**STANDARD BRIEFING NOTE 7**

**RIGHTS IMPACTS OF PROPOSED CHANGES TO USE OF RESTRICTIVE PRACTICES IN MEDICAL SETTINGS IN SA**

This Briefing Note contains key points, key terms, background information and examples of practical application as well as links to further information and local contacts. It does not contain legal advice and should be used as a starting point for further research t rather than an authoritative source. Feedback on its contents is welcome.

*This was prepared in a hurry to provide a rough overview -* ***Current as of 9 September 2020***

**Key Points**

* The South Australian Government is proposing changes to the [*Consent to Medical Treatment and Palliative Care Act 1995*](https://www.legislation.sa.gov.au/LZ/C/A/CONSENT%20TO%20MEDICAL%20TREATMENT%20AND%20PALLIATIVE%20CARE%20ACT%201995.aspx) (Consent Act). The proposed changes include changes to the circumstances in which **restrictive practices** can be used, including without a person’s consent.
* The proposed changes will enable:
	+ authorised persons to use restrictive practices to assess and provide medical treatment, without consent, in strictly limited circumstances
	+ authorised medical practitioners to exercise their powers for as long as necessary or for up to 24 hours, whichever is the lesser
	+ nurse practitioners, advance practice nurses and SA Ambulance Officers to be added to the scope of authorised medical practitioners, in line with current practice.
* 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 patients who exhibit behaviours which create a risk of harm to themselves or other people. It recognises that these patients may have impaired decision making capacity and are not able to consent to their own treatment. The draft Bill facilitates the use of restrictive practices in these circumstances to prevent harm to the patient or others during assessment and treatment. To this end, the draft Bill advances some important human rights, including the right to access adequate health care and the right to life,
* However, the Bill it also has the potential to negatively impact other rights, including:
	+ The right to self determination
	+ The right to liberty and security of person and freedom from arbitrary detention
	+ The right to liberty of movement
	+ The rights of the child (including those rights contained in the *Convention on the Rights of the Child*)
* The rights of persons with disabilities, including those rights contained in the [*United Nations Convention on the Rights of Persons with Disabilities*](https://www.humanrights.gov.au/our-work/disability-rights/united-nations-convention-rights-persons-disabilities-uncrpd) (UNCRPD) which also provides a framework for government and non-government bodies to move from a medical model of health care to a social model of care, with positive rights outcomes for persons with disabilities.
* The draft Bill also raises particular rights concerns around issues covered in Standing Briefing Note No 2. As this Briefing Note documents, 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.
* For these reasons, it is important to consider the following questions when providing a submission on the draft Bill:
	+ 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?
	+ 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?
	+ Are the proposed safeguards in the Bill appropriate/necessary to protect patients and monitor the use of restrictive practices?
	+ 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?
* **Closing date for comments is Thursday 17 September 2020**

This Briefing Note provides some legal perspectives and mental health care perspectives that may be of interest to other Network members. Network members are strongly encouraged to contribute to this Briefing Note and/or use its content in their own submissions.

**Preliminary Mental Health Care observations**

From a mental health care perspective, the following questions and considerations are

* 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 under current processes?
* What kind of 'illnesses' or situations are likely to require this restrictive practice? So far materials provided by government seem to suggest the focus is on patients with drug induced psychosis, recently acquired brain injury and people agitated and considered at suicide risk. However the Bill itself does not limit the use of restrictive practices to these scenarios.
* The draft Bill does not contain any clear principles or a commitment to a human rights, trauma informed approach to mental health care.
* There is a need to ensure the changes proposed in the draft Bill will be accompanied by appropriate training and clear cultural direction for health care service providers. Lived experience must be seen as important in informing service delivery.
* There is a need to ensure that people with lived experience are partners in implementing the legislation in practice.
* More information is needed as to the draft Bill’s interaction with the concept of supported decision making .
* The draft Bill appears to embed the medical model of health care at the expense of social model. For some of the target cohort it is unclear whether medical treatment will be helpful -. The lack of access to services and support, particularly regarding psychosocial issues, is problematic. The evidence base is strong that psychosocial supports help people to solve problems and avoid the need to use crisis and emergency services. The legislation to some extent prioritises medical support and reinforces the marginalisation of preventative services. For information is available from the [WA Mental Health Commission’s study](https://www.mhc.wa.gov.au/media/1834/0581-mental-health-planprintv16acc-updated20170316.pdf.) which analysed levels of unmet need across different service types. p. 20 This work clearly showed underinvestment across all types of services relative to population need. For hospital beds it was 26% underinvested vs need. For community support it was 80% underinvested vs need. This is a practical example of what the UNCRPD is meaning about the need to move from a medical model to a social model.

**Preliminary Legal Observations**

* This is a missed opportunity to adopt a rights-based approach to health care (and in particular to health care for vulnerable South Australians).  It is also a missed opportunity to respond to relevant findings of the [Office of the Public Advocate](http://www.opa.sa.gov.au/article/view/42/preventing_restraint_in_aged_care)(2017) and the [Disability Royal Commission (2020).](https://disability.royalcommission.gov.au/news-and-media/media-releases/restrictive-practices-issues-paper-26-may-2020)
* 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](https://www.sahealth.sa.gov.au/wps/wcm/connect/60a8fe8048b404ce8fd0ff7577aa6b46/Directive_Minimising_Restrictive_Practices_in_HealthCare_Oct2018.pdf?MOD=AJPERES&amp;CACHEID=ROOTWORKSPACE-60a8fe8048b404ce8fd0ff7577aa6b46-n5hBku-)
* The discretion provided in the Bill to the Minister  - and in particular the heavy reliance on Guidelines rather than statutory provisions - is too broad and not subject to adequate limitations, safeguards, reporting or review - we are effectively being asked 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 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' (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 periods of time restrictive practices can be used, with no clear maximum included and no judicial or other oversight used.  The time frames contained in the Bill (up to 12 hours for children for example) are not accompanied by any clear justification.
* The reporting requirements contained in the Bill lack detail and rigour and will end up being dependent on the regulations or guidelines rather than being set by the Parliament.
* It is not clear what forms of external or independent oversight will be applied to regime (nothing is in this Bill but perhaps it intersects with existing regimes?). Same issue when it comes to complaints.
* 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*](.%20%20%20http%3A/ais.act.edu.au/wp-content/uploads/Senior-Practitioner-Act-2018.pdf)(ACT) whichsets 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 provides they must be considered in a way that:
	+ promotes the person’s (i) development and physical, mental, social and vocational ability; and (ii) opportunities for participation and inclusion in the community; and
	+ responds to the person’s needs and goals; and (c) 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— (i) a person must be assumed to have decision-making capacity unless it is established that they do not; and (ii) 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 (iii) a person must not be treated as being unable to make a decision only because they make an unwise decision; and
	+ involves— (i) positive behaviour support planning informed by evidence based best practice; and(ii) 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— (i) as a last resort and when necessary to prevent harm to the person or others; and (ii) if the use is the least restrictive way of ensuring the safety of the person or others; and (h) recognises that restrictive practices should not be used punitively or in response to behaviour that does not cause harm to the person or others; and (i) aims to reduce or eliminate the need to use restrictive practices; and (j) ensures that any restrictive practices are only used in a way that is consistent with a positive behaviour support plan for the person.

**Further Information**

* YourSAy consultation info can be found [here](https://yoursay.sa.gov.au/decisions/consent-to-medical-treatment/about)
* Copy of the Draft Bill can be found [here](https://s3-ap-southeast-2.amazonaws.com/assets.yoursay.sa.gov.au/production/2020/08/11/00/57/22/d3010eec-2174-437d-8ebd-04271d77a515/Consent%20to%20Medical%20Treatment%20etc%20Draft%20for%20Consultation.pdf)
* Current version of the *Consent to Medical Treatment and Palliative Care Act 1995* (SA) is [here](https://www.legislation.sa.gov.au/LZ/C/A/CONSENT%20TO%20MEDICAL%20TREATMENT%20AND%20PALLIATIVE%20CARE%20ACT%201995.aspx)
* SA Govt Frequently Asked Qus are [here](https://yoursay.sa.gov.au/decisions/consent-to-medical-treatment/facts-page)
* Information about the SA Parliament’s Select Committee on COVID-19 can be found [here](https://www.parliament.sa.gov.au/Committees/Committees-Detail)

**Local Contacts**

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