

# Rights Resource Network SA

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Attorney General's Department  
Government of South Australia  
GPO Box 464, Adelaide SA 5001

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Dear Attorney

## ***Consent to Medical Treatment and Palliative Care (Restrictive Practices) Amendment Bill 2020***

Thank you for the opportunity to provide comments in response to the draft Consent to Medical Treatment and Palliative Care (Restrictive Practices) Amendment Bill 2020 (the draft Bill).

The Rights Resource Network SA is a social enterprise organisation connecting researchers and community organisations with law-makers and policy-makers in South Australia. The Network exists to address the absence of any human rights framework for developing or enacting laws and policies in our State. On behalf of the Network, I warmly invite you and your department to make use of our extensive Network to share information about the draft Bill and to encourage a range of relevant community organisations, experts and individuals with lived experience to share their views with you.

The following comments have been informed by discussions with a range of Network members, in particular the Mental Health Coalition of South Australia (MCHSA) and Lived Experience Leadership & Advocacy Network (LELAN), and have been drafted by Dr Sarah Moulds, Director of the Rights Resource Network SA and Senior Lecturer in Law at the University of South Australia. As you may know, the MCHSA is the peak body for the non-government mental health sector in South Australia that works to reduce stigma and increase an understanding of mental illness and its prevention. LELAN represents individuals with personal lived experience of distress and mental health issues in South Australia and amplifies the voice, influence and leadership of lived experience to drive change. Together these organisations provide a unique insight into the impact of the draft Bill on the lives and rights of South Australians, particularly those South Australians who experience distress and mental health issues. It is our shared view that South Australia should be committed to the goal of eliminating the need to use coercive, non-consensual restrictive practices in any context.<sup>1</sup> Given the severe and often traumatising impact the use or threat of restrictive practices can have on people accessing medical treatment and care, it is imperative that this draft Bill be revised with meaningful engagement with those with lived experience of mental illness or other behaviours sought to be addressed by this Bill. The Network has also had the benefit of having discussed the draft Bill with SA Mental Health Commissioner Professor Sharon Lawn. We share the concerns raised by the Commissioner with respect to the draft Bill and commend her written submission to you.

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<sup>1</sup> This is consistent with the relevant findings of the [Office of the Public Advocate](#) (2017) and the [Disability Royal Commission](#) (2020).



## Positive aspects of the draft Bill

The draft Bill seeks to implement legitimate public objectives including ensuring that health practitioners, especially staff in emergency departments, are able to effectively assess or treat people who exhibit behaviours which create a risk of harm to themselves or other people. It recognises that some people accessing care and treatment may have impaired decision-making capacity and are not able to consent to their own treatment. The draft Bill does this by making changes to the *Consent to Medical Treatment and Palliative Care Act 1995* (SA) (Consent Act), setting out the circumstances in which restrictive practices can be used, including without a person's consent, and authorising medical practitioners (including nurses and SA Ambulance Officers) to exercise these powers for up to 24 hours (for adults, 12 hours for children).

To this end, the draft Bill advances some important human rights, including the right to access adequate health care and the right to life, through the facilitation and authorisation of emergency medical care in certain high-risk scenarios (such as responding to people with drug induced psychosis, recently acquired brain injury and people agitated and considered at suicide risk). By authorising the use of restrictive practices in certain circumstances, the Bill also offers legal and physical protections for those tasked with administering medical care in these scenarios. The draft Bill also aims to clarify a number of existing legislative frameworks that apply to the use of restrictive practices in medical contexts in South Australia, including the way different existing frameworks (such as those relating to guardianship and advanced care directives) interact with the provisions of the Consent Act.

To this end, we understand why the South Australian government is seeking to make changes to the existing Consent Act. However, like the Mental Health Commissioner, we hold strong concerns that as currently drafted, the Bill fails to provide the type of clear, evidence-based legal framework necessary to address these important policy objectives. We are also concerned that the draft Bill risks retraumatising those seeking treatment and care and undermines key human rights principles. In drafting this kind of legislation we would ask that the process include strong reference to rights frameworks such as the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) and lived experience from outset in order to generate a better balance between treatment oriented views and those of care recipients and families. These concerns, and our responses to your specific discussion questions, are outlined below.

## Key rights concerns with the draft Bill

1. The broad scope of coercive powers constitutes a disproportionate impact on the rights of people accessing treatment and care

By authorising the use of restrictive practices by medical practitioners in circumstances where a person does not is or is unable to consent to the use of such practices, the draft Bill interferes with international protected human rights. These rights include the right to self-determination, liberty and security of person, freedom from arbitrary detention, the right to liberty of movement and the rights of the child (including those rights contained in the *UN Convention on the Rights of the Child*). While each of these rights may be subject to valid limitations, such limitations must be shown to be necessary and proportionate having regard to the legitimate policy end being sought. This demands identifying a clear evidence base for broadening the circumstances in which restrictive practices can be used in medical



settings and identifying robust safeguards to protect against any disproportionate or unjustified interference with the rights listed above. As discussed further below, as currently drafted the Bill fails to meet these criteria in several important areas. For example, the scope of behaviours to which the Bill applies is unclear. Subsection 14(2) provides that behaviours constituting a risk of harm and therefore invoking the use of restrictive practices extend well beyond physically threatening behaviours and include implied threats of force or self-harm, behaviour that substantially increases the likelihood that physical or mental harm will be caused to the person or to any other person (whether intentionally or unintentionally) and any other behaviour of a kind prescribed by the regulations. Given the severe and often traumatic impact of restrictive practices on the rights and wellbeing of persons presenting for treatment and care, including this broad scope of behaviours does not appear to be a necessary or proportionate response to the legitimate policy ends being sought by this draft Bill. The broad scope of the draft Bill also appears to extend the use of restrictive practices well beyond the context of hospital emergency rooms to other health care environments. Proposed section 14I, for example, does not contain any limits on the health care environments in which a health practitioner (defined to include nurses and ambulance staff and other practitioners prescribed by regulation) can be authorised by the Minister to use restrictive practices provided the criteria in proposed section 14K are met.

Central to these rights concerns is (a) the lack of clear justification for the need for the coercive measures contained in the draft Bill having regard to alternative, trauma-informed approaches to mental health care designed to respond to the types of scenarios set out in the materials accompanying the draft Bill and (b) the broad scope of the powers contained in the Bill and the potential for these powers to be further broadened by regulation or the exercise of executive discretion. For example, there is a lack of clarity within the provisions of the draft Bill as to:

- Who will be impacted by these changes and what 'gap' or problem is the draft Bill trying to address when it comes to the use of restrictive practices? As noted above, the scope of key terms in the Bill (including 'risk of harm', 'health practitioner' and 'restrictive practices') can be extended by regulation and is not limited to the categories and examples set out in the accompanying materials.
- What kind of 'illnesses' or situations are likely to require the use of restrictive practices authorised by the Bill, and in particular whether the Bill will extend beyond the category of people accessing care and treatment listed in the accompanying materials (eg people with drug induced psychosis, recently acquired brain injury and people agitated and considered at suicide risk) to broader categories of people displaying 'challenging behaviour'.
- Whether the changes proposed in the draft Bill will be accompanied by appropriate training and clear cultural direction for health care service providers, informed and designed by those with lived experience.



2. The draft Bill's clinician and systems-focused approach excludes those with lived experience and departs from the principles contained in the *United Nations Convention on the Rights of Persons with Disabilities* (UNCRPD)

By authorising the use of coercive or non-consensual medical treatment for people experiencing physical or mental disabilities, the draft Bill also undermines a number of rights contained in the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) which sets out a framework for government and non-government bodies to move from a medical model of health care to a social model of health care. Under the UNCRPD mandated model of health care, participation and inclusion are crucial elements in adopting rights-based approaches to health care, including for persons with mental illness. Through participation and inclusion the needs and concerns of persons with mental illness become clearer, persons with mental illness have the opportunity to raise issues and hold decision-makers accountable, persons with mental illness become more visible and persons without mental illness have the opportunity to learn and change from the experience.

The South Australian Parliament has recognised and committed to observe the principles contained in the UNCRPD in the context of the *Mental Health Act 2009* (SA) which includes the following provision:

*7—Guiding principles*

(1) *The Minister, the Tribunal, the Chief Psychiatrist, health professionals and other persons and bodies involved in the administration of this Act are to be guided by the following principles in the performance of their functions:*

(a) *mental health services should be designed to bring about the best therapeutic outcomes for patients, and, as far as possible, their recovery and participation in community life;*

(ab) *mental health services should meet the highest levels of quality and safety;*

(ac) *mental health services should (subject to this Act or any other Act) be provided in accordance with international treaties and agreements to which Australia is a signatory;*

(b) *mental health services should be provided on a voluntary basis as far as possible, and otherwise in the least restrictive way and in the least restrictive environment that is consistent with their efficacy and public safety, and at places as near as practicable to where the patients, or their families or other carers or supporters, reside; ...*

The UNCRPD also requires State parties to 'take immediate steps to end' restrictive practices in order to 'ensure that persons with disabilities, including psychosocial disabilities, are not subjected to intrusive medical interventions'.<sup>2</sup> The UN Special Rapporteur on Torture has also called for "an absolute ban on seclusion and restraints" in psychiatric contexts<sup>3</sup> and the UN Committee on Economic, Social and Cultural Rights has called upon Australia to "[r]epeal all legislation that authorizes medical

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<sup>2</sup> Committee on the Rights of Persons with Disabilities, Concluding observations on the initial report of Australia, adopted by the Committee at its tenth session (21 October 2013), UN Doc CRPD /C/AUS/CO/1 [35]-[36].

<sup>3</sup> General Assembly, Human Rights Council, *Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment*, Juan E. Méndez, (1 February 2013), UN Doc A/HRC/22/53 at [63]-[64].



intervention without the free, prior and informed consent of the persons with disabilities concerned, abolishing the use of restraint and the enforced administration of intrusive and irreversible treatments.”<sup>4</sup>

Contrary to these principles and voluntarily assumed human rights obligations, the draft Bill appears to embed the medical model of health care at the expense of social model, displaying a clinician and system centred approach, sidelining or excluding the voice of people whose lives will be affected by these extraordinary powers.

Instead of incorporating and reflecting on the views of those with lived experience, the proposed changes appear to assume that coercive medical treatment is the preferred method of responding to these behaviours. This departs from existing clinical evidence which suggests that strong psychosocial supports help people to solve problems and avoid the need to use crisis and emergency services.<sup>5</sup> The need for a strong evidential base for the effectiveness of restrictive practices as a form of health care treatment is particularly critical if the draft Bill is intended to apply to people presenting for care and treatment who are displaying suicidal ideations.

## Responses to key discussion questions

1. Is it appropriate/necessary for health practitioners to use restrictive practices to assess and treat patients who are exhibiting challenging behaviours, do not have decision making capacity, and who are presenting a risk to themselves and others?

We challenge the assumption inherent within the draft Bill that there is a demonstrated need for health practitioners to use restrictive practices to assess and treat people accessing care and treatment who are exhibiting challenging behaviours. There may be clinical evidence to support the assertion that restrictive practices are needed to respond effectively to a limited range of behaviours. If this is the case, the onus is on the South Australian Government to establish and share this evidence base, and to limit the scope of the draft Bill to those specific, identifiable behaviours that have been shown to require this form of clinical response. The Bill itself (s14K(2)) recognises that the fact that some people accessing care and treatment present with certain behaviours that are considered ‘challenging’ or inconvenient or even threatening to health care practitioners does not of itself justify the use of restrictive practices, unless it can be shown that other less rights intrusive forms of medical care are ineffective at meeting the legitimate objectives sought by this Bill. It remains unclear how this test will be applied in practice, particularly in circumstances where health practitioners are given a broad discretion to interpret the scope of their powers under the draft Bill. For example, according to the section 14K(2), an authorised health practitioner can only use restrictive practices if ‘there is no other way (a) to minimise the risk of harm, or to prevent further harm from being caused; or (b) to undertake a medical assessment or examination of the patient, that is reasonably available in the circumstances.’

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<sup>4</sup> Economic and Social Council, Committee on Economic, Social and Cultural Rights, Concluding Observations on the Fifth Periodic Report of Australia, 11 July 2017, UN Doc. E/C. 12/AUS/CO/5 [46].

<sup>5</sup> Further information is available from Australian Institute of Health and Welfare, *Mental Health Services in Australia: in brief* (9 October 2019) available at <https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia-in-brief-2019/contents/table-of-contents>



It is unclear whether this is intended to be a subjective or objective test, nor is it clear how 'reasonably available' should be interpreted in the context of responding to acute health care needs in under-resourced or peak-capacity hospital environments. Further guidance on these matters may be intended to be provided in the Guidelines referred to in the Bill, however this type of critical detail should be included in the provisions of the draft Bill itself if it is to be relied upon to justify the use of such extraordinary, coercive powers.

2. Is the timeframe for the use of restrictive practices (up to a maximum of 24 hours for adults, and 12 hours for those who are under 18 years) appropriate?

The *Convention on the Rights of the Child* requires special consideration of the rights of people under the age of 18 when designing rights-intrusive legal frameworks such as this one. This demands that clear temporal limits be placed on the use of any non-consensual, coercive medical treatment with respect to children under 18 years. In order to be proportionate to the interference with children's rights to physical integrity, such temporal limits must be justified by clinical evidence relating to specific behaviours or presentations. While the draft Bill distinguishes between adults and children when it comes to temporary limits on authorised restrictive practices, we challenge the evidence base for selecting the 12-hour and 24-hour timeframes. These time frames appear to artificially elevate the age of the patient as the primary consideration, rather than adopting an approach that focuses on clinical need or the risk of harm posed by the individual patient. As Professor Lawn has noted in her written submission, the Bill assumes that the clinical needs and danger posed by a 17 year old person experiencing a drug-induced psychotic episode justify the use of restrictive practices for a period of up to 12 hours, whereas a 19 year old patient displaying the same behaviours can be subject to restrictive practices for twice as long. This demonstrates the arbitrary nature of selecting maximum time frames that are not informed by clinical need or harm-based criteria. In addition, it is not clear what clinical circumstances would justify applying restrictive practices (which could include coercive, physical restraints such as shackles) to a young child for 12 hours. If such circumstances exist, they need to be explicitly set out in the provisions of the draft Bill.

3. Are the proposed safeguards in the Bill appropriate/necessary to protect patients and monitor the use of restrictive practices?

In order to constitute a justifiable limitation of the rights of those subject to the coercive, restrictive practices contained in the draft Bill, robust safeguards must be included to (a) ensure the powers contained in the Bill are subject to clear, identifiable limits (b) guard against misuse and overuse and (c) provide transparency and effective oversight to enable robust review of the appropriate use and ongoing need for such extraordinary measures. As currently drafted, the Bill fails to meet this standard. For example:

- The Bill appears to dilute the safeguards contained in the existing policy directive and guidelines on the use of restrictive practices being used by SA Health,<sup>6</sup> which require an

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<sup>6</sup> See eg. Policy Directive: Minimising Restrictive Practices in Health Care Policy Directive  
[https://www.sahealth.sa.gov.au/wps/wcm/connect/60a8fe8048b404ce8fd0ff7577aa6b46/Directive\\_Minimising\\_Restrictive](https://www.sahealth.sa.gov.au/wps/wcm/connect/60a8fe8048b404ce8fd0ff7577aa6b46/Directive_Minimising_Restrictive)



imminent of risk of harm and set out a range of criteria for determining whether alternatives might exist.

- The draft Bill fails to clearly differentiate between the power for health practitioners to 'waive consent' (s14L) and the application of restrictive practices (s14K). Instead of explicitly requiring a staged approach to the provision of health care that begins with waiver of consent, and moves to the use of restrictive practices if no alternative options are reasonably available, the Bill may work to encourage the use of coercive, restrictive practices as the 'first step' or 'normal practice'. This is exacerbated by the counter-intuitive requirement to provide the person with notice of the medical treatment being provided (s14L(8) and s14K(7)) despite having already determined that the person is incapacitated and unable to understand or assert his or her right to withdraw consent. When these factors are combined, it becomes clear that a person subject to a decision made under s14L (waiver of consent) has little practical recourse to avoid or resist the use of restrictive practices under s14K.
- The discretion provided in the draft Bill to the Minister, and in particular the heavy reliance on regulations and Guidelines to prescribe the scope of the powers contained in the draft Bill - is too broad and not subject to adequate limitations, safeguards, reporting or review. These provisions effectively ask the community to 'trust the Minister' and his/her delegates to take a best practice approach without seeing any detail and without having the Parliament scrutinise these aspects of the law.
- The test for using restrictive practices (s14K) appears too broad and inconsistent with the findings of past reports and human rights standards - in particular the (a) absence of the requirement to show imminent threat of harm (b) broad scope of meaning of 'risk of harm' (s14F) (c) absence of any positive duty to demonstrate alternatives have been sought or considered - combine to give rise to a significant broadening of access to restrictive practices by health professionals.
- There is a general lack of safeguards when it comes to the length of time restrictive practices can be used. For example, there is no requirement to seek authorisation from a court or tribunal to extend the use of such practices beyond the period of the imminent risk of harm, nor is there any requirement to obtain the views of another health practitioner or independent officer as to the ongoing need for restraint or coercive treatment.
- It is not clear what forms of external or independent oversight will be applied to the restrictive practices regime, for example, it is not clear whether the Ombudsman or the Chief Psychiatrist or other statutory officer will have the power to review the use of these powers or investigate complaints of misuse or overuse. Proposed section 14Q requires the Minister to undertake a review of the use of restrictive practices, but does not require that review to be conducted by independent officers or an independent statutory body, and leaves the review criteria to the



Minister to determine (significantly undermining the potential for meaningful, independent scrutiny and review of the rights impacts of the draft Bill).

4. Is it appropriate/necessary to require that health practitioners seek consent from responsible persons, or substitute-decision makers, or a guardian, before providing treatment to conditions arising from these situations?

We support the requirement for health practitioners to seek consent from responsible persons, or substitute-decision makers, or a guardian, before providing coercive medical treatment or restrictive practices to people presenting with the types of behaviours being targeted by this draft Bill. This may operate as an important safeguard against the misuse or overuse of the powers contained in the draft Bill, provided the practical and legal ramifications of this requirement can be effectively addressed. However, the utility of this safeguard will be substantially undermined if the relevant health practitioner or the Minister/Minister's delegate is unable to ascertain, locate or contact the person's guardian or substitute decision maker in a timely way. The chances of these practical and legal challenges arising appears relatively high having regard to the examples and categories provided in the materials accompanying the draft Bill, and in the context of busy, under-resourced hospitals or other health care settings. For these reasons, we support the observations of Professor Lawn who explains that a more preferable scenario is one in which health clinicians actively facilitate supported decision making when providing care to people whose capacity may be impaired. This includes a recognition that a person may have greater or lesser capacity to decide varying aspects of life that impact them. For example, a person may be experiencing psychosis, but they retain a preference for choices about what they wear or eat, or the gender of a worker (especially where they may have experienced past trauma or abuse).

## Areas in need of revision and reform

In light of the above concerns, we recommend that the draft Bill be ***revised and redesigned with direct input from those with lived experience*** of the types of behaviours sought to be addressed by these measures, and having regard to the clinical effectiveness of each of the restrictive and coercive measures proposed in the Bill (including each individual measure contained in s14F). Additional areas for revision and reform include:

- The inclusion of a clear objects clause or guiding principles in the Bill that recognises the harm caused by the use of restrictive practices and reflects a commitment to avoiding or minimising the use of coercive medical treatment and /or restrictive practices in health care, and that make explicit reference the human rights principles contained in the UNCRPD and other relevant international human rights principles;
- Remove the power to expand the scope of key definitions contained in ss14E and 14F by regulation, and refine the term 'risk of harm' within s14E(2) to include a requirement of imminent risk of harm and/or clarify that objective criteria should be used to determine the scope of any implied threat of harm, or any increase in likelihood of harm.





- Amend s14F(5) to make it clear that nothing in the proposed Part authorises the use of restrictive practices to improve the efficiency of the provision of health care to that person or any other person, or for the convenience of any staff member.
- Amend s14J to clarify that any Guidelines made under the draft Bill must take the form of a reviewable legislative instrument (and therefore subject to disallowance by Parliament) and adhere to the key principles and objects of the draft Bill (as recommended above).
- Reduce the maximum period of time a person can be subject to restrictive practices and mandate periodic independent review of the use of restrictive practices, to ensure any coercive or restrictive treatment is justified by reference to ongoing clinical need or risk of harm.
- Ensure the provisions of the draft Bill are subject to independent oversight and detailed reporting requirements, that include a specific focus on the impact on the rights of the person subject to these powers, and the clinical effectiveness of the coercive treatment or restrictive practices applied.

An alternative way to approach the use of restrictive practices that would better align with human rights standards can be found in the *Senior Practitioner Act 2018* (ACT) which sets up a framework for reducing the use of restrictive practices, and has a strong focus on prevention, oversight and accountability. This legislation was enacted in a different context to the draft Bill (applying to non-medical settings such as schools) but sets out some key principles to govern the use of restrictive practices that could be included in the draft legislation in SA. For example, the ACT legislation explains that it aims to

- provide a framework for reducing and eliminating the use of restrictive practices by providers; and
- ensure that restrictive practices are used by providers only in very limited circumstances, as a last resort and in the least restrictive way and for the shortest period possible in the circumstances; and
- state principles to be taken into account by providers in providing services to people with behaviour that causes harm to themselves or others; and
- establish the role of senior practitioner; and
- regulate the use of restrictive practices by a provider in relation to a person in a way that (i) is consistent with the person's human rights; and (ii) safeguards the person and others from harm; and (iii) maximises the opportunity for positive outcomes and aims to reduce or eliminate the need for use of restrictive practices; and (iv) ensures transparency and accountability in the use of restrictive practices.

The ACT legislation also provides that when restrictive practices are contemplated by service providers they must be considered in a way that:

- promotes the person's development and physical, mental, social and vocational ability; and opportunities for participation and inclusion in the community; and

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- responds to the person's needs and goals;
- ensures that, in the development of strategies for the person's care and support, the provider works closely with the person and their family, their carers, any guardian or advocate for the person and any other relevant person; and
- recognises that a person must be assumed to have decision-making capacity unless it is established that they do not; and a person must not be treated as being unable to make a decision unless all practicable steps to help them do so have been taken; and a person must not be treated as being unable to make a decision only because they make an unwise decision; and
- involves positive behaviour support planning informed by evidence based best practice; and the implementation of strategies, to produce behavioural change, focused on skills development and environmental design; and
- ensures transparency and accountability in the use of restrictive practices; and
- recognises that restrictive practices should only be used as a last resort and when necessary to prevent harm to the person or others; and if the use is the least restrictive way of ensuring the safety of the person or others; and
- recognises that restrictive practices should not be used aims to reduce punitively or in response to behaviour that does not cause harm to the person or others; and or eliminate the need to use restrictive practices; and ensures that any restrictive practices are only used in a way that is consistent with a positive behaviour support plan for the person.

Including these principles within the South Australian draft Bill would significantly improve the rights compatibility of the scheme and help to address a number of the concerns outlined above.

In making these observations, we strongly encourage you and your department to engage in further discussions with LELAN, MHCSA and the broader membership of the Rights Resource Network SA as you finalise the content of the draft Bill. We can be contacted via Dr Sarah Moulds on 0401132544 or [sarah.moulds@unisa.edu.au](mailto:sarah.moulds@unisa.edu.au)

Yours sincerely

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