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Submission Restrictive Practices Inquiry

Justice Action was not notified of this Consultation to create a legislative framework to regulate restrictive practices. This is despite being deeply engaged in that issue before the NSW Mental Health Inquiry in 2023-4, before and after.

In the past we have taken focus cases on mental health rights to the Supreme Court four times, and for decades represented people as Indicated Carer before the NSW Mental Health Review Tribunal.

Last year we followed through the invitation to present to the Mental Health Inquiry. Our credentials to be involved is in our submitted documents in our Report of the Inquiry. It was distributed to the Health Department and the other participants. We then issued our Analysis of the Final Report and distributed it to the key people with a media release. Our key focus was on Restrictive Practices and the misleading Chief Psychiatrist's Communique 2014. We continued our negotiation with NSW Health as well as nationally on coercion in mental health. We were informally told that changes were being considered but not about this Consultation.

We feel it was at least disrespectful not to engage us, if not deliberately to avoid our focus. Please ensure that we are now included in the databases and part of the Consultation. Our community expects us to be involved and not excluded as are many of them.

With the limited time available we make some clear objections to the proposals in the Consultation paper. We believe that they attempt to weaken the existing protections of the law to prevent abuses of vulnerable people. We ask that the papers we presented to the NSW Mental Health Inquiry, linked to the paragraph above, be received as part of this Submission.

Overview

The right of people to be different, be unique, believe and behave according to their own wishes is part of the social contract in a democracy and a legal right.

Interference in that freedom is strictly controlled by the Constitution, Legislation and the Courts. Charges of false imprisonment and assault are the normal responses to any breaches, even if agents of the state are involved.

People who could be described as “disabled” due to “mental illness” have special entitlements under the law. They are entitled to social services, housing and care on their own terms, in a non coercive way, paid by public money. International conventions as well as domestic structures support that statement.

Incursions into their right of self determination can only happen through activating the MENTAL HEALTH ACT 2007 - S. 14. The risk of “serious harm” to themselves or others. The courts have decided what that means. It is a risk to life or sexual assault. See analysis of the Limits of Forced Medication.

The Consultation paper seems to suggest that some other criteria should be adopted, without explaining what would happen to the existing provisions of the Mental Health Act, the position of Chief Psychiatrist, the Mental Health Review Tribunal and the associated structures.

Would the new structure justify the Chief Psychiatrist’s Communique 2014 despite it being misleading to clinicians on the legal limits of coercion? If so, the Consultation paper should clearly say so and acknowledge that coercion will increase without legal recourse.

We support the DRC Recommendation 6.35(c) for “promoting the … elimination of the use of restrictive practices” and affect all people in settings where restrictive practices might be used, including aged care and mental health sectors.

No person should be held in a justice setting, youth or adult, if they are deemed “mentally ill”.

The abuse of restrictive practices, specifically “chemical restraint” justified as “treatment” despite it being forced medication, is a topic Justice Action has engaged in for many years. The law doesn’t give permission to forcibly treat people, as a non coercive act.

Injecting people against their will, ie involuntary treatment, is a restrictive practice according to the pub test, has to comply with the law, and be counted as such.

We will be addressing a variety of the questions proposed in the Consultation Paper, including the following:

- **Question 4** – “Do you support legislation requiring that restrictive practices on NDIS participants in the disability service provision, health, education and

justice settings should be governed by the principles recommended by DRC Recommendation 6.35(b)?"

- **Question 7** – "Do you agree that the framework should use the NDIS definitions of restrictive practices?
- **Question 12** – Should APOs be required to be employed by a single provider? Or should APOs be permitted to be consultants to a number of providers? If so, what safeguards should there be in relation to this?
- **Question 13** – Do you support the proposed duration of authorisation and emergency use proposals for restrictive practices?
- **Question 15** – Should authorisation decisions be open to internal review or be reviewable at NCAT?
- **Question 16** – Should rights to seek review be limited to the person or a person concerned for their welfare? Should the service provider have a right to seek review of a decision not to authorise a restrictive practice?
- **Question 17** – Should a person have a right to request the service provider review the BSP at any time?
- **Question 25** – Should the proposed framework provide for a legislated immunity from liability from the use of restrictive practices where the use was in accordance with an authorisation and done in good faith?

Justice Action's Response to Specific Questions

Question 4 – "Do you support legislation requiring that restrictive practices on NDIS participants in the disability service provision, health, education and justice settings should be governed by the principles recommended by DRC Recommendation 6.35(b)?"

The law should be the basis of governing principles for restrictive practices, not Senior Practitioners. The law is clear on the basis of which restrictive practices should be accepted and, for this reason, should be the foundation on which regulations surrounding restrictive practices should be drawn up.

Governmental limits on this power to forcibly medicate are further examined in Justice Action's paper: "Limits of the Power to Forcibly Medicate".

Question 7 - "Do you agree that: the framework should use the NDIS definitions of restrictive practices?

Justice Action is paying particular attention to Question 7 regarding the definition of chemical restraint.

The current definition of “chemical restraint”, as included in Section 6 of the NDIS Act, states that chemical restraint is:

> “The use of medication or chemical substance for the primary purpose of influencing a person’s behaviour. It does not include the use of medication prescribed by a medical practitioner for the treatment of, or to enable treatment of, a diagnosed mental disorder, a physical illness or a physical condition.”

The use of forced medication against the disabled person, overcoming their stated preferences, expressed orally or by physical resistance, is obviously a restrictive action. To exclude it is dishonest. The law permits an order against the person’s preferences after a decision by a Tribunal, otherwise the treatment cannot be administered. It is a legally justified restrictive practice. Our paper on the issue is here.

The definition for chemical restraint, as used in most jurisdictions shows the power of the medical profession. It states “the use of medication, substances, or drugs primarily to restrict movement or behaviour unless it is for treatment”. With this definition, the coercion that takes place in mental health settings is masked behind the word “treatment”, rather than addressing the realities of forced medication.

The law on the use of restrictive practices is carefully established. Force is only permitted when strict criteria are met. This must be accepted as the guidance for the Senior Practitioners.

Section 14 of the New South Wales *Mental Health Act* establishes a two-stage test for determining whether a person should be classified as mentally ill. The first criterion looks for the presence of behaviour that indicates a mental illness as per the Act’s definition, and the second pertains to the person’s behaviour and condition. Specifically, the Court has to consider whether there are “reasonable grounds for believing that care, treatment or control is necessary for:

> (a) the person's own protection from serious harm or
> (b) the protection of others from serious harm”

The Mental Health Review Tribunal, on the application of the Health Department, must be satisfied that certain criteria are met. The actual meaning of the terms used are not clearly established in legislation. Questions as to who is “mentally ill”, what is “serious harm”, what are “reasonable grounds” for belief in “necessary ” treatment and alternative approaches to personal problems are ill-defined in law and inconsistently addressed in practice. Previous legal challenges have interpreted the

law carefully, but lack of access to legal assistance and the vulnerability of consumers have created an entrenched culture of abuse among medical professionals and health authorities.

The proposed NDIS definition fails to include the crucial concept of consent, which would allow forced administration of prescribed medication against the will of the consumer without the restriction being acknowledged and respected.

The exclusion in the definition quoted, has contributed to harmful behaviours that are happening, despite the law being clear and required to be followed. The law determines the actions of the Senior Practitioners and Authorised Program Officers. Section 14 of this Act is a caveat to assault. Without it, forced medication would qualify as harm and not be sanctioned. The law is in agreement that treatment cannot be imposed on anyone without an order for the restrictive practice.

Definition Negotiations

The definition of “chemical restraint” is highly disputed.

BEING in its Submission believes the definition of restraint and seclusion should be aligned with the background research supported by the Disability Royal Commission. The definition under the Disability Royal Commission states: “Involuntary mental health treatment, and other non-consensual or coercive interventions said to be undertaken for protective, behavioural or medical reasons”. Thus, this would include the use of forced medication as a restrictive process.

The organisations which are currently being involved in negotiating the definition of chemical restraint include:

- National Mental Health Commission (NMHC)
- Mental Health and Suicide Prevention Data Governance Forum (MHSPDGF)
- Australian Commission on Safety and Quality in Health Care (ACSQHC)
- Mental Health and Suicide Prevention (MHSP)
- Australian Institute of Health and Welfare (AIHW)
- National Mental Health Consumer Alliance

Specifically, NMHC’s Executive Director Alex Hains said, on 7 August 2024, in regards to the definition of chemical restraint, that “a practical definition that is useful for monitoring or collecting data has been an ongoing challenge and national data on this type of restraint is currently unavailable.” Similarly, the AIHW informed Justice Action that there is “no nationally agreed definition for chemical restraint.”

Not having a working definition for chemical restraint may contribute to issues surrounding reports of chemical restraint cases due to ambiguity in the term. This

further emphasizes the need for a working definition, given that the current lack of a uniform definition may be preventing the accurate documentation of cases.

A consistent definition would better facilitate the collection of data and would allow coercive practices, including chemical restraint, to be monitored and properly controlled across all care services in Australia.

Medication Statistical Failure

The use of psychotropic medication in treating psychosocial challenges has long been criticised as largely ineffective and extremely disruptive to the consumer's wellbeing. In Harrow et al.'s (2022) 20 year longitudinal study, medicated patients were approximately six times less likely to recover than their unmedicated peers. In cross-cultural studies conducted by the World Health Organization, schizophrenia outcomes were found to be significantly better in developing countries, where only a small percentage of patients are regularly maintained on antipsychotics.

Medication is currently the main approach to mental health treatment within the Australian medical field. The 2015 report from the Mental Health Commission of NSW brought to light an alarming trend - an increasing dependence on medication as a means of mental health management. The reliance on medication is especially apparent in lower income facilities as it is seen as the 'easier option' with considerations to their inadequate funding. Yet, there is numerous research that demonstrates the dangers and ineffectiveness of long-term medication in helping people with psychosocial challenges, when used as a stand-alone treatment or for 'management'.

Medication, primarily in reference to antipsychotics, can cause many serious side effects to the physical and mental health of the consumer. In Lapane et al.'s (2007) study, three-quarter of patients in the study reported medication effects that were not mentioned by their physician, including hair loss, poor sleep, weight loss/gain and chronic cough. Additionally, excessive sweating, fatigue, reduced emotional expression, suicidal thinking and higher rehospitalisation rates have also been significantly linked to the use of antipsychotic medication (Brown, et al. 2016; Stip et al., 2002).

Changes to body appearance has been shown to further deteriorate the consumer's self-esteem and can lead to further stigmatisation, thus creating a vicious cycle that ultimately threatens the individual's mental wellbeing (Mental Health Commission 2015, pp. 42). MRI brain scans have revealed neurobiological changes in medicated individuals, contributing to an increased vulnerability to psychosis (Chouinard 1991; Gur et al. 1998).

The administration of medication itself also poses threats to the consumer's wellbeing. Moreover, as noted by the National Institute of Mental Health, medications often necessitates multiple attempts to identify the most suitable treatment.

The process of "trial and error" in determining the right medication creates disillusionment with treatment and can lead to heightened side effects, including developing exacerbated depressive symptoms (Cusin et al. 2007). With considerations to the wellbeing of mental health service consumers, there is a need to implement alternatives to medication.

The best means of addressing psychosocial distress is with non-medicalised, community-based, peer designed and led mutual support groups. Participants can then decide for themselves in a non-coercive, non-authoritarian environment what role - if any - medication, self-help, psychological and behavioural therapies, social support services, etc might play in their ongoing care and personal development.

In a study conducted by Justice Action to collect data regarding the issue of forced medication, 81% of respondents from five mental health wards in Australia and New Zealand reported they would not take their medication if they did not have to. Of the 19% who reported they would take their medication, their reasons for doing so included reasons indirectly related to their mental wellbeing. Reasons included better sleep and the belief that compliance with officials would help them leave the system sooner.

Side Effects

It is counterproductive to take the approach of using chemical restraints as a means of control because of their lasting long-term effects on individuals and their inferior results in comparison to other methods.

The harms associated with the use of chemical restraints can fall into four primary categories including:

1. The pharmacological effects of the drug on the consumer.
2. Physical and cognitive decline from the fact of restraint.
3. The psychosocial effects of removing the consumer's autonomy and agency, especially where the consumer feels coerced into receiving drugs.
4. The damaging effect on the 'therapeutic relationship' with carers.

The use of certain medications, such as antidepressants and antipsychotics, have been found to create emotional dullness in individuals taking these medications. This

can contribute to a feeling of numbness that takes away a person's ability to experience their emotions accurately. Victims of forced medication have reported feeling as if they are "being poisoned" by the medications forcibly administered to them. One forensic consumer stated, "We are forced to be compliant, broken down, life and energy sucked from our essence. They create sedated, manageable people not fit to function."

The administration of chemicals or medication without consent violates a person's right to make informed choices about their medical care, and it denies them their bodily autonomy and right to self determination. In particular, the consumer loses all authority over their physical integrity, and the feeling of degradation overwhelms them. When these fundamental rights are violated, it may potentially lead to further personal distress or harm. The current approach is counterproductive as the side effects of antipsychotic drugs are well documented and in the longer term have been proven to be more damaging than non-medical interventions.

Question 12: "Should APOs be required to be employed by a single provider? Or should APOs be permitted to be consultants to a number of providers? If so, what safeguards should there be in relation to this?"

Authorised Program Officers (APO) cannot take the place of the current Mental Health Review Tribunal with three trained functions/people. That lessens the quality of a fundamental decision on restrictive practices.

The APO, whatever the function, should be an independent person and obviously not hired by an organisation with the interest of managing the person in its care. APOs should be employed by the Senior Practitioner and trained by them. They should be able to function with a number of providers. This would be similar to the role of Ombudspeople and Inspectors with their staff.

Question 13: "Do you support the proposed duration of authorisation and emergency use proposals for restrictive practices?"

The current order for forced treatment, i.e. the CTO, is normally limited to 6 months. Any extension of time in the used structure would represent a lessening in the control of restrictive practices, which Justice Action would regard as a negative development. As regards emergency use, see the Justice Action paper on Crisis Intervention.

Question 15: "Should authorisation decisions be open to internal review or be reviewable at NCAT?"

Authorisation decisions should be open to internal review. The proposed right to seek review is consistent with the Disability Royal Commision (DRC). The DRC recommended that all decisions to authorise restrictive practice should be subject to independent review (Recommendation 6.35(b)). (Consultation Paper).

This would enable patients to have more control over their own treatment, whether by preventing chemical restraint or taking care with prescribed medications. In the "ACT and Victoria a person can request a review by the service provider of the BSP at any time" and that would help determine if the restrictive practice is still necessary and hopefully that will reduce the need for the practices altogether. If the practice is reviewed internally as well as by multiple people, it will often become clear that the practice is harmful and/or unnecessary.

Once the restrictive practice is open to internal review, it should then be reviewable at the NSW Civil and Administrative Tribunal (NCAT). Further, NCAT should enable a private person or Public Guardian to take guardianship over an individual who is incapable of making personal decisions, including decisions with regard to restrictive practices. .

Question 16: "Should rights to seek review be limited to the person or a person concerned for their welfare? Should the service provider have a right to seek review of a decision not to authorise a restrictive practice?"

The right to seek review of authorisation of restrictive practices should not be extended to service providers. They are much stronger than the subject person and must respect direction and standards rather than easy management by chemical restraint.

Question 17: "Should a person have a right to request the service provider review the BSP at any time?"

People should have the right to request review of their Behaviour Support Plans(BSP) at any time, as mental health circumstances may change frequently. There are other options to restrictive practices that should be up for negotiation. The findings from the L Webber, 2012 research are important because they suggest that increases in the quality of BSPs may lead to decreases in restraint and seclusion over time.

Webber, L., Richardson, B., Lambrick, F. and Fester, T., 2012. The impact of the quality of behaviour support plans on the use of restraint and seclusion in disability services. *International Journal of Positive Behavioural Support*, *2*(2), pp.3-11.

Question 25: "Should the proposed framework provide for a legislated immunity from liability from the use of restrictive practices where the use was in accordance with an authorisation and done in good faith?"

No. If people are doing something illegal, then they have to be held responsible for their actions.

The law is already flexible enough to be fair. Immunity would suggest the law doesn't have validity and would encourage disrespect for the law. An absence of of immunity would ensure compliance with the regulations and also ensure that providers would be liable in the case of negligence.

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