OPAN Webinar Transcript

Title Restrictive practices:
What older people need to know, and why it matters
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Video Link [OPAN Webinars]

Panellists

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Webinar resources:

OPAN

- Supported decision-making toolkit
- New Aged Care Act information
- Webinar: Navigating aged care complaints
- Webinar: Substitute decision-making

Aged Care Quality & Safety Commission

- Overview of restrictive practices - Booklet
- Raising a complaint - General information & resources
- Statement of Rights - Fact Sheet
- Aged Care Quality Standards - Information

Other links

- Dementia Support Australia - Help & resources
- Dementia Australia - Help & resources
- 1800 ELDERHelp | Compass
- Royal Commission - Final report: Recommendation 15

[Announcer]

Across Australia, there's a network of independent, not-for-profit organisations giving a voice to older people at every stage of their aged care journey. Nationally, these organisations come together as members of OPAN, the Older Persons Advocacy Network.

Whether you or a person you care for is seeking aged care services or is receiving aged care services at home or living in residential aged care, our network of advocates are here to help you. Understand your rights. Resolve any issues you may be having with your provider. Help you express your needs and concerns. And we can help you access services you are entitled to.

Plus, our support is free and confidential, and we're independent from both government and aged care providers, meaning we're on your side. Nationally, we also raise awareness of aged care issues, taking your voice all the way to government.

To be put through to your local, state or territory aged care advocacy service, call OPAN's National Support Line on 1800 700 600, or for more information, visit opan.org.au. OPAN, the Older Persons Advocacy Network.

[Kyle Olsen]

Hello, my name's Kyle Olsen. And on behalf of the Older Persons Advocacy Network or OPAN for short, I'd like to welcome you to this webinar, Restrictive practices: What older people need to know, and why it matters.

Before we begin, in the spirit of reconciliation, the Older Persons Advocacy Network acknowledges the traditional custodians of Country throughout Australia and their connections to land, sea, and community, and acknowledge the Gadigal from the Eora Nation on whose lands we are on today. We pay our respects to elders, past and present, and extend that respect to all Aboriginal and Torres Strait Islander peoples joining us.

Restrictive practices are actions, taken by someone else, that limit your freedom of movement, your choices, and everyday life. In aged care settings, they can take many forms, such as medication used to manage behaviour, locked doors, equipment that restrains movement, or even rules that stop you from doing the things you've always done.

Internationally, restrictive practices are increasingly recognised as a human rights issue. The position set out by the Royal Commission into Aged Care Quality and Safety and supported by OPAN is that older people have the right to live free from restrictive practices, and that their use should be reduced and ultimately eliminated.

Now under the new Aged Care Act, providers can only use restrictive practices as a last resort, in the least restrictive way, in a way that is proportionate to potential risk, and for the shortest possible time.

And while the act does more clearly set out obligations of the provider and has strengthened the rights of older people, there are concerns being raised about whether the current framework is doing enough. Particularly as the outcomes of the Disability Royal Commission goes further, calling for the elimination of the use of restrictive practices altogether.

Now before we move on, we recognise that this topic may be sensitive or upsetting for some people. So please feel free to take a break, step away, or access support if you feel uncomfortable at any stage during today's webinar.

Okay, so there is a lot to discuss, and with that in mind, here's what we'll be covering in today's webinar.

Firstly, we'll look at what restrictive practices are, the different types, and why they're recognised as a human rights issue. We'll then unpack what the new Aged Care Act requires of providers, including the role of substitute decision-makers. We'll cover risks and harms, what safer alternatives look like, including around dementia care. Then we're gonna bring it all together, looking at the safeguards in place and where to turn for support if you're concerned. And we'll close at the end and have a look at the road ahead. Plus our live Q&A.

So on that note, I'd like to introduce today's expert panel.

First up, joining from the Aged Care Quality and Safety Commission, is Loren deVries, Assistant Commissioner, Senior Practitioner Behaviour Support.

Next up, joining us is Karen Williams, who is principal solicitor at Aged and Disability Advocacy Law or ADA Law.

And please, welcome Theresa Flavin, a long-standing dementia advocate, who is also a lived experience dementia consultant. Welcome, everyone.

And if you need further support or are having any issues with your government-funded aged care services, OPAN's member advocates are here to provide free, independent, and confidential support. You can access them by calling the Aged Care Advocacy Line on 1-800-700-600.

WHAT ARE RESTRICTIVE PRACTICES

Right, let's get started by first of all taking a look at what restrictive practices are. Loren, I'm going to start with you. Can you please walk us through what we mean by restrictive practices, so the different types, and what they might look like in everyday aged care?

[Loren deVries]

Yeah, thanks, Kyle. The use of restrictive practices is governed by the Aged Care Act, and also the associated rules that come with that. The definition of restrictive practices, which is what I always think about when I'm working with providers and older people is, does it impact the rights or freedom of movement of an aged care consumer? And I think that's really key in this discussion today.

There are five types of restrictive practices, and it's really important to understand each type of restrictive practice and the potential impact that it might have on the older person.

We look at chemical restraint. That is using a medication or any chemical substance to influence the behaviour of an older person.

If we think about environmental restraint, that is thinking about restricting an older person's free access to all parts of their environment, including the community, and it might be also items or activities.

Mechanical restraint is using a non-therapeutic device to restrict or subdue a person's movement.

And then we have physical restraint, so using physical force to prevent, restrict, or subdue movement. And that might be holding an older person's hands while attending to care.

And then we have seclusion. And seclusion, is that solitary confinement of an older person, in a room or an area, even if they can leave, but they think that they can't. They're the five types of restrictive practices.

[Kyle Olsen]

Thanks, Loren. I just want to clarify something. When you referred to aged care consumers, does this then mean for everybody who's receiving aged care at home as well as in residential aged care?

[Loren deVries]

That's right. Home care, you need to apply best practice principles. And it's best practice to minimise the use of restrictive practice. And so even people that are receiving home care services, the provider would need to consider if there was a restrictive practice in place.

[Kyle Olsen]

All right, thank you, Loren. That's a really useful grounding for what we're going to be talking about today.

Now, if you'd like to find out more about the definition of those five types of restrictive practices that we just mentioned, there is a free downloadable booklet covering this on the Aged Care Quality and Safety Commission's website, and you can see the details there on your screen right now.

Now, Theresa, I'll come to you now. You've been a longstanding dementia advocate and have lived experience with dementia. Can you talk us through how restrictive practices are recognised internationally as a human rights issue? And also just from your perspective, where are we at with addressing restrictive practices in Australia?

[Theresa Flavin]

Sure, thank you, Kyle. So as we know, every person is born with equal rights and equal worth, and the Universal Declaration of Human Rights that was adopted back in 1948 gave us a platform across the world of common understanding that we could build a better and fairer world.

We've got numerous treaties that are binding and that we're following here in Australia, importantly including the Convention on the Rights of Persons with Disabilities.

Now, I know that not all older people live with disability, but the statistics are showing that disability increases more or less in line with age. For example, 80% of 80-year-olds, 90% of 90-year-olds will be living with disability. So this Convention for the Rights of Persons with Disability, which was signed by Australia, should be providing equal rights across the life course. But it doesn't seem to be applied equally across the life course, either here or internationally. It might be linked to stigma and ageism.

Restrictive practice in residential aged care is a really good example of what we're accepting as a society for older people, but not for any other group. And this is why it's quite important to really work towards an international convention on the rights of older persons, just to restore that balance and guarantee the same rights for all of us humans across the life course.

[Kyle Olsen]

Thank you very much, Theresa. Karen, I'll bring you in now. You work as a lawyer in aged care advocacy and this is a topic that you are close to. Now from that vantage point, what do older people, their families and support networks most need to understand about their rights here, and also any challenges here?

[Karen Williams]

Thanks, Kyle, and there's a lot in that question. I think, you know, understanding the definitions that Loren's gone through is a key starting point. And I think, as you mentioned in your introduction that, you know, the restrictions are least restrictive, proportionate to risk, and for the shortest possible time.

They're all really key concepts that we really need to understand. It's important, and Theresa's very importantly brought in the UNCRPD, the Convention on the Rights of People with Disability, because the Aged Care Act actually rests on this convention as one of the key underpinning pieces. And, you know, people have equal rights, and they're not to be discriminated against because of a particular disability that they may have. So this is a challenge for our clinicians because they may not, you know, have been as exposed to this convention and the rights that are given with it.

And as part of the ongoing cultural change that the new Age Care Act is bringing in, that will continue hopefully to evolve and improve as people better understand what their obligations are as providers and what to expect. So the Statement of Rights, which is included in the new act, importantly talks about independence, autonomy, empowerment, and freedom of choice, and the other rights are listed there as well.

And these rights are not dependent on your ability. They're for all people receiving aged care services. So it doesn't matter if you have a disability or a health condition that makes it difficult for you to communicate, participate, the rights don't diminish.

So in order to unpack that, it's important to understand the law and challenges around informed consent.
So I just want to just take a moment to explain what that is. It's a voluntary process of giving accessible, accurate, and relevant information to the person, and going through the expected outcomes, risks, and any alternative options that may be for their situation.

People have a right to support, they have a right to interpreter, to have the information repeated, to take time to process the information, and to seek a second opinion. The key principles in informed consent are receiving the full information, comprehending or understanding the information, having the ability to make a decision, and making sure the decision is voluntary, that it's free from coercion.

So often the challenges are in this space, is that when people, professionals, providers, family members, the person themselves, there's a question mark on their ability to receive the information, comprehend it, and make a decision. So that's the difficulty around informed consent.

And another confusion around informed consent is that people, when they're proposing a treatment option or similar, they expect the person to agree with them. But, you know, if you have capacity, you can disagree with the proposed course of treatment as well. So that's confusion on the provider side.

And, the other alternative to this approach, the informed consent model, is an authorisation model, which we might touch on later. And important through all of this, and as touched on in the informed consent process, is the right to support. And OPAN has done a lot of work in this space and have developed specific toolkits. If people want further information, that's going up on the screen there now.

[Kyle Olsen]

Yeah, thank you very much, Karen. And look, just following up from what you said, we know that currently the commission supports the consent model. But as you were saying, we're hearing from older people that they prefer the authorisation model. But can you just explain what that is and where that's at at the moment?

[Karen Williams]

Yeah, there's a lot of strange words that are being thrown around here. The authorisation model envisages independent from the process expert in being able to authorise the use of restrictive practices, and tailoring it to the person's circumstances. And the consent model rests on the ability of the older person themselves or their substitute decision-maker to fully understand the process.

The authorisation model provides a level of independence in the process and also some consistency. So the consent model, you know, there can be a lot of power imbalances in understanding what options people have and all the rest of it. So for consistency and independence and monitoring people's rights, the authorisation model is becoming more popular.

[Kyle Olsen]

Okay, thank you for clarifying that for us, Karen.

WHAT THE AGED CARE ACT REQUIRES OF PROVIDERS

Let's take a closer look now at what the new Aged Care Act actually requires of providers. Loren, the new Aged Care Act, as we know came into effect last November. Can you walk us through what providers must do, and also importantly must not do when considering applying or using a restrictive practice?

[Loren deVries]

Yeah, absolutely. So I guess the really key thing is to understand the older person and their needs and their wishes. That is key to the legislation, but also key to best practice principles.

The most important way that a provider can do that and support the older person is in their behaviour support planning. And this is really fundamental to the appropriate use of restrictive practices and also upholding the rights of the older person.

Providers don't need to think of a behaviour support plan as a task or a job that needs to be done. It's really a document that's there to support the rights of the older people, but communicate to the people that are in the lives of that older person how to support that older person.

There are specific requirements in regards to the use of restrictive practices. And that includes that it must be a last resort, the least restrictive, and for the shortest period of time. And a really quick sort of example of that is that the older person might have been assessed as not being safe to independently go down the street because of previous incidents or the risk that it poses. However, they're very appropriately safe to use the full facilities of the aged care facility. And that would be a least restrictive option.

Or it might be that only at nighttime they're restricted from going out into the community because they might experience, you know, more confusion at that time and there's less ways to find their way back home.

There also needs to be very clear consent processes, and this is where the provider really needs to engage in that consultation with either the older person, if they're able to consent, or restrictive practice substitute decision-makers that have been either appointed or are in the older person's life.

This provider needs to have this consultation and document this consultation and really explore what are the risks, what are the benefits of the use of a restrictive practice, what are the risks of the use of a restrictive practice, and how is that restrictive practice going to be reviewed and monitored for impact, and even to see if it's effective.

So I think that that sort of framework really ensures that the use of restrictive practice is appropriate, and it's in the best interest of the older person to reduce the risk of harm. And that is an ongoing process. It's not a set and forget.

And so as a restrictive practice substitute decision-maker, you really need to have that ongoing discussion with the provider to ensure that, you know, it is in the best interest of the older person and there is that monitoring and review process that's occurring.

[Kyle Olsen]

Thank you, Loren. And just staying with you for a moment and focusing in on consent, which seems to be absolutely central here. Where the older person can give informed consent themselves, that's the starting point. But there's also the role that you've been talking about, restrictive practice substitution decision-maker or RPSDM.

Can you just go more into how that role does work and how it relates to supported decision-making, which we did cover in our February webinar?

[Loren deVries]

Yeah, sure. So what really needs to happen is if the older person can't consent, there is what we call an interim hierarchy. And that interim hierarchy is where there is a restrictive practice substitute decision-maker.

And that decision-maker can act on the individual, and, you know, cannot give that full informed consent, but they are supporting that older person to make a decision that the older person would make if they could make that decision.

They do have that ability to withdraw consent at any time, which I think Karen has touched on, and I think that's a really key point. And they also can make a decision that, you know, might need further discussion with the provider as well.

But it's important to consider the hierarchy. So an older person may have, is the best person to consent to the use of a restrictive practice. But then it might be that approved restrictive practice substitute decision-maker, which can be an individual in the older person's life, or it might be somebody that has been appointed in the older person's life. We then look at other alternatives.

So it might be the older person's partner. It might be a relative or a friend who was a carer, and that's an unpaid carer. It might be the relative or friend that was not the carer, but just someone that knows that older person quite well. Or it might be that medical treatment authority, and that is somebody that has been appointed to make medical decisions about the older person. So that's the sort of hierarchy that you can utilise. And that really ensures that the older person has got somebody overseeing those decisions and supporting the appropriate use of a restrictive practice.

[Kyle Olsen]

Thank you, Loren. And we did cover the topic of supported decision-making in our February webinar. That's available to watch on the OPAN website. We've got the details there for you on the screen right now.

RISKS, ALTERNATIVES & DEMENTIA CARE

Okay, we're going to move on and have a look at risks and alternative approaches, including around dementia care.

Karen, let's talk risks. Can you provide some insight and maybe some examples into what the patterns or warning signs may be for when restrictive practices are being misused? And, what are some examples where people assume everyday routine things aren't a restrictive practice, when they actually are one?

[Karen Williams]

Yes, thank you. I think where people fall into that business as usual or assuming that it's not restrictive practice goes to the environmental restraint, because as Loren has talked about, you know, the person has a right to full use of the facility or the home in which they live, and this includes access to items and activities.

So it can be restrictions around having mobility aids taken away so that you can't move freely around your living area. It could be overly restricting about access to smoking areas. I've seen people who wanted to access their own GP but were prevented from leaving the facility, which was not proportionate to the risks involved to that particular person. So it's very much the individualised approach.

In relation to chemical restraints, sometimes we've seen people so medicated that they're unable to complete their meal. So there are concerning signs out there.

So then essentially, as Loren said, it's an individualised approach. There can't be blanket rules. And it's least restrictive for the least amount of time. So it can't be set and forget. It's set and reviewed through behaviour support planning. Dementia-specific considerations would be that too often a diagnosis alone, whether it be dementia or any other particular diagnosis, is used by people or thought to prevent people from giving or refusing informed consent, or making a decision or agreeing or disagreeing.

So there can be too quick resort to the substitute decision-making framework when the person may be able to participate with appropriate supports. So yeah, I think there's a lot there to unpack and for people to think about.

[Kyle Olsen]

Yeah, thank you, Karen. It's really important to look out for those signs there. Look, Loren, can we talk about restrictive practices in dementia care, including the use of locked units as a form of environmental restraint? How is the commission thinking about this, and what do the alternatives look like?

[Loren deVries]

Yeah, I think the key thing that we're learning at the commission and from the legislation is that the central to all of this is that behaviours are a way that an older person can communicate. And so we really want providers to understand that and to really analyse and try and find out, well, what is that behaviour telling us about the older person? Because if we provide appropriate behaviour support, that will minimise the inappropriate use of restrictive practices.

We know that older people, there is a risk at times when there has been an assessment that the older person is at risk if they go out into the community or go out, you know, down the street for a range of different reasons. And this is where it might be appropriate for a memory support unit or something similar for that older person to be subject to environmental restraint.

But what we also know is that it might be that in terms of environmental restraint, it's not just that an older person is residing in a memory support unit. It might be that they're in another area of the facility, but they don't have that free access to the community, because the front door is locked or they can't access that. So that means that a human right has been taken away from them.

An older person, you know, just like you or I go home, we lock the front door at night, so there does need to be that safety and security. But the provider needs to find a way that they can support that older person to leave. Just like if I wish to leave my home at night or whatever time of day, I have my home locked, but I'm able to freely come and go as I wish.

So I think we really need to shift away from, you know, is it or is it not a restrictive practice to actually look at what is the assessment of that older person? What is that behaviour that we're trying to understand? And what is that older person trying to really communicate to us?

It's also important that we understand how previous trauma in an older person's life might be impacting them now, particularly as we look at, you know, more care that, you know, is quite at times can be institutionalised. And that's why we really need to understand how the environment potentially is impacting that older person, and what that care looks like around that. We know that there is some really great care that occurs out there.

And often that's really about understanding the older person, that case conferencing involving the older person. And also involving the older person and the key people that are in the older person's life. So it's not necessarily just the person that's got that legal right to make decisions if the person does not have capacity, but it might be the friend that they've known for 40 years that visits every week.

They also need to be a part of that, you know, engagement to really understand that older person. So that are some of the key things that we're thinking about. We also acknowledge that it can be challenging.

I think that we definitely understand that. But it's really about that older person being central to the care that's provided.

[Kyle Olsen]

Thank you, Loren. Now, Theresa, on the dementia care context, do you have anything to add here?

[Theresa Flavin]

Yeah. Dementia care, it's a really difficult subject, and it's a big subject. So I'm going to speak to it from the point of view of the person living with dementia.

And what I'm seeing is that here in Australia, we're not really tracking all that well. And the reason I feel that is because we have such vastly different standards and expectations around institutionalisation and restrictive practice across disability and age care. It's a really bad surprise to reach to level 65 in the game of life, only that you find out that if you've got dementia, and someone somewhere thinks you need to be restrained in your best interests, that this can be approved by a restrictive practices substitute decision-maker that you didn't choose and that you can't unchoose.

We've got 33% of our older people in residential aged care in the Northern Territory at the minute, who are living in what we used to call locked wards. I think there's a better term for it. I'm sorry, I can't remember. Secure units. What I notice is with the secure units is, and I know that the legislation says that it's got to be for the shortest time, but you never see anyone coming back out.
And I'm struggling to find anyone who's returned to the sort of general areas from a secure unit that hasn't gone more or less into palliative care. I've also heard stories of restrictive practice being implemented to stop people with dementia from entering areas which are restricted for the Higher Everyday Living Fee people, to stop them from eating their hot breakfasts. That's still a restrictive practice to me.

I find that a locked environment, when I look around here in Southwest Sydney, and I hear the reports from friends, relatives, and other members, of the levels of harm that's happening, it doesn't feel safe.

The density of violent incidents is so much higher than any other carcerative environment in Australia. It poses a situational risk that's largely unmanageable for providers, in my view. This boils down to our assessment tool.

The assessment tool used to estimate the costs of behaviour support in residential aged care, it's not really fit for purpose because it wasn't designed for that. It was designed to assess the costs of supporting a disabled school leaver to try and find work. So it's not surprising to find that restrictive practice is often used more as a crowd control measure and a behaviour suppression measure in a resource-constrained environment that's closed.

But there's so much that we can do to make this a less horrific experience, but we really have to examine what we're going to accept as a society if we're going to move forward.

[Kyle Olsen]

Thank you, Theresa. Thank you for sharing your insight there.

SAFEGUARDS, & WHERE TO TURN FOR SUPPORT

Let's take a look now at the safeguards in place, including around your rights and where to turn to for support if you're concerned.

Loren, can you take us through the key safeguards under the new act, including how the Statement of Rights and the Aged Care Quality Standards underpin protection from inappropriate restrictive practices?

[Loren deVries]

Yeah, absolutely. So the Statement of Rights is very clear that it outlines the right that older people have when accessing any aged care services. The rights help to ensure that older people and their needs are at the centre of the aged care system.

We know the Statement of Rights calls out that every older person accessing aged care has the right to, you know, that independence, equitable access, quality and safety. You can see that on the screen, but it's really about exercising and making decisions that affect their life. And if they can't make that decision, be supported in that decision making.

It's also, I think fundamental that an older person can take personal risk, just like I do and probably you do every day as well. So that's really key to this Statement of Rights.

[Kyle Olsen]

Thank you, Loren. Karen, from a legal advocacy perspective, if an older person or a family member is concerned that a restrictive practice is being misused, what should they do? Can you walk us through the steps?

[Karen Williams]

Yes, certainly. I think you just start from very general basic information gathering, and I think we have some information about general tips around advocacy. But you request to talk to the provider, information seeking, behaviour support plan, and any reviews. And just keep a record of your activities and your requests and conversations. And there's some really clear steps outlined there for you on your screen.

You have a right to be supported, so you can bring someone along with you. And often say support's like beauty, it's in the eye of the beholder. So the person that you find to be supportive is the person you find to be supportive.

An important question through all of this is to, and that I've noticed from the advocates that I work with is, identifying who's made the decision, if it's a particular concern about the use of restrictive practices. You know, if you as the older person didn't make the decision, being able to identify who's made the decision, and for what and for how long, et cetera.

If your questions aren't being answered to your satisfaction, you can then utilise the complaints pathway with the new complaints commissioner. And there's some information there going onto the screen. And that people can raise complaints anonymously as well.

Also, that if the framework, as has been outlined here particularly by Loren, isn't being followed, that there are whistleblower provisions in the Aged Care Act, and whistleblower protections. So that's an important thing to note as well.

[Kyle Olsen]

And thank you for that, Karen. Look, we just had a webinar focusing on the topic of navigating aged care complaints, which is on the OPAN website. And you can see the details of that one on your screen right now.

But a quick reminder on where you can also find key resources to support older people, their families, and their support networks in navigating restrictive practices.

Firstly, the Aged Care Quality and Safety Commission and the Department of Health, Disability and Ageing both have detailed provider resources that can be useful for older people too. Just search for restrictive practices on their website. And of course, you can always give them a call as well.

But for dementia-specific support, the National Dementia Helpline is 1-800-100-500. They've got resources also available on their website, which is dementia.org.au.

And as always, for free, independent, and confidential information and support, you can always speak with an aged care advocate by calling the Aged Care Advocacy Line on 1-800-700-600.

Now, before we finish, it's important to remember that today we've been talking about restrictive practices in the context of aged care. However, if you or someone you know is experiencing similar restrictions from a family member, a friend, a carer, or another person, that's not something you should ignore. Everyone has the right to make their own choices, be treated with dignity and respect, and live free from abuse. So if you're concerned about yourself or someone else, support is available through the National Elder Abuse Helpline on 1-800-ELDERHelp. And that phone number is 1-800-353-374.

Now, on this topic, this will actually be the topic for our next webinar, on elder abuse.

THE ROAD AHEAD

Right, before we move on to our live Q&A, let's finish up now with a look at the road ahead.

There are big conversations happening right now about how restrictive practices should be regulated into the future.

Now, Theresa, from your perspective as an advocate in the dementia space, where does the system need to go to next?

[Theresa Flavin]

Yeah, thank you, Kyle. I think there's a lot of room for improvement. What we do have at the minute that we can start on is the supported decision-making provisions. And those provisions for supported decision-making do extend to behaviour support planning.

So that expectation is now set that people are supported to contribute to, and really have an ownership of their own behaviour support planning. And that to me, is a very empowering thing. But we've got some things that we can do. We do have a bit of a problem with the evidence that's underpinning the policies that we're living under. Because the evidence that has been developed from observation of people who are in these carcerated environments, who are living in pain and difficult circumstances, and the view of creating this evidence has been to find ways to keep them compliant at the least financial cost. That's reasonable, that's to be expected, but I think we can do better.

Commercial expediency drives much of the more subtle restrictive practice, including the permanent aged care model, as opposed to a system that we actually want and need, which is geared towards respite, restorative care, and palliative care, and hospice.

I would love to see Australia partnering with people in early-stage dementia to develop a balanced, person-led set of evidence that will take us into a new and better future.

We can start by reviewing the Behavioural Resource Utilisation Assessment. That's the component of the aged care assessment that deals with behaviour support.

We can develop evidence for person-led interventions supports. We can pivot to mandatory positive behaviour support planning aligned with the broader disability sector.

We can advocate for supported advanced planning, post-diagnosis, and move towards a short-term six months programme, residential if need be, and respite for those most severely impacted.

We can revisit Recommendation 15 of the Aged Care Royal Commission for a dementia support pathway that's actually based on contemporary evidence, developed in partnership with us, that includes access to supported advanced positive behaviour support planning, enhanced focus on short-term respite, and properly assessed and targeted behavioural support, restorative care, and supported palliative care planning.

This might give us a sense of safety and at least an element of control of our uncertain futures.

[Kyle Olsen]

Thank you, Theresa. Some really good ideas there. Now, Loren, is there anything else you'd like to share on the road ahead?

[Loren deVries]

Yeah, thank you. I guess I just wanted to highlight, because there has been some discussion about the sunset clause and some questions that have come across.

So the sunset clause is a clause where the interim hierarchy will finish at the end or in the 1st of December in 2026. However, just to reassure everyone that there has been some consultation. And the Department of Health have been engaging with providers and key stakeholders to get your feedback about those potential changes.

I think what's really important to remember is that the law of the state or territory will continue to, of course, prevail on consent for the use of restrictive practices. And the department is continuing to engage with states and territories and providers to really understand what those possible changes might mean. So the department will provide further clarity in regards to that in the future.

[Kyle Olsen]

Thank, you Loren. Now, Karen, one more for you. From your perspective working alongside older people and their families, what is the one thing you'd want every viewer to take away from today's conversation?

[Karen Williams]

I think today we've looked at the Statement of Rights several times over, and I think if you haven't looked at it for yourself, to do that. The rights are for everybody. They're not just rights for the most able, competent. They're for everybody. And you have a right to support, receive information, have an advocate, have information kept private.

There's a whole range of things that are really, really important and a game changer. And that's something that we can all lean into and rest on.

[Kyle Olsen]

Thank you very much for that. Now, let's move along to our live Q&A.

LIVE Q&A

Thank you to everyone who submitted questions. You may notice some are being archived as they come through, but rest assured that we are receiving them all and are working hard behind the scenes to collate and feed them through to my iPad.
We'll gonna answer as many as we can in the time we have. So panellists, I respectfully ask you to keep answers as succinct as possible.

Theresa, the first question is for you, and it's from Yasmina. Yasmina asks, how does the older person have the conversation, start the conversation about restrictive practices with their families?

[Theresa Flavin]

Well, I suppose it very much depends on the context, but I can just give you my personal situation, that I can anticipate that my behaviour will change, and already has from time to time.

What I've been able to do with my family is, as this comes up, I've tried very hard to explain what's happening inside of me so that they understand why I'm doing the things I do. And that's been a real game changer for them, because when I do something that looks very peculiar or it doesn't look rational, if they actually give me the space to ask me, why are you doing that, I actually have a sensible reason. And what that comes down to is my brain's broken.

The connection between my brain and my body doesn't work very well. But inside, I'm adapting. So for example, if I'm in a lot of back pain, I'm inclined to walk. On the outside, that looks like wandering. But in my mind, that's my brain adapting to propel me away from the pain that's in my back. So it makes perfect sense to me.

And when you can take that time to do that little bit of explanation, sometimes what we see as a behaviour isn't actually a behaviour, it's an adaptation.

And sometimes if no one is watching carefully at how you adapt, that can get harder and harder as you're trying and trying to adapt, and that can become explosive with frustration.

And then sometimes you just give up, and that can be called apathy when it's actually not apathy. It's actually us trying to save you the trouble and frustration of looking after us.

[Kyle Olsen]

Thank you so much for that insight there, Theresa. Loren, is a seat or a lap belt on a wheelchair considered to be a restrictive practice?

[Loren deVries]

Thank you so much. And I guess what's really key for any person that's trying to decide whether something is or isn't a restrictive practice, it's really about that individualised assessment that you have done.

So part of a provider's responsibility is to assess the need for the use of a restrictive practice and also look at the impact that that has on an older person. And I always go back to the definition. Does it impact on the older person's human rights or free movement?

So we would potentially think that that would impact, a wheelchair, the free movement of an older person. And so it's really about that assessment. And then working out, well, why have we had to look? Why have we had to use a seatbelt? You know, what's driving that person trying to reach out or climb out? Or, you know, highlighting that risk.
So it really is about that individualised assessment, and then, of course, having that conversation with the older person, and/or their advocates or decision-maker.

[Kyle Olsen]

Thank you, Loren. Karen, a question for you from Alan. Alan's asked, do these laws about restrictive practices apply to family and friends?

[Karen Williams]

Yes, certainly, and it depends. Restrictive practices, you know, of the particularly severely restricting people, we don't have that authority in our day-to-day lives to restrict people.

So that's why we need to look at a consent and a framework. So it depends whether the person is. And they certainly do. You need lawful approval in order to utilise restrictive practices. And I'll probably throw to Loren to talk about if it's concerning a restrictive practice in the community.

[Loren deVries]

Yeah, thanks, Karen. I think what's really important is we sometimes do see the use of restrictive practices by family members, and often it's because they've got that carer's stress and are not knowing or just don't have that ability to support the person because it can be very stressful.

I think that's what's really important is if you're providing services and you observe a family member utilising a restrictive practice, or you are a family member, that there is support out there for you.
So Dementia Support Australia can provide that support in-home for an older person and their families as well. And maybe that's the first point of call that you can go to. And of course, Dementia Australia or your GP that might be able to support as well. But it is important to think about that from a human rights lens. And I think that's, you know, key to all of this.

[Kyle Olsen]

Thank you, Loren. Just while we've got you there, there's another question that's come through on this topic. It's from Jojo. It just goes a little bit further. Can you elaborate the last resort when restrictive practices can be used?

[Loren deVries]

Yeah. I think it really depends on the risk that is being posed. So, you know, somebody that's not supportive of personal care being done, there might be some other strategies that you might be able to utilise in the interim, or it might be that you talk to that older person or their decision-maker about, well, actually, what are we trying to achieve?

So that type of last resort might be very different to somebody that's very distressed and is throwing furniture, and, you know, really very, very distressed. That last resort would look very, very different.

So it's about the risk and the provider ascertaining what that risk is, and then working out what might be potentially driving that changed behaviour.

So again, assessing that changed behaviour is always central to what, you know, the risk might be, and then also to what is a last resort and potentially is not a last resort. Unfortunately, restrictive practices is not black and white. It can be very complex.

[Kyle Olsen]

Absolutely. Thank you for that. Theresa, I've got a question for you from Erin. Are there limitations of dignity of risk with regards to restrictive practices, for example, wanting bed rails?

[Theresa Flavin]

That's a great question, Erin, and thank you for the opportunity. Dignity of risk is something that I think is very personal. The difficulty is with dementia, because our symptoms are so compressed, everyone talks about the very last stages, but it's kind of a journey. And the good part of the Aged Care Act is the appointment of a registered supporter and supported decision-making.

So as you're developing dementia and going through, that registered supporter ideally would be in partnership with you, supporting your decisions but also learning about you so that you can together understand what your tolerance of risk is.

And that, for example, in my situation, I can actually express what I'm comfortable with almost in advance.

So like almost we've trained each other in that partnership. And that is how I think ideally dignity of risk would be managed, would be in partnership with your registered supporter.

If, of course, you're a solo ager, you know, you will have different supports in place. You know, we all make our own plans. But I think that's a very personal thing. And I think establishing what your perimeter is and what your tolerance is, and do you want quality of life or quantity of life.

I think establishing those and that type of, in my ideal world would be supported behaviour support planning, supported palliative care planning, that would go along into this post-diagnostic support pathway.

[Kyle Olsen]

Thank you very much. Loren, a question for you. Please explain the subtle differences between medication for treating a mental illness and chemical restraint.

[Loren deVries]

Yeah. And this, again, is about that individualised assessment and having those systems and processes in place. But what we do know is it's not about a diagnosis, it's more about what is the intention of the prescribing of that medication. And that's not the prescriber that will make the decision about whether something is or isn't a restrictive practice. It's the provider that needs to make that assessment.

And it is purely, has that medication been prescribed to influence behaviour? So it doesn't matter if they've got a diagnosis or their doctor or GP prescriber has written a diagnosis. It's really about you as the provider understanding what that medication has been prescribed for and if it has been prescribed to influence behaviour, rather than they've got a diagnosis. And again, it's complex at times.

[Kyle Olsen]

Thank you, Loren. Unfortunately, we are coming to the end of our webinar for today. I'd like to extend a big thank you to our guests for joining us and sharing their knowledge and insights. So thank you, Loren, Karen, and Theresa.

And just as a reminder, for those of you who did register, you will get this email with all the links as well that we mentioned today in the coming days.

So to find out more about our past webinars and also what's coming up, please sign up for our newsletter, and we'll be sure to inform you of any upcoming topics.

And of course, if you have any questions, do not hesitate to reach out to one of our network member advocates, and you can see the contact details are there on your screen.

It's been an absolute pleasure to be with you today. Until next time, I'm Kyle Olson. Stay well, stay connected, but most importantly, look after each other. Thank you.

[Announcer]

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