Eliminating restrictive practices in disability settings

There is a strong movement both in Australia and internationally to reduce and eliminate where possible the use of restrictive practices in disability settings. **John Brayley**, South Australia's Public Advocate, reports.

RESTRICTIVE practices involve the use of physical restraint, mechanical restraint, chemical restraint, detention and seclusion. People with intellectual disability, autism spectrum disorders, brain injuries, and some neurological diseases can be subject to these practices.

Doctors will see people who either live in the community in group homes, or in institutions, who may be subject to unnecessary restriction, and doctors can be in a unique position to take action to stop such practices.

The use of restrictive practices can depend on the quality of care. Factors such as access to suitable, spacious housing, meaningful activities, sufficient support staff, and skilled assessments from psychologists and others can prevent behavioural problems and the need for restrictive practices. Conversely, people living in overcrowded, understaffed settings who do not have the opportunity to pursue their goals and interests are more likely to become behaviourally disturbed and then to be restrained and detained.

Victoria and Queensland have legislation aimed at reducing the use of restrictive practices there. It is likely that the same will happen in South Australia, but in the interim we can all take action to prevent these human rights abuses. We can all be part of the solution, rather than unwitting contributors to the problem.

Definitions of different types of restrictive practices

A key step is recognising when a restrictive practice is being used. A recently released Office of the Public Advocate policy has definitions which are reproduced here.

What are restrictive practices? – Office of the Public Advocate

'Detention' means a situation where a person is unable to physically leave the place where he or she receives disability services. The means of detention may include locked doors, windows or gates, and the constant supervision and escorting of a person to prevent the person from exercising freedom of movement.

'Seclusion' means the sole confinement of a person with a disability at any hours of the day or night in any room or area in the premises in which that person is detained.

'Physical restraint' means the use of any part of another person's body to restrict the free movement of a person with a disability with the aim of controlling that person's behaviour.

'Mechanical restraint' means the use of a device to restrict the free movement of a person with a disability or to prevent or reduce self-injurious behaviour. It does not include the use of devices for therapeutic purposes or to enable the safe transportation of that person.

'Chemical restraint' means that if the primary purpose of administering medication is to subdue or control the behaviour of a person with a disability, then the use of the medication is a chemical restraint. Likewise, the use of medication when needed (ie, 'PRN'), for the primary purpose of controlling behaviour, is a restraint. If information regarding the primary purpose of administering the medication is not available, the intervention should be considered a chemical restraint. If the medication is used to treat a person's illness (psychiatric or physical), then it is not viewed as a restraint but as a treatment.

These definitions require careful scrutiny and application, because the use of a restrictive practice may not be initially apparent. For example, a person may live in a suburban house and only be allowed to leave with staff. This is detention. If a person is locked in his or her bedroom either day or night, this is seclusion.

The definition of chemical restraint not only includes the emergency administration of medication, but any use of a psychotropic drug to control behaviour when not prescribed for a specific physical or mental disorder. This definition can encompass situations where a person has been suspected of having a diagnosis of a psychiatric disorder which has never been confirmed, but nevertheless, he or she has stayed on the medication for years.

After the introduction of restrictive practices legislation interstate, significant numbers of people with intellectual disability, autism and head injury who have been on long-term psychotropic medication, have been identified. This medication has frequently not been required for psychiatric treatment and once the situation has been uncovered, it has often been possible to reduce and/or cease the medication.

Actions a medical practitioner can take

General practitioners may be asked to give advice on a behavioural problem, or may become aware of a restrictive practice when consulting a person about something else.

Steps to reduce the use of a restrictive practice:

1. Ensure that an appropriate behavioural assessment by a psychologist or other professional has been undertaken. If not completed, it should be requested.
2. Ask to see a copy of the patient's behaviour support plan.
3. Ensure that the use of the restrictive practice conforms to ▶

the organisation's policy. Practices usually need to be recommended by a senior manager or clinical professional, and cannot be implemented without appropriate authority.

4. Ensure that the use of the practice is legal and that consent has been given.

A good behaviour support plan will identify the function of a problem behaviour, and will seek to support new behaviours and activities to replace it. The plan will identify environmental factors such as accommodation and staffing issues that may also need to be addressed. As well, if ongoing medication is contemplated, a patient will need review by either a psychiatrist or a medical practitioner skilled in managing behavioural problems for people with disabilities.

While South Australia is yet to have comprehensive restrictive practice provisions in legislation, there are existing legal requirements under the *Guardianship and Administration Act 1993* (GAA) which still need to be met, including the provision of consent in various circumstances.

So for example, if a person is detained in a suburban house without the consent of a guardian or enduring guardian who has been authorised by the Guardianship Board under the GAA, s.32(1)(b) to detain the person, this may constitute unlawful imprisonment. The use of physical restraint without the authority of the Guardianship Board under the GAA,s.32(1)(c), may constitute assault.

With respect to chemical restraint, it is unlikely in most situations that the person receiving such treatment can give informed consent. The prescribing doctor will need to speak with a substitute decision maker such as a guardian or medical power of attorney about the benefits and risks of chemical restraint. While the GAA does permit service managers and directors of nursing to consent to medications on behalf of patients (ie, 'someone who is charged with overseeing the ongoing day-to-day supervision, care and well-being of the person': meets the GAA definition of 'relative'), it is the policy position of the Public Advocate that this should not occur for chemical restraint. There is an obvious conflict of interest in such a situation. Rather, an application should be made to the Guardianship Board for a guardian to be appointed.

While it is likely that South Australia will get new laws similar to those in Victoria and Queensland, in the interim we can all take action to ensure that people receive necessary assessments and care so that restrictive practices are avoided.

For more information:

The Public Advocate's policy 'Guardian Consent for Restrictive Practices in Disability Settings' *can be downloaded from www.opa.sa.gov.au.*

For telephone queries about individual patients' needs, the Office of the Public Advocate enquiry line can be called on (08) 8342 8200 or for country callers 1800 066 969.