



Advocating for restraint minimisation

1. Definition of restraint

A restraint is a physical, chemical or psychological mechanism used to limit an individual's voluntary response or movement. The use of restraint can be justifiable if it is lawfully imposed upon an individual to prevent harm to the person themselves, or others.

Restraint can include:

- physical (holding someone to prevent them harming self or other or escaping)
- mechanical (bed rails, wrist and chest restraints)
- chemical (administration of anti-psychotic medication, libido suppressants, medication that sedates a person who does not have an underlying medical condition)
- psychological/social (threats, punishments)
- environmental (perimeter fencing, keypad entry, alarms, specialling).

2. OPA policy on the use of restraint

There will be occasions when the use of restraint will be lawful and justifiable. However, by definition, restraint is a limitation of a person's autonomy and freedom of movement. Therefore, the use of restraint should be a matter of last resort when there is no less restrictive option available which would promote the rights of the person to be restrained.

OPA has an important role to play in challenging the use of restraint against people with disabilities which is in contravention of legislative requirements, professional and industry standards and organisational policy expectations.

OPA also has an important role to play in raising awareness about the unjustifiable use of restraint and advocating for restraint minimisation.

3. Examples of restraint

The issue of the use of restraint may arise because it becomes apparent that restraint is being used and should be challenged. Or, it may be that a guardian or family member is asked to consent to the use of restraint or to endorse such decision.

- A hospital wants to special a patient (one on one nursing) to prevent them from leaving
- A doctor indicates that post operative care for a patient will require the patient to be partly immobilised to prevent them interfering with their surgical wounds.
- It is proposed that a libido suppressant be administered to an elderly person in a nursing home to manage sexually inappropriate behaviour.

- A family member of a resident complains that the resident seems overly sedated in order to prevent them wandering at night and that the GP has not consulted with them about this.
- It is recommended to a guardian that a person needs to be discharged from hospital into 'secure' accommodation.

4. Advocating for promotion of rights through legislative compliance

At times, guardians and family members may be asked to consent to some type of restraint which is governed by a legislative process.

4.1 Mental Health Act 1986

The *Mental Health Act 1986* specifically defines 'mechanical restraint' and 'seclusion'.

Example 1

A guardian or family member is asked to consent to a person receiving psychotropic medication as treatment for their mental illness. Under the *Mental Health Act* a guardian, medical agent or person responsible is not able to provide substitute consent for such treatment.

The role of an advocate would be to advocate for legislative compliance.

4.2 Disability Act 2006

The *Disability Act 2006* specifically defines 'chemical restraint', 'mechanical restraint' and 'seclusion'.

Example 2

A disability service provider operating a day program asks the guardian or family member to consent to the client being secluded when his behaviour becomes threatening to others. In this instance, the disability service provider should have a behaviour management (or support) plan for the represented person and comply with the requirements of the *Disability Act*.

The role of an advocate would be to advocate for legislative compliance. The Senior Practitioner has the responsibility for ensuring appropriate standards in relation to restrictive interventions and compulsory treatment.

4.3 Aged Care Act 1997

The Quality of Care principles made pursuant to s.96-1(1) of the *Aged Care Act 1997* do not explicitly address the issue of restraint minimisation. However, the User Rights Principles provide for the rights of people in receipt of residential aged care or community care packages. These rights include:

- full and effective use of his or her personal, civil, legal and consumer rights
- to quality care appropriate to his or her needs
- to full information about his or her own state of health and about available treatments
- to be treated with dignity and respect, and to live without exploitation, abuse or neglect
- to move freely both within and outside the residential care service without undue restriction
- to the promotion and achievement of optimum mental and physical health in partnership with their health care team.

An advocate could challenge the use of restraint by reference to these rights.

Example 3

A resident has a tendency to wander into other people's rooms and complaints have been made by family members of other residents. The resident is confined to a deep chair from which she finds it difficult to rise.

An advocate could argue that the resident's right to move freely is overly restrictive and that she is not being treated with dignity and respect.

4.4 Charter of Human Rights and Responsibilities Act 2006

The Charter imposes an obligation on public authorities to act in a way which is compatible with human rights.

Rights named in the Charter which may be relevant in relation to the use of restraint:

s.10 A person must not be—

- (a) subjected to torture; or
- (b) treated or punished in a cruel, inhuman or degrading way; or
- (c) subjected to medical or scientific experimentation or treatment without his or her full, free and informed consent.

s.12 Every person lawfully within Victoria has the right to move freely within Victoria and to enter and leave it and has the freedom to choose where to live.

Example 4

A public hospital is treating a patient. The patient is physically restrained by the use of wrist and ankle shackles.

An advocate could challenge the hospital to justify that the patient's rights are being justifiably limited.

4.5 Patient rights

The Victorian Government has endorsed the Australian Charter of Health Care Rights. These rights relate to:

- *access* – access to health care
- *safety* – safe, high quality care
- *respect* – respect, dignity and consideration
- *communication* – clear, understandable information
- *participation* – active role in health care and to participate in decisions
- *privacy* – privacy of information and confidentiality.

Some hospitals may have their own Charter of Patient Rights.

An advocate, in addition to using any Charter argument for the promotion of a patient's rights might make reference to the Australian Charter of Health Care Rights. In relation to example 4 above, the advocate might also argue the patient is not being treated with respect.

5. Advocating for promotion of rights through questioning those who propose to exercise restraint

5.1 Name and describe the restraint

Restraint may need to be named as such. Some service providers will be defensive and say that an intervention is not restraint since they assume it to be a criticism of their conduct. The denial of the intervention as restraint, especially if it is common practice, may mean that the service provider cannot engage in a rights based discussion.

Restraint *may* be justifiable and lawful. In order to keep communication open it would be helpful to be clear with the service provider about definitions (“A restraint can be anything which limits an individual’s voluntary response or movement.”)

The restraint needs to be described. It will then be possible to explore whether it can be justified – and by whom.

5.2 Name and describe the behaviours of concern, challenging behaviour

Often restraint is used when a resident or patient is engaging in behaviour which is considered challenging and is placing themselves or others at risk.

- Name and describe the behaviour.
- When did this behaviour commence? Is it new?
- How often does it occur?
- When does it occur?
- What appears to be the trigger?
- How is it being interpreted by people who know the resident/patient?
- How is it being interpreted by care givers?
- Is the behaviour independently observed; ie are people forming an opinion based on case notes, rather than their own observation?
- Would the behaviour change if other issues were addressed; for example, is the patient receiving adequate pain management, is the patient suffering from a urinary tract infection or delirium?
- Has the person been assessed by a relevant expert – such as a geriatrician?
- Has a review been conducted of the medication the patient is being administered?
- What is the risk to the resident/patient if restraint is not utilised?
- What are the risks to others?

5.3 Justify the use of restraint

- Is the use of restraint consistent with best practice?
- Are there alternative and less restrictive ways to achieve the stated goals?
- Is it lack of resources which is informing the use of restraint when there may be alternative ways to achieve the stated goals?
- Is the use of restraint expedient and for the convenience of others?
- Why does the person who is administering or proposing the restraint consider it to be in the best interests of the person?
- Are there any risks to the resident/patient if restraint is utilised – how will these risks be managed?
- How have competing rights been weighed; for example, has the right to dignity been sufficiently considered or the right to safety been considered paramount?

- Has there been compliance with legislation, relevant professional standards and with organisational policy?

5.4 Communication and documentation

- Has the resident/patient been informed about the fact restraint is to be used and why? What are their wishes, so far as they can be ascertained?
- Have the people who have an interest in the welfare of the person to be restrained been consulted (family members, friends, advocate, guardian, etc)?
- Have the carers who are involved in the administering of the restraint been informed about the purpose of why the restraint is being utilised?
- Has the decision, and the reasons for it, to use restraint been documented?

5.5 Authorisation

- Is formal authorisation required? By whom?
- If guardians are asked to sign forms they should be clear about they are being asked to authorise and whether it is within their powers and duties to do so.

6. Guardian decision-making

Much of the time, the issue of the use of restraint will be a matter of advocacy, rather than formal guardianship decision-making.

However, if a guardian needs to make a decision about restraint being used in relation to a represented person they should be clear about:

- which decision-making power in the guardianship order permits them to make such decision
- whether the use of the restraint is in the best interests of the represented person/patient (see s.28 and s.38 of the *Guardianship and Administration Act 1986*) and whether the use of the restraint is the least restrictive measure possible in the circumstances and whether the wishes of the represented person are being given effect to, if possible (see s.4(2) GAA)
- any Charter implications of a decision for a represented person to be restrained – are their human rights engaged and limited, if so, is this justifiable?

The usual practice is to ask the medical practitioner why restraint is required and what would be involved. This information should be factored into the decision-making as to whether it is in the best interests of the patient to consent to the proposed medical treatment, inclusive of restraint. The guardian should document the details of the decision, including what restraint might be used and for what period of time. The guardian should maintain close involvement in such matters in order to remain informed about all relevant factors which might necessitate a review of a decision.

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