 July 2013, 31 (Mr Glenn Rees).

^[17] Commonwealth, *Committee Hansard*, Senate, 16 December 2013, 36 (Professor Constance Dimity Pond); see also evidence by the General Manager of Residential Care,

HammondCare: Commonwealth, *Committee Hansard*, Senate, 17 July 2013, 17 (Ms Angela Raguz).

^[18] Caxton Legal Centre, *Submission 67*.

^[19] Australian Government, *National Framework for Reducing and Eliminating the Use of Restrictive Practices in the Disability Service Sector* (2014).

^[20] Justice Connect and Seniors Rights Victoria, *Submission 120*.

^[21] *UN Convention on the Rights of Persons with Disabilities*, opened for signature 30 March 2007, 999 UNTS 3 (entered into force 3 May 2008).

^[22] *Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, opened for signature 10 December 1984, 1465 UNTS 85 (entered into force 26 June 1987).

^[23] Disability Rights Now, ‘Australian Civil Society Parallel Report Group Response to the List of Issues, CRPD 10th Session Dialogue with Australia, Geneva’ (September 2013) 13.

^[24] Committee on the Rights of Persons with Disabilities, ‘Concluding Observations on the Initial Report of Australia, Adopted by the Committee at Its 10th Session (2–13 September 2013)’ (United Nations, 4 October 2013) [35]–[36].

^[25] See PWDA and Disability Rights Research Collaboration, *Submission 111*; Queensland Advocacy Incorporated, *Submission 45*; Mental Health Coordinating Council, *Submission 07*.

^[26] *Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, opened for signature 10 December 1984, 1465 UNTS 85 (entered into force 26 June 1987).

^[27] *Optional Protocol to United Nations Convention on the Rights of Persons with Disabilities*, opened for signature 30 March 2007, UN Doc A/61/611 (entered into force 3 May 2008).

^[28] Australian Human Rights Commission, *Optional Protocol to the Convention against Torture (OPCAT)* <www.humanrights.gov.au>.

^[29] Offices of the Public Advocate (SA and Vic), *Submission 95*.

^[30] See, eg, PWDA and Disability Rights Research Collaboration, *Submission 111*.

^[31] See, French, Dardel and Price-Kelly, above n 5, 64–65; 97–98.

^[32] *Disability Act 2006* (Vic) pt 8.

^[33] See policies of Disability Services and OPA (SA); *Guardianship and Administration Act 1993* (SA).

^[34] PWDA and Disability Rights Research Collaboration, *Submission 111*.

^[35] *Ibid.*

^[36] *Ibid.*

^[37] See, eg, National Association of Community Legal Centres and Others, *Submission 78*; Central Australian Legal Aid Service, *Submission 48*; NSW Council for Intellectual Disability, *Submission 33*; Physical Disability Council of NSW, *Submission 32*; Office of the Public Advocate (Vic), *Submission 06*; Office of the Public Advocate (Qld), *Submission 05*.

^[38] National Association of Community Legal Centres, *Submission 127*; Advocacy for Inclusion, *Submission 126*; National Mental Health Consumer & Carer Forum, *Submission 100*; Office of the Public Advocate (SA and Vic), *Submission 95*; Central Australian Legal Aid Service, *Submission 48*; Public Interest Advocacy Centre, *Submission 41*; Office of the Information Commissioner, Queensland, *Submission 20*; Carers Queensland Australia, *Submission 14*.

[39] Michael Williams, John Chesterman and Richard Laufer, 'Consent vs Scrutiny: Restrictive Liberties in Post-Bournewood Victoria' (2014) 21 *Journal of Law and Medicine* 1.

[40] *Disability Act 2006* (Vic); *Disability Services (Restrictive Practices) and Other Legislation Amendment Act 2014* (Qld); *Disability Services Act 2011* (Tas).

[41] For example, in NSW, guidelines govern the use of restrictive practices in relation to adults: NSW Department of Family and Community Services, *Behaviour Support Policy*, Version 4.0 (March 2012). In addition, the use of a distinct number of restrictive practices requires completion of a documented plan, involving authorisation by an internal Restricted Practices Authorisation mechanism. Guardians appointed under the *Guardianship Act 1987* (NSW) may be authorised to consent to the use of restrictive practices for people over 16 years of age. Restrictive practices in relation to children are governed by *Children and Young Persons (Care and Protection) Act 1998* (NSW) and *Children and Young Persons (Care and Protection) Regulation 2012* (NSW). The WA *Disability Services Commission is reviewing its 2012 Voluntary Code of Practice for the Elimination of Restrictive Practices in 2014*.

[42] *Mental Health Act 1986* (Vic) ss 81–82; Victorian Chief Psychiatrist's Guideline, *Seclusion in Approved Mental Health Services* (2011).

[43] *Mental Health Act 2000* (Qld) pt 4A; Queensland Health Department, *Policy Statement on Reducing and Where Possible Eliminating Restraint and Seclusion in Queensland Mental Health Services* (2008). See also, Queensland Health Department, *Mental Health Act 2000 Resource Guide* (2012).

[44] See, eg, *Mental Health Act 2009* (SA) ss 7(h), 90, 98; *Mental Health Act 1996* (WA) ss 116–124; *Mental Health and Related Services Act 1998* (NT) ss 61–62; *Mental Health (Treatment and Care) Act 1994* (ACT).

[45] NSW Health, *Aggression, Seclusion & Restraint in Mental Health Facilities in NSW*, Policy Directive (June 2012).

[46] In Tasmania, the *Mental Health Act 2013* (Tas) which regulates restrictive practices, commenced on 17 February 2014; and the new *Mental Health Act 2014* (Vic) commenced on 1 July 2014. There are also several reviews of mental health legislation in a number of jurisdictions: in ACT, the second exposure draft of the *Mental Health (Treatment and Care) Act 1994* (ACT) was drafted in 2013; in WA, the *Mental Health Bill 2013* (WA) was adopted by the Legislative Assembly on 10 April 2014; review of the Bill in the Legislative Council is pending; in SA, the Department of Health has completed public consultation on the *Mental Health Act 2009* (SA) and its report to Parliament is expected in June 2014; in Queensland, submissions to a review focusing on areas for improvements to the *Mental Health Act 2000* (Qld) closed in August 2013; in NSW, a report was tabled in Parliament in May 2013: 'Review of the NSW Mental Health Act 2007: Report for NSW Parliament, Summary of Consultation Feedback and Advice' (NSW Ministry of Health, May 2013). See also Ch 10.

[47] Australian Government, *National Framework for Reducing and Eliminating the Use of Restrictive Practices in the Disability Service Sector* (2014) 2.

[48] The six core strategies are: person-centred focus; leadership towards organisational change; use of data to inform practice; workforce development; use of restraint and seclusion reduction tools; and debriefing and practice review. See further Australian Government, *National Framework for Reducing and Eliminating the Use of Restrictive Practices in the Disability Service Sector* (2014).

[49] COAG Disability Reform Council, *Meeting Communiqué*, 21 March 2014.

^[50] Australian Government, *National Framework for Reducing and Eliminating the Use of Restrictive Practices in the Disability Service Sector* (2014) 2–3; *Intergovernmental Agreement on the NDIS Launch*, 7 December 2012.

^[51] National Disability Insurance Scheme, *Quality and Best Practice Framework* <www.ndis.gov.au>. The revised National Standards for Disability Services were endorsed by all governments on 18 December 2013. The six standards are: Rights; Participation and Inclusion; Individual Outcomes; Feedback and Complaints; Service Access; and Service Management.

^[52] Royal Australian and New Zealand College of Psychiatrists, *Statements and Guidelines* <www.ranzcp.org>.

^[53] ‘Evidence-Based Guidelines to Reduce the Need for Restrictive Practices in the Disability Sector’ (Australian Psychological Society, 2011).

^[54] Alzheimer’s Australia, *Quality Dementia Care Papers* <www.fightdementia.org.au>.

^[55] See, eg, Department of Health, *Decision-Making Tool: Supporting a Restraint Free Environment in Residential Aged Care* (2012). See also Senate Committee on Community Affairs, Parliament of Australia, *Care and Management of Younger and Older Australians Living with Dementia and Behavioural and Psychiatric Symptoms of Dementia* (2014).

^[56] Offices of the Public Advocate (SA and Vic), *Submission 95*.

^[57] National Mental Health Commission, *National Seclusion and Restraint Project* <www.mentalhealthcommission.gov.au>.

^[58] Associate Professor Renata Kokanovic of Monash University is leading an ARC Linkage Project for 2013–2016 investigating options for supported decision-making to enhance recovery of people with severe mental health problems.