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Submission to the Royal Commission into Victoria's Mental Health System

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1. The Castan Centre welcomes the opportunity to make this submission to the Royal Commission into Victoria's Mental Health System. The Castan Centre is a leading academic centre using its human rights expertise to create a more just world where human rights are respected and protected, allowing people to pursue their lives in freedom and with dignity.

2. Pursuant to Terms of Reference 2.1 and 4, this submission focuses on the legal framework regulating the use of restrictive practices in closed mental health treatment settings in Victoria. The submission draws on research which the Castan Centre is currently undertaking, comparing laws governing the use of force, restraint and seclusion in a range of closed environments in all Australian states and territories, and assessing their compliance with international human rights standards.

3. This submission also provides an overview of applicable human rights standards, in order to assist the Commission in applying these standards to the formulation of recommendations (Terms of Reference, s. IIIg).

HUMAN RIGHTS OBLIGATIONS OF THE STATE OF VICTORIA

1. Under section 38 of the *Charter of Human Rights and Responsibilities Act 2006* (Vic) ('the Victorian Charter'), it is unlawful (subject to certain exceptions) for a public authority to act in a way that is incompatible with, or in making a decision fail to give proper consideration to, a human right which is protected under the Charter.

2. In addition to the Charter, the State of Victoria carries obligations under international human rights law. Australia is a party to a number of international treaties which impose obligations relevant to the measures proposed in the Bill. These include the International Covenant on Civil and Political Rights ('ICCPR'), [1] and the Convention on the Rights of Persons with Disabilities ('CRPD'). [2]

3. The specific content and contours of these rights have been elaborated through international jurisprudence, interpretation aids (known as 'general comments' or 'general recommendations') published by relevant treaty bodies, and rules adopted by the UN General Assembly.

4. International human rights law is not automatically enforceable in Australian courts. However, by entering into these treaties, Australia has voluntarily committed to comply with their provisions in good faith and to take the necessary steps to give effect to those treaties under domestic law. [3] That implementation depends on the actions of the states and territories – including Victoria - is no justification for failure to meet treaty obligations.[4]

5. A number of international human rights obligations have been directly incorporated into domestic legislation. However, even when treaties have not been directly incorporated by legislation, they are

[1] Dec. 16, 1966, 999 U.N.T.S. 171.
[2] Dec. 13, 2006, 2515 U.N.T.S. 3.
[3] Vienna Convention on the Law of Treaties, May 23, 1969, 1155 U.N.T.S. 331, art. 26.
[4] As above, art. 27. However, note Australia's declaration in respect of the ICCPR: "Australia has a federal constitutional system in which legislative, executive and judicial powers are shared or distributed between the Commonwealth and the constituent States. The implementation of the treaty throughout Australia will be effected by the Commonwealth, State and Territory authorities having regard to their respective constitutional powers and arrangements concerning their exercise." This declaration does not, however, alter Australia's obligations under international law.

an indirect source of rights. They give rise to a legitimate expectation of compliance by the executive, and they provides guidance on how particular domestic laws and obligations should be understood. [5]

OVERVIEW OF RELEVANT HUMAN RIGHTS STANDARDS

1. Restrictive practices in mental health settings engage a range of human rights, under both international law and the Victorian Charter. Prohibitions on cruel, inhuman and degrading treatment are central to any discussion of restrictive practices, and are found in a number of instruments. Other rights which are specific to the CRPD are also relevant. It is important for the purposes of the Royal Commission to note that, while the CRPD does not define 'disability', article 1 states that 'Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.' This is generally taken to include persons with ongoing mental ill-health.

Restraint and seclusion as cruel, inhuman or degrading treatment or punishment

2. Cruel, inhuman or degrading treatment or punishment are prohibited under article 7 of the ICCPR, article 16 of the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment ('CAT'), article 15 of the Convention on the Rights of Persons with Disabilities ('CRPD') and section 10 of the Victorian Charter.

3. There is clear international authority for the proposition that restrictive practices may constitute cruel and inhuman treatment. The Committee on the Rights of Persons with Disabilities has repeatedly called for States to take steps to abolish the use of non-consensual measures such as restraint and seclusion with regard to persons with psychosocial disabilities. [6] In the Committee's Concluding observations on the initial report of Australia, adopted by the Committee at its tenth session in 2013, it expressed concern that:

> persons with disabilities, particularly those with intellectual impairment or psychosocial disability, are subjected to unregulated behaviour modification or restrictive practices such as chemical, mechanical and physical restraints and seclusion, in various environments, including schools, mental health facilities and hospitals.[7]

The Committee recommended that Australia 'take immediate steps to end such practices'.[8]

4. The UN Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment has also clearly asserted that prolonged seclusion and restraint 'for even a short period of time' may constitute torture and ill-treatment,[9] and that the imposition of solitary confinement of

[5] *Minister for Immigration and Ethnic Affairs v Ah Hin Teoh* (1995) 183 CLR 273.

[6] See e.g., Committee on the Rights of Persons with Disabilities, Concluding observations on the initial report of Denmark (30 Oct. 2014) CRPD/C/DNK/CO/1, paras. 38-39; Committee on the Rights of Persons with Disabilities, Concluding observations on the initial report of Mexico (27 Oct 2014) CRPD/C/MEX/CO/1, paras. 31-32; Committee on the Rights of Persons with Disabilities, Concluding observations on the initial report of Austria (30 Sep. 2013) CRPD/C/AUT/CO/1, paras 32-33.

[7] Committee on the Rights of Persons with Disabilities, Concluding observations on the initial report of Australia (21 Oct. 2013) CRPD/C/AUS/CO/1, para 35.

[8] Ibid, para 36.

[9] Juan Mendez, *Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment* (1 Feb. 2013) A/HRC/22/53, para 63. It is beyond the scope of this submission to consider the experienced of people with psychosocial disability in the justice system, however we note the clear guidance that the use of solitary confinement in detention facilities against persons with psychosocial disability constitutes and should be abolished (see: Juan Mendez, *Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or*

any duration, on persons with mental disabilities is cruel, inhuman or degrading treatment.[10] Successive Special Rapporteurs have raised particular concerns about the prolonged use of seclusion and restraint, for which 'there can be no therapeutic justification.'[11] According to the Special Rapporteur:

> 'It is essential that an absolute ban on all coercive and non-consensual measures, including restraint and solitary confinement of people with psychological or intellectual disabilities, should apply in all places of deprivation of liberty, including in psychiatric and social care institutions.'[12]

Restraint and seclusion as exploitation, violence and abuse

5. Restrictive practices may also engage article 16 of the CRPD, which imposes on States an obligation to 'take all appropriate legislative, administrative, social, educational and other measures to protect persons with disabilities, both within and outside the home, from all forms of exploitation, violence and abuse, including their gender-based aspects.'[13] While restrictive practices have more frequently been considered to fall within the purview of article 15, McSherry makes the argument for considering such practices as forms of violence and abuse under article 16.[14] Of particular note is article 16's focus on prevention and protection, and specifically the requirement for States to properly legislate against, and monitor, violence and abuse. This provides a broad framework for States on how to reduce the use of restrictive practices – and the violence and abuse associated with them – while aiming for their elimination.

Restraint and seclusion as coercive and unequal treatment

6. More generally, the CRPD reconceptualises the idea of capacity in a way which raises questions about the fundamental permissibility of restrictive practices. Article 12 of the CRPD requires that, among other things, State Parties 'recognize that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life.' In General Comment 1, the Committee has affirmed that compliance with article 12 requires the replacement of substitute decision-making arrangements with supported decision-making, and the abolition of involuntary detention and forced treatment regimes.[15]

7. The Committee has found further support for this position in article 14, which contains protections for people with disability against unlawful or arbitrary deprivation of liberty. Critically, article 14(1)(b) states that 'the existence of a disability shall in no case justify a deprivation of liberty.' Read together with other CRPD provisions, the Committee has interpreted article 14 in strict terms, observing that the involuntary commitment of persons with disabilities on health care grounds contradicts the

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punishment (5 Aug. 2011) A/66/268) para. 78; Committee Against Torture, Concluding observations on the report submitted by Canada (25 Jun. 2012) CAT/C/CAN/CO/6, para. 19 (d)).

[10] Juan Mendez, *Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment* (1 Feb. 2013) A/HRC/22/53, para 63. See also See CAT/C/CAN/CO/6, para. 19 (d).

[11] Manfred Nowak, *Interim report of the Special Rapporteur of the Human Rights Council on torture and other cruel, inhuman or degrading treatment or punishment* (28 July 2008) A/63/175, para 55.

[12] Juan Mendez, *Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment* (1 Feb. 2013) A/HRC/22/53, para 63.

[13] Art. 16(1).

[14] Bernadette McSherry, 'Regulating seclusion and restraint in health care settings: The promise of the Convention on the Rights of Persons with Disabilities' *International Journal of Law and Psychiatry* 53 (2017) 39–44.

[15] Committee on the Rights of Persons with Disabilities, General comment No. 1: Article 12: Equal recognition before the law (19 May 2014) CRPD/C/GC/1.

absolute ban on deprivation of liberty on the basis of impairments and the principle of free and informed consent of the person concerned for health care.[16]

8. The use of restrictive practices is clearly problematic when viewed in light of articles 12 and 14. Restrictive practices are, by their nature, coercive interventions, in which individuals are deprived of liberty, and in the case of chemical restraint, exposed to non-consensual medical treatment.[17] Individuals subjected to restraint or seclusion have rarely provided their consent to the intervention, which is generally employed to address behaviours which are a manifestation of disability, including mental ill-health.

9. The precise implications of articles 12 and 14, and their interpretation by the Committee, remain vigorously contested.[18] However, it is clear that they add considerable weight and urgency to the arguments against the use of restrictive practices in the management and treatment of mental ill-health. At a minimum, these human rights norms demand a deliberate, concerted shift away from coercive approaches to people with disability.

Obligations to monitor places of detention

10. In December 2017, Australia ratified the Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT). OPCAT requires states to establish independent National Preventative Mechanisms (NPMs), with specific powers to prevent torture and ill-treatment, including through inspections of places of detention. States are also required to cooperate with the UN Subcommittee on Prevention of Torture, which also plays a monitoring role.

11. Australia has not yet implemented OPCAT, which it is required to do within three years of ratification. Progress is, however, being made. The Commonwealth Ombudsman has been appointed as National NPM Co-ordinator, and as the NPM for Commonwealth places of detention. The Australian Human Rights Commission is currently conducting the second phase of an extensive consultation process, with a final report due to be published in mid-2019.[19] Steps have also been taken in Victoria, with the Victorian Ombudsman undertaking a pilot inspection of Dame Phyllis Frost Centre to OPCAT standards,[20] and planning another OPCAT-related project, this time on solitary confinement of young people.[21]

12. While mental health facilities are currently subject to certain independent oversight and inspection mechanisms (including through the OPA's Community Visitor programme), these fall well short of the rigorous inspection requirements of OPCAT. When considering the monitoring and oversight of mental

[16] Committee on the Rights of Persons with Disabilities, *Guidelines on article 14 of the Convention on the Rights of Persons with Disabilities: The right to liberty and security of persons with disabilities* (Adopted during the Committee's 14th session, held in September 2015) para 10.

[17] Chemical restraint may also constitute a violation of article 25(d), which requires 'health professionals to provide care of the same quality to persons with disabilities as to others, including on the basis of free and informed consent…'

[18] See, e.g.: Rosemary Kayess and Phillip French, 'Out of darkness into light? Introducing the convention on the rights of persons with disabilities', *Human Rights Law Review* 8(1) (2008) 1–34; Melvyn Freeman, et al, 'Reversing hard won victories in the name of human rights: A critique of the general comment on article 12 of the UN convention on the rights of persons with disabilities' *The Lancet Psychiatry,* 2(9) (2015) (2015) 844–50.

[19] Australian Human Rights Commission, OPCAT Consultation Page, https://www.humanrights.gov.au/opcat-consultation-page.

[20] Victorian Ombudsman, *Implementing OPCAT in Victoria: report and inspection of the Dame Phyllis Frost Centre* (2017).

[21] Victorian Ombudsman, 'Ombudsman to investigate the use of 'solitary confinement' and young people', Press release (6 December 2018) <https://www.ombudsman.vic.gov.au/News/Media-Releases/Ombudsman-to-investigate-the-use-of-solitary-confi>.

health facilities, the Royal Commission must take into account Australia's obligations under OPCAT, and the broader strategy for implementing OPCAT in Victoria.

REGULATION OF RESTRICTIVE PRACTICES IN MENTAL HEALTH SETTINGS IN VICTORIA

13. The use of restrictive practices in mental health settings in Victoria is regulated under the *Mental Health Act 2014* (Vic). Broadly, the Act allows for the use of restrictive practices on a person where it is necessary to prevent imminent and serious harm to the person or to another person (or, in the case of bodily restraint, it is necessary to administer treatment or medical treatment to the person), and after all reasonable and less restrictive options have been tried or considered and have been found to be unsuitable.[22] Appendix 1 compares the provisions of the *Mental Health Act 2014* with a number of key indicators, and with the regulatory regimes of other Australian jurisdictions.

14. The Act does not contain nor express a specific goal of reducing the use of restrictive practices. This aim is however reflected in Victorian government policy. As part of its Reducing Restrictive Interventions project, in 2013, the Victorian government released the Framework for reducing restrictive interventions to 'assist health services to comply with mental health reform objectives and the *Charter of Human Rights and Responsibilities Act* 2006 by providing guidance in developing a local response to reduce the use of restrictive interventions through a culture of safety and recovery.'[23] The Framework is described as 'central to the government's commitment to reduce restriction.'[24] The initiative includes other measures, such as the 'Safewards' model of interventions.

15. The Victorian Government is to be commended for these steps, and for articulating the aim of reducing the use of restrictive interventions in mental health settings. There are, however, reasons to believe that these measures are not enough to significantly reduce the use of restraint and seclusion, and not sufficient to meet international human rights standards. The Australian Institute of Health and Welfare's (AIHW) 2018 statistics on the rate of restraint events in public sector acute mental health hospital services were the highest of any Australian jurisdiction – over double the national average.[25] Victoria's rates of seclusion were also among the highest. While the AIHW indicates that Victoria's service model means that these figures may be inflated, they remain deeply concerning.[26]

16. There are complex reasons for the prevalence of restrictive practices in Victoria's mental health facilities. However, our research suggests that the legislative framework for restrictive practices may be contributing to the problem. Appendix 1 analyses the compliance of each Australian state and territory's laws on restrictive practices with a number of indicators. These indicators are, where possible, based on international human rights standards. Where the relevant standards are insufficiently specific, we have drawn on minimum standards for detainees and prisoners. Consequently, it is important to note that these indicators should be regarded as absolute minimum

[22] Ss. 105, 110 and 113.
[23] State of Victoria Department of Health, Providing a safe environment for all: Framework for reducing restrictive interventions (2013) 2.
[24] Ibid.
[25] Australian Institute of Health and Welfare, Mental health services in Australia, Web Report (last updated 5 Dec 2018) < https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/restrictive-practices/restraint>.
[26] For a discussion of these statistics, see: Piers Gooding and Yvette Maker, 'Why are the rates of restrictive practices in Victoria's mental health services so high?' *Pursuit* (Blog) (undated) < https://pursuit.unimelb.edu.au/articles/why-are-the-rates-of-restrictive-practices-in-victoria-s-mental-health-services-so-high>.

requirements, and not as best practice. This analysis reveals clearly that more could be done to bring Victoria's laws and policies into greater alignment with international human rights law.

RECOMMENDATIONS

17. The Government of Victoria should:

    I. explicitly adopt as a policy aim the reduction, with the aim of eliminating, the use of restraint and seclusion in mental health facilities. This should be clearly reflected in the *Mental Health Act 2014* (Vic)

    II. adopt evidence-based programmes to reduce and eventually eliminate restrictive practices

    III. strengthen legislative protections for people subjected to restraint and seclusion, including by:

        i. regulating the use of chemical restraint as a form of restraint;

        ii. enhancing regulation and oversight of the use of seclusion, including through the introduction of time limits; and

        iii. making it an offence to use of restrictive practices contrary to the Act.

    IV. Improve accountability and oversight of the use of restraint and seclusion in mental health settings, including by fully implementing all aspects of OPCAT.

Appendix 1

State	ACT	NSW	NT	QLD	SA	TAS	VIC	WA
Legislation	Mental Health Act 2015 (ACT)	Mental Health Act 2007 (NSW)	Mental Health and Related Services Act 1998 (NT)	Mental Health Act 2016 (Qld)	Mental Health Act 2009 (SA)	Mental Health Act 2013 (TAS)	Mental Health Care Act 2014 (Vic)	Mental Health Act 2014 (WA)
Policy		NSW Health policy directive on "Aggression, Seclusion and Restraint in Mental Health Facilities in NSW"		Chief Psychiatrist Policies	Minimising Restrictive Practices in Health Care Policy Directive (under review from 31 May 2019) - mandatory compliance for SA Health providers	Office of the Chief Psychiatrist	Chief Psychiatrist guidelines on restrictive practices	Mental Health Regulations 2015 (WA)
Notes	From 1 September 2018, the Senior Practitioner Act 2018 (ACT) provides a formal framework for the reduction and elimination of restrictive	Under review: Mental Health Safety and Quality in NSW: A plan to implement recommendations of the Review of seclusion, restraint and observation of consumers with a		Restrictive practices guidance	Restraint and Seclusion in Mental Health Services Policy Guideline		Royal Commission into mental health system	Recent review of the Act (PIR)

	practices by service providers in the ACT.	mental illness in NSW Health facilities						
Restrictive practices are regulated under law, not only policy	YES[i]	NO[ii]	YES[iii]	YES[iv]	YES[v]	YES[vi]	YES[vii]	YES[viii]
Restraint may only be used as a last resort	YES[ix]	PARTLY: under policy only[x]	YES[xi]	YES[xii]	YES[xiii]	PARTLY[xiv]	YES[xv]	YES[xvi]
Use of restraint is prohibited for any reason other than: - to prevent a patient causing injury to him/herself or another person; - to prevent absconding contrary to a treatment order or to effect transfer; or - for the lawful administering of treatment.	YES[xvii]	NO[xviii]	NO[xix]	NO[xx]	NO[xxi]	YES (Except for forensic patients)[xxii]	YES[xxiii]	NO[xxiv]
Any application of force must be the minimum	YES[xxv]	PARTLY[xxvi]	YES[xxvii]	PARTLY[xxviii]	PARTLY[xxix]	YES[xxx]	PARTLY[xxxi]	YES[xxxii]

necessary and / or reasonable								
Every use of restraint must be reported	YES[xxxiii]	NO[xxxiv]	NO[xxxv]	NO[xxxvi]	PARTLY[xxxvii]	YES[xxxviii]	YES[xxxix]	YESs[xl]
The administering of sedating medication is regulated as a form of restraint	YES[xli]	PARTLY[xlii]	NO	PARTLY[xliii]	YES[xliv]	YES[xlv]	PARTLY: for transport to/between health facilities[xlvi]	NO
The Act imposes a specific limit on the amount of time a patient may be secluded	NO[xlvii]	NO[xlviii]	NO[xlix]	YES[l]	NO[li]	YES (but extendable without maximum limit)[lii]	NO[liii]	YES (but extendable without maximum limit)[liv]
Minimum conditions for seclusion are established in law or policy	NO	PARTLY: in policy only[lv]	YES[lvi]	YES[lvii]	PARTLY: in policy only[lviii]	YES[lix]	PARTLY[lx]	YES[lxi]
Policies on restrictive practice include minimum requirements for staff training on use of restraint and seclusion	NO	YES[lxii]	NO	YES[lxiii]	PARTLY: in policy only[lxiv]	PARTLY: recommended only[lxv]	PARTLY: recommended only[lxvi]	PARTLY: recommended only[lxvii]
An independent visitor scheme is in place	YES[lxviii]	YES[lxix]	YES[lxx]	YES[lxxi]	YES[lxxii]	YES[lxxiii]	YES[lxxiv]	YES[lxxv]

Administrators are required (under law or policy) to escalate serious complaints to an independent, external body	NO	NO[lxxvi]	YES[lxxvii]	YES[lxxviii]	PARTLY: in policy only[lxxix]	NO	NO[lxxx]	PARTLY[lxxxi]
Use of restrictive practices contrary to the law is an offence under the Act	PARTLY: provision not yet in force[lxxxii]	PARTLY[lxxxiii]	YES[lxxxiv]	YES[lxxxv]	PARTLY[lxxxvi]	PARTLY[lxxxvii]	NO[lxxxviii]	YES[lxxxix]
Officials are civilly and criminally liable under the Act in relation to restrictive practices	PARTLY: exempt from civil liability[xc]	YES	NO[xci]	PARTLY: exempt from civil only[xcii]	YES	NO[xciii]	PARTLY[xciv]	NOs[xcv]

[i] Restrictive practices are regulated under s 65(2) of the *Mental Health Act 2015* (ACT): Powers in relation to a Psychiatric treatment order and s 73(2): Powers in relation to a Community care order. Further, from 1 September 2018, the *Senior Practitioner Act 2018* (ACT) provides a formal framework for the reduction and elimination of restrictive practices by service providers in the ACT. It also provides the powers and functions of the Senior Practitioner.

[ii] Restrictive practices are regulated under (mandatory) Policy Directive 'Aggression, Seclusion & Restraint in Mental Health Facilities in NSW', PD2012_035 ('Policy Directive')

[iii] The *Mental Health and Related Services Act 1998* (NT) regulates mechanical restraint at s 61, and seclusion at s 62.

[iv] S 24 of the *Mental Health Act 2016* (QLD) Mechanical restraint, seclusion, physical restraint and other practices:
(1) The use of mechanical restraint, seclusion, physical restraint, and other practices are regulated under this Act.

(2) The use of mechanical restraint on an involuntary patient in an authorised mental health service must be approved by the chief psychiatrist.
(3) Mechanical restraint and seclusion may be used only if there is no other reasonably practicable way to protect the patient or others from physical harm.

[v] Restrictive practices are primarily regulated under policy, however several provisions in the *Mental Health Act 2009* (SA) regulate the use of force in specific settings (i.e. s 34A(2)(a) regarding treatment of involuntary patients, and Part 9 relating to —Powers relating to persons who have or appear to have mental illness).

[vi] Seclusion and restraint is regulated under Division 5 of the *Mental Health Act 2013* (TAS)

[vii] Part 6 of the *Mental Health Care Act 2014* (Vic) regulates 'Restrictive interventions', specifically seclusion and restraint. The use of sedatives is outlines at Division 3, specifically in the context of 'Bodily restraint and sedation...when taking [a] person' (s 350).

[viii] Bodily restraint is regulated by Division 6 of the *Mental Health Act 2014* (WA) and Division 5 outlines Seclusion.

[ix] Under the *Mental Health Act 2015* (ACT), the Chief Psychiatrist or Care Coordinator may only subject the person to involuntary seclusion if satisfied that it is the only way in the circumstances to prevent the person from causing harm to themself or someone else (s 65(2)(c), s73(2)(c)). The *Senior Practitioner Act 2018* (ACT) provides '[a] restrictive practice should only be used if it is the 'least restrictive way of ensuring the safety of the person or others…' (Senior Practitioner Act 2018 (ACT) ss 9(g), 14(2)(b)).

[x] The Policy Directive states 'physical/manual restraint should be an option of last resort to manage the risk of serious imminent harm' (Part 4.1, page 9).

[xi] S 61 and s 62 of the *Mental Health and Related Services Act 1998* (NT) provide mechanical restraint or seclusion (respectively) may only be applied where no other less restrictive method of control is applicable or appropriate.

[xii] Under the *Mental Health Act 2016* (QLD), physical restraint may only be used if there is 'no other reasonably practicable way to protect the patient or others from physical harm' (s 24(3)). This is reiterated in each of the Chief Psychiatrist policies on restraint authorised under s 273 of the *Mental Health Act 2016* (QLD): mechanical restraint, seclusion, physical restraint and clinical need for medication. The use of restraint is further outlined at Chapter 8.

[xiii] Guiding Principles at s 7 of the *Mental Health Act 2009* (SA) include 'restrictive practices should be used only as a last resort for safety reasons and not as a punishment or for the convenience of others' (s 7(h)); this is reiterated at part 4.3 of the Chief Psychiatrist Guidelines on Restraint and Seclusion, which states 'It is an intervention of last resort to control imminent or actual risk to self or others' - and includes the Mandatory Requirement 11: 'Restraint is used as an option of last resort.'

[xiv] Under Direction 1 of the Chief Civil Psychiatrist Standing Order 10 – Chemical Restraint and Direction 1 of the Chief Civil Psychiatrist Standing Order 10A - Mechanical and Physical Restraint (made pursuant to the *Mental Health Act 2013* (Tas)), 'The decision to physically or mechanically restrain a patient must

only be made after less restrictive interventions and de-escalation techniques have been tried without success, or when these have been considered but excluded as inappropriate or unsuitable in the circumstances.'

[xv] Under the *Mental Health Care Act 2014* (Vic), physical or mechanical restraint may only be used 'after all reasonable and less restrictive options have been tried or considered and have been found to be unsuitable' (s 105).

[xvi] A person cannot give an oral authorisation or make a bodily restraint order in respect of a person unless satisfied 'there is no less restrictive way of providing treatment or preventing the injury or damage.' (*Mental Health Act 2014* (WA), s 232(1)(b)).

[xvii] Under the *Senior Practitioner Act 2018* (ACT), restrictive practices can only be used on a person in accordance with their registered positive behaviour support plan (s 10). A positive behaviour support plan will only be approved if there is satisfaction that any restrictive practice included in the plan is necessary to prevent harm to the person or others (s 14(2)(b)). It is an offence to use a restrictive practice on a person where it is not permitted under their registered positive support plan (s 46(1)(b). However, it is a defence to this offence if the defendant proves that they believed, on reasonable grounds, that the restrictive practice was necessary to prevent serious and imminent injury to any person (s 46(2)).

[xviii] S 81(2) of the Mental Health Act 2007 (NSW) provides '[r]easonable force and restraint is also permitted for the purpose of transporting persons to and from mental health facilities and other health facilities'.

[xix] Restraint is also allowed on the grounds of preventing the patient from persistently destroying property (s 61(3)(c)) *Mental Health and Related Services Act 1998* (NT).

[xx] Restraint is also allowed on the grounds of preventing the patient from causing serious damage to property *(Mental Health Act 2016* (QLD), s 270(c)).

[xxi] Restraint may also be used as reasonably required for 'carrying the inpatient treatment order applying to the patient into effect, and ensuring compliance with the [*Mental Health Act 2009* (SA)]' (s 34A(2)(a)), and 'for the maintenance of order and security at the centre or the prevention of harm or nuisance to others.' (*Mental Health Act 2009* (SA), s 34A(2)(b)).

[xxii] In addition to the general grounds prescribed reasons for placing a patient under restraint (which include facilitating the patients treatment to ensure patient's health or safety, to ensure the safety of other persons, or to effect the patient's transfer to another facility, per s 57(6)), forensic patients may also be restrained placed in emergency short-term restraints to prevent the patient from damaging, or interfering with the operation of, a facility or any equipment; to break up a dispute or affray involving the patient; or to ensure, if he or she is uncooperative, the patient's movement to or attendance at any place for a lawful purpose (*Mental Health Act 2013* (Tas) s 57(4)(b)-(d)).

[xxiii] Restrictive interventions may only be used if it is 'necessary to prevent imminent and serious harm to the person or to another person' the *Mental Health Care Act 2014* (Vic) s 110). S 113 of the Act provides bodily restraint may be used on a person receiving mental health services in a designated mental health service if the bodily restraint is necessary to prevent imminent and serious harm to the person or to another person; or to administer treatment or

medical treatment to the person. S 350 of the Act states bodily restraint can also be used when taking a person to or from a designated mental health care service or any other place, provided it is reasonable and no other less restrictive options are suitable; and the restraint is necessary to prevent harm.

[xxiv] Restraint may also be used to prevent the patient from persistently causing serious damage to property (*Mental Health Act 2014* (WA) s 232(1)(a)(iii)).

[xxv] Under the *Senior Practitioner Act 2018* (ACT), restrictive practices can only be used on a person in accordance with their registered positive behaviour support plan (s 10). The panel may only approve the positive behaviour support plan if it is satisfied that any restrictive practice included in the plan is the least restrictive approach reasonably available (s 14(2)(b)).

[xxvi] The Policy Directive states that seclusion or restraint must be for the minimum amount of time, and any restraint must be the least restrictive to ensure safety (Part 4.3, at p 12).

[xxvii] S 61(3) and s 62(3) of the *Mental Health and Related Services Act 1998* (NT) provide mechanical restraint or seclusion (respectively) may only be applied when it is necessary for the purposes listed at (a)-(d).

[xxviii] The Chief Psychiatrist's policies on seclusion, physical restraint and mechanical restraint states that the use of force should be for the minimum period of time necessary (at Part 1, p 1).

[xxix] The Principles in the Restraint and Seclusion in Mental Health Services Policy Guideline states mechanical body restraints and seclusion can only be used 'as a last resort for safety reasons and not as a punishment or for the convenience of others'. Part 4.7.3, the Minimising Restrictive Practices in Health Care Policy Directive states 'any use of restraint should be reasonable in the circumstances and use the minimum amount of force or sedation for the shortest duration required in response to the threat or risk of harm.'

[xxx] Under the *Mental Health Act 2013 (*TAS), an involuntary patient, who is not a forensic patient, may be placed in seclusion if the seclusion is authorised as being necessary for a prescribed reason by the Chief Civil Psychiatrist (CCP), a medical practitioner or approved nurse (s 56(1)(b)(ii)) and if the person authorising the seclusion is satisfied that it is a reasonable intervention in the circumstances (s56(1)(c)). Further, the period of seclusion must not exceed the period authorised under section 56 (s 56(1)(d)). The Act also provides that an involuntary patient, who is not a forensic patient, may be placed under restraint if the restraint (including both chemical and physical restraint) is authorised as being ‘necessary for a prescribed reason’ by a Chief Civil Practitioner; and in the case of physical restraint, may also be authorised by a medical practitioner or an approved nurse (s 57(1)(b)). The person authorising physical restraint must also be satisfied that the restraint is a reasonable intervention in the circumstances. (s 57(1)(c)) – and the restraint must not exceed the period authorised under the section 57 (s 57(1)(d)).

[xxxi] S 113 of the *Mental Health Care Act 2014* (Vic) provides 'A restrictive intervention may only be used on a person receiving mental health services in a designated mental health service after all reasonable and less restrictive options have been tried or considered and have been found to be unsuitable.' This can be read alongside the General Principles at section 11, which includes 'persons receiving mental health services should be provided assessment and

treatment in the least restrictive way possible with voluntary assessment and treatment preferred' (s 11(a)), placing an obligation on mental health service providers to apply the minimum necessary restraint in their provision of mental health services (s 11(2)).

[xxxii] At s 228 of the *Mental Health Act 2014* (WA), Principles relating to use of bodily restraint state the degree of force used to restrain the person must be the minimum that is required in the circumstances; and while the person is restrained, there must be the least possible restriction on the person's freedom of movement consistent with the person's restraint; and the person must be treated with dignity and respect.

[xxxiii] Under the *Mental Health Act 2015* (ACT), s 65(5); s 73(5): If the chief psychiatrist or care coordinator subjects a person to restraint, involuntary seclusion or forcible giving of medication, they must make a record of the use of force (including reasons for same), tell the public advocate of the use of force, and maintain a register of the restraint, seclusion or forcible giving of medication.

In terms of external reporting, under s 20(b) of the *Senior Practitioner Act 2018* (ACT), a service provider must notify the senior practitioner about the use of restrictive practices in accordance with the guidelines made under s12. According to s 12(1)(e) the senior practitioner must make guidelines about positive behaviour support plans, including notifying the senior practitioner about the use of restrictive practices under plans. Depending on the guidelines made, a service provider may not necessarily need to notify the senior practitioner every time a restrictive practice is used.

[xxxiv] The Policy only requires each incident to be reported in an internal register, which is made available to the Official Visitor to review (Part 5.3, p 25); however there is no requirement under the Policy Directive for each incident of restraint or seclusion to be reported to an external body.

[xxxv] In cases where a patient has been mechanically restrained or secluded, a record must be made and placed on the patient's medical record, and the principal community visitor must ensure that the record is inspected by a community visitor at intervals not longer than 6 months (ss 61(12)-(14), and 62(12)-(14)) *Mental Health and Related Services Act 1998* (NT).

[xxxvi] The use of restraint must only be reported when it results in the death of a patient: Under the Chief Psychiatrist's policies relating to restrictive practices (namely Mechanical Restraint policy, Physical restraint policy, Seclusion policy and Clinical Need for Medication policy), an incident of use of a restrictive practice must be reported to the Chief Psychiatrist where it results in, or is associated with the death of a patient during or within 24 hours, or significant harm to a patient or other person during physical restraint or within 24 hours. This data is then publically reported in the Chief Psychiatrist Annual Report in accordance with national standards (as at March 2017).

[xxxvii] Per Mandatory Requirement 14 of the Principles in the Restraint and Seclusion in Mental Health Services Policy Guideline, every use of restraint must be recorded. Under the Restraint and Seclusion Recording and Reporting Chief Psychiatrist Standard (under review from February 2017) and Fact sheet 8: Restraint and Seclusion Reporting, 'critical incidents' must be reported.

[xxxviii] Where a patient is placed in seclusion or under restraint, the person who authorises the seclusion or restraint must make an appropriate internal record of the matter give a copy of the record to the Chief Civil Psychiatrist and the Tribunal (ss 58 and 96 of the *Mental Health Act 2013* (Tas)).

[xxxix] S 108 of the *Mental Health Care Act 2014* (Vic) states an authorised psychiatrist must give a written report to the chief psychiatrist on the use of any restrictive intervention on a person in a designated mental health service. This report must contain the details required by the chief psychiatrist and be given to the chief psychiatrist within the time stipulated by the chief psychiatrist (s 108(1)-(2)).

[xl] Reporting of seclusion and restraint episodes to the Chief Psychiatrist through Approved Forms is mandatory (the *Mental Health Act 2014 (*WA) s 224 and s 240 respectively). Where a patient has been secluded, the treating psychiatrist or person in charge of the authorised hospital must as soon as practicable provide certain documents (set out in s 224(3)) to the Chief Psychiatrist, and if the person is a mentally impaired accused — the Mentally Impaired Accused Review Board (s 224(2)). The same requirements apply to the use of restraint (s. 240(2)-(3)). S 254 sets out a Duty to report certain incidents - specifically at s (1)(c) regarding the unreasonable use of force on the person by a staff member of a mental health service - in relation to a person for whom the Chief Psychiatrist is responsible under s 515(1) who is being provided with treatment or care by the mental health service; the person must report the suspicion to either the person in charge of the mental health service; or the Chief Psychiatrist (penalty - a fine of $6,000, s 254(2)). See also policy on Reporting of Notifiable Incidents: https://www.chiefpsychiatrist.wa.gov.au/standards-guidelines/policy-for-mandatory-reporting-of-notifiable-incidents-to-the-chief-psychiatrist/

[xli] Chemical restraint is listed as a restrictive practice in the *Senior Practitioner Act 2018* (ACT), s 7(1)(b)(i)). Chemical restraint is defined as meaning the use of a chemical substance that restricts or subdues a person's movement; but does not include the use of a chemical substance that is (i) prescribed by a medical practitioner or nurse practitioner for the treatment, or to enable the treatment, of a mental or physical illness or condition in a person; and (ii) used in accordance with the prescription (s 7(2)).

[xlii] The *Mental Health Act 2007* (NSW) states that 'medication should only be given for therapeutic and diagnostic needs, not as a punishment or for the convenience of others' (s 68(c)). Under s 81(3) of the Act, a person may be sedated by an authorised person for the purpose of being taken to or from a mental health facility (or other health facility) if it is necessary to do so, to enable to person to be transported safely. The Policy Directive does not allow for the use of medication solely to restrict the movement or freedom of a consumer, or the overuse of sedation as a form of restraint. It does however allow the use of sedative medication or the management of disturbed behaviour.

[xliii] Under s 272 of the *Mental Health Act 2016* (QLD), a person must not administer medication (including sedation) to a patient unless it is clinically necessary for the patient's treatment and care for a medical condition. However, the Act specifies that a patient's treatment and care for a medical condition includes preventing imminent serious harm to the patient or others (s 272(3)). The administering of medication is then outlined under Chief Psychiatrist policy on the 'clinical need for medication'.

[xliv] Under the s 3(1) of the *Mental Health Act 2009* (SA), 'restrictive practice' is defined to include 'the use of chemical means to restrain the patient'. The use of chemical restraint is further outlined under the Restraint and Seclusion in Mental Health Services Policy Guideline (under review from 31 May 2018), at Part 4.3.4 (p 13), which states medication must be for therapeutic purposes (consistent with Personal Prevention Plan) or standard sedation protocols (outlining safety reasons); and that sedation protocols informed by current evidence and best practice must be in place within the treatment centre (mandatory requirements 16 and 17, respectively). Further, under s 56(3)(d) of the Act, an authorised officer (defined under s 3(1) to include a mental health clinician, an ambulance officer, a person employed as a medical officer or flight nurse on a Flying Doctor service, a person or person of a class approved by the Chief Psychiatrist, or any other person or person of a class prescribed by the regulations) may restrain a person who appears to have a mental illness, by means of the administration of a drug when that is reasonably required in the circumstances (outlined at s 54A(1) or s 55(1)).

[xlv] The *Mental Health Act 2013* (TAS), chemical restraint is defined as medication given primarily to control a person's behaviour, not to treat a mental illness or physical condition (s 3(1)). Chemical restraint is included under restraints generally (under s 57(1)), except for the specific requirement that chemical restraint be authorised by the Chief Civil Psychiatrist (CCP) (s 57(1)(b)(i))/ Chief Forensic Psychiatrists (CFP) (s 95(1)(a)(i)) (and not by a medical practitioner or nurse).

[xlvi] The use of sedatives is only regulated at Division 3 of the *Mental Health Care Act 2014* (Vic), specifically in the context of 'Bodily restraint and sedation...when taking [a] person' to and from a designated mental health care service or other place - in which case a registered medical practitioner may administer sedation to the person or direct a registered nurse or ambulance paramedic to administer sedation to the person if all reasonable and less restrictive options have been tried or considered and have been found to be unsuitable; and the sedation to be administered is necessary to prevent serious and imminent harm to the person or to another person (s 350(1)(b)).

[xlvii] The *Mental Health Act 2015* (ACT) only provides a minimum time period for monitoring: both s 65(3) regarding Psychiatric Treatment Orders and s 73(3) regarding Community Care orders provide that a person subjected to involuntary seclusion must be examined by a relevant doctor of the relevant place at least once within a 4-hour period.

[xlviii] According to the policy, seclusion should be used for the ‘minimum necessary time’. At 4.8.3, the Policy Directive on Aggression, Seclusion & Restraint in Mental Health Facilities in NSW (PD2012_035) directs the Medical Officer (M.O.) to conduct a physical examination at four hours after the intervention, and every four hours until the intervention is ceased (page 16). If a consumer is in a mechanical restraint, part 4.9 of the Policy also directs staff to release the restraints each hour for a minimum of 10 minutes to allow motion exercising and skin integrity checks (p 18).

[xlix] Although at s 62(6), the *Mental Health and Related Services Act 1998* (NT) states that the period of seclusion must be determined and noted in the patient's case notes by the authorised psychiatric practitioner or senior registered nurse. The Act outlines intervals at which a patient in seclusion must be visited by a registered nurse (every 15 minutes), and that the patient is regularly examined at intervals specified in approved procedures (s 62(8)(a) and (b)). At s 62(10), 'a patient admitted as a voluntary patient must not be kept in seclusion for longer than continuous period of 6 hours. The Act also provides a patient must not be kept in seclusion for longer than necessary, per the medical practitioner, senior registered nurse on duty or authorised psychiatric practitioner is satisfied (s 62(11)).

[l] The Chief Psychiatrist policy on Seclusion provides that an individual authorisation of seclusion must not exceed three hours, however a subsequent authorisation may immediately follow a previous authorisation, provided the total seclusion time in a 24 hour period is not more than nine hours. Seclusion may exceed nine hours in a 24 hour period if an approved s 267 reduction and elimination plan provides as such. An authorised doctor may extend seclusion beyond nine hours in a 24 hour period for a further period of up to 12 hours, under certain conditions set out in the Act.

[li] The *Mental Health Act 2009* (SA) does not impose any specific limit on period of isolation - the only time frames provided relate to the observation requirements i.e. The Guidelines on Restraint and Seclusion outline observation requirements (part 4.4 on Seclusion, page 15-16); reiterated in Part 4 (page 4) of the Restraint and Seclusion Application and Observation Requirements Chief Psychiatrist Standard states 'Continuous observation for the period of the seclusion with 15 minute documentation of behaviour.'

[lii] The seclusion must not extend beyond 7 hours unless: (i) the patient has been examined by a medical practitioner within those 7 hours; and (ii) the extension is authorised by the Chief Civil Psychiatrist (CCP) within those 7 hours; and (iii) if applicable, each subsequent extension (regardless of duration) is also authorised in advance by the CCP; and (e) the CCP may impose conditions on any extension authorised under paragraph (d); and (f) the CCP, on authorising an initial extension of the seclusion, must stipulate the maximum time frame for its continuance (s 56(2)(d) of the *Mental Health Act 2013* (TAS)).

[liii] Restrictive interventions in designated mental health services notes observation requirements at page 8. During the use of seclusion, a registered nurse or registered medical practitioner must undertake an assessment to determine the clinical observation frequency, but this should not occur less than every 15 minutes (the *Mental Health Care Act 2014* (Vic) s 112(2)). If the observation indicates the need for more frequent observations (than every 15 minutes), then this must occur.'

[liv] The *Mental Health Act 2014* (WA) outlines a two hour maximum time limit for seclusion, with examination by a medical practitioner required before any further extension (to a maximum of two hours) is allowed (s218 Extending seclusion order). The Act includes provisions relating to observation requirements at s 222(3)-(4).

[lv] The Policy Directive outlines food, hydration, toileting facilities, clothing, and personal items are covered (at Part 4.9, p 17 and Part 4.11, p 20-21). The Directive also includes other requirements i.e. information that must be provided to a person in seclusion (at Part 4.7, p 14-15).

[lvi] S 62(8) of the *Mental Health and Related Services Act 1998* (NT) outlines the minimum conditions for a patient kept in seclusion - including bedding and clothing, food and drink, adequate toilet facilities and any other psychological and physical care appropriate to the patient's needs.

[lvii] S2 60(b) provides a patient kept in seclusion must have their reasonable needs met, including sufficient bedding and clothing, sufficient food and drink, and access to toilet facilities. This is reiterated throughout the Chief Psychiatrist policy on seclusion.

[lviii] At Part 4.4.1 of the Restraint and Seclusion in Mental Health Services Policy Guideline (under review from 31 May 2018) (pp 15-16)
And at Part 4.4 of the Policy Guideline - Restraint and Seclusion in Mental Health Services.

[lix] The *Mental Health Act 2013 (*TAS) outlines that if an involuntary patient, who is not a forensic patient, is placed in seclusion under s 56, they must be provided with minimum conditions listed at s 56(2)(g).

[lx] S 106 of the *Mental Health Act 2014* (VIC) states that any person who authorizes a restrictive practice (including seclusion) ‘must ensure that the person's needs are met and the person's dignity is protected by the provision of appropriate facilities and supplies.’ The Act does not however specify what facilities and supplies are appropriate.

[lxi] S 222(5) of the *Mental Health Act 2014* (WA) outlines the minimum conditions for isolation: including bedding, food and drink, toilet facilities and any other care appropriate to the persons needs.

[lxii] The policy directive states the Chief Executive must ensure that all staff are made aware of their obligations regarding this policy and procedure through staff education (at p 2) - however specific requirements of that training or education are not listed.

[lxiii] Chief Psychiatrist policies on seclusion, physical restraint and medical restraint include minimum requirements for staff training to include appropriate training 'to protect the welfare and dignity of the patient (for staff using restraint under the Act, training must include de-escalation strategies, physical restraint techniques, trauma-informed care, recovery-oriented practice and de-briefing strategies). The Chief Psychiatrist practice guidelines on mechanical restraint states, as a minimum requirement, that relevant staff have been provided specific training in relation to the use of the approved mechanical restraint device (Part 1.1, p 4)

[lxiv] The Principles in the Restraint and Seclusion in Mental Health Services Policy Guideline includes the Mandatory Requirement 12, that 'Restraint is administered safely by a team trained in application of method used.'

[lxv] Chief Civil Psychiatrist Clinical Guideline 10 and 10A on Chemical Restraint, and Mechanical and Physical Restraint provides 'Staff members who are directly involved in the provision of patient care should ensure that they receive specific training in how to ensure that mechanical and/or physical restraint is used minimally and safely, and in de-escalation techniques.'

[lxvi] S 121 of the *Mental Health Care Act 2014* (Vic) outlines the Functions of the chief psychiatrist, which includes the development of appropriate guidance, standards (and ensuring compliance with same) and education for mental health service staff (s 121(1)(a)-(c). The chief psychiatrist has issued guidelines for 'Restrictive interventions in designated mental health services 'which includes minimum staff training and education requirements (at p 7).

[lxvii] The Chief Psychiatrist Standards on Clinical Care (as required under s 547 of the *Mental Health Act 2014* (WA)) include the standard on 'Seclusion and Bodily Restraint Reduction', which includes the requirement of training for all relevant staff - specifically an approved age-appropriate training program for prevention of aggression and early intervention in a crisis situation, and the necessary elements of the training (pp 19-21).

[lxviii] Part 12.3 of the *Mental Health Act 2015* (ACT) outlines the official visitors scheme; see also the *Official Visitor Act 2012* (ACT).

[lxix] Part 3 of the *Mental Health Act 2007* (NSW) outlines the official visitors scheme.

[lxx] Part 14 of the *Mental Health and Related Services Act 1998* (NT) outlines the Community Visitors scheme.

[lxxi] See the *Public Guardian Act 2014* (QLD).

[lxxii] The Community Visitor Scheme is outlined at Division 2 of the *Mental Health Act 2009* (SA).

[lxxiii] Official Visitors scheme is set out at Part 2 of the *Mental Health Act 2013* (TAS).

[lxxiv] Part 9 of the *Mental Health Care Act 2014* (Vic) sets out the Community visitors scheme.

[lxxv] Part 20 of the *Mental Health Act 2014 (*WA) outlines the mental health advocacy services which includes the appointment of the Chief Mental Health Advocate under s 349. The functions of the advocacy services are outlined at s 351 and s 352 of the Act.

[lxxvi] If informal processes and the collaborative review processes are unsuccessful, the complaint will be managed in line with the requirements of PD2006_073 Complaint Management Policy and GL2006_023 Complaint Management Guidelines.

[lxxvii] At Part 13 of the *Mental Health and Related Services Act 1998* (NT) regarding Internal Complaints Procedures, s 100(10) provides 'Where the person-in-charge of an approved treatment facility or an approved health care agency considers, after an investigation of a complaint under this section, that a person (a) may have committed a criminal offence; or (b) may have committed a breach of discipline, as defined in section 3(1) of the Public Sector Employment and Management Act 1993; or (c) may be guilty of professional misconduct; the person-in-charge must inform the CEO.' Under s 100(11), the CEO must immediately, on being informed under subsection (10) either (a) notify a police officer; or (b) under subsection (10)(b), take appropriate action under Part 8 of the Public Sector Employment and Management Act 1993; or (c) under subsection (10)(c), notify the relevant professional body.

[lxxviii] Under the Chief Psychiatrist's Management of Complaints about Treatment and Care of Patients Policy (as at 5 March 2017) per s 305(1)(c) of the *Mental Health Act 2016* (QLD), AMHS administrator must notify the Chief Psychiatrist of complaints relating to significant non-compliance with the Act and for specified critical incidents.

[lxxix] The SA Health Consumer Feedback Management Policy Guideline and Toolkit states '[c]onsumer feedback should be dealt with by the unit involved where possible, with support from a supervisor, line manager or Consumer/Patient Adviser. However, for more serious matters or those with broader implications for the health service, senior management and the executive must be notified and participate in the resolution' (at 2.11, p 2). Part 4.3.6 of the Policy Guidelines state '[t]he seriousness of the complaint should be rated by using the Seriousness Assessment Matrix (SAM)', which is provided at Appendix 3.

[lxxx] See Part 10 of the *Mental Health Care Act 2014* (Vic) regarding complaints processes.

[lxxxi] Part 19 of the *Mental Health Act 2014* (WA) outlines the complaints process, which can involve Director of the Health and Disability Services Complaints Office appointed under the Health and Disability Services (Complaints) Act 1995 section 7(1). S 309 in particular provides 'Prescribed service providers (defined by regulations under the section) must provide the Director [of Health and Disability Services Complaints office] with information about complaints.'

[lxxxii] The *Senior Practitioner Act 2018* (ACT) outlines offences with respect to using restrictive practice other than under positive behaviour support plan at Part 8 - however this part is not yet in force. Section 46(1) provides that a provider, or a relevant person for a provider, commits an offence if (a) the provider or relevant person uses a restrictive practice on another person; and (b) the use of the restrictive practice, or the way in which the restrictive practice is used, is

not permitted under a registered positive behaviour support plan for the other person. The maximum penalty is 50 penalty units, imprisonment for 6 months or both. S 46(2) outlines it is a defence to a prosecution for an offence against this section if the defendant proves that the defendant believed on reasonable grounds that the restrictive practice was necessary to prevent serious and imminent injury or illness to any person; while s 46(3) provides the exemption that this section does not apply to a relevant person for a provider if the person was acting reasonably under the instruction or direction of the provider or otherwise in accordance with the provider's policy.

[lxxxiii] S 69 of the *Mental Health Act 2007* (NSW) Provides an authorised medical officer or a staff member at a facility must not wilfully strike, wound, ill-treat or neglect a patient or person detained in a mental health facility (maximum penalty is 50 penalty units or imprisonment for 6 months, or both). Staff may also be criminally liable for up to 50 penalty units if the use of chemical restraint involves administering, or causing to be administered, to a person, a drug or drugs in a dosage that, having regard to professional standards, is excessive or inappropriate (s 85 of the *Mental Health Act 2007* (NSW).

[lxxxiv] Under the *Mental Health and Related Services Act 1998* (NT), s 61(2) states a person must not apply a mechanical restraint to a patient (maximum penalty is 40 penalty units), and s 62(1) states a person must not keep a patient in seclusion (maximum penalty is 40 penalty units).

[lxxxv] The *Mental Health Act 2016* (QLD) makes it an offence to use physical restraint (s269), mechanical restraint (s 245), or seclusion (s 255), contrary to the Act (maximum penalty—200 penalty units) or to administer medication to a patient unless the medication is clinically necessary for the patient's treatment and care for a medical condition (s 272(1)(maximum penalty—200 penalty units). Note that patient care for a medical condition can include the use of chemicals (i.e., sedation) to a prevent 'imminent serious harm to the patient or others' (s 272(2)). The Act also includes an offence relating to ill-treatment of a patient, including to wilfully abuse, neglect or exploit at s621 (maximum penalty is 2 years imprisonment or 200 penalty units).

[lxxxvi] Although the *Mental Health Act 2009* (SA) does not make it an offence to use restraint or seclusion contrary to the Act, s 49 creates an offence for the wilful neglect or ill-treatment by a person having 'oversight, care or control of a patient' - which has a broad scope. This provision carries a maximum penalty of $25,000 or 2 years' imprisonment.

[lxxxvii] Although the *Mental Health Act 2013* (Tas) does not make it an offence to use restraint or seclusion contrary to the Act, s 214 makes it an offence to intentionally ill-treat a person knowing that the person has a mental illness, and is, in consequence of the mental illness, unable to take proper care of himself or herself. The offence carries a penalty of a fine not exceeding 50 penalty units or imprisonment for a term not exceeding 2 years, or both.

[lxxxviii] However see Division 5 of the *Mental Health Care Act 2014 (*Vic) for Compliance notices scheme - which outlines the framework for non-compliance with an undertaking given under s 243 with regards to notices to complaints. Under this scheme, it is an offence not to comply with compliance notice - 240 penalty units (s262).

[lxxxix] S 213 of the *Mental Health Act 2014* (WA) provides seclusion must be authorised - A person must not keep another person in seclusion except in accordance with an oral authorisation or a seclusion order (penalty: a fine of $6000). S 229 provides bodily restraint must be authorised - A person must not use bodily restraint on another person except in accordance with an oral authorisation or a bodily restraint order (penalty: a fine of $6 000). More generally: s 253 provides Duty not to ill-treat or wilfully neglect patients: A staff member of a mental health service must not ill-treat or wilfully neglect a person for whom

the Chief Psychiatrist is responsible under s 515(1) who is being provided with treatment or care by the mental health service. Penalty: a fine of $24 000 and imprisonment for 2 years.

[xc] Under s 23 of the *Mental Health Act 2015* (ACT) a nominated person (defined at s22) and under s 265 of the Act the officials (defined at s 265(3) to include chief psychiatrists, care coordinator or mental health officer) is exempt from civil liability for anything done or omitted to be done honestly and without recklessness in the exercise of their function under the Act, or in the reasonable belief that the act or omission was in the exercise of a function under this Act. Similarly, an official is not civilly liable for anything done or omitted to be done honestly and without recklessness (a) in the exercise of a function under this Act; or (b) in the reasonable belief that the act or omission was in the exercise of a function under this Act (*Senior Practitioner Act 2018* (ACT), s 51). Official means (a) the senior practitioner or (b) any other person exercising a function under this Act (s 51(3)).

[xci] The *Mental Health and Related Services Act 1998* (NT) immunity from suit provision states: '[n]o proceedings, civil or criminal, may be commenced or continued against a person for anything done in good faith and with reasonable care by the person in reliance on any authority or document apparently given or made in accordance with this Act' (s 164).

[xcii] S 797 of the *Mental Health Act 2016* (QLD) provides protection of official from civil liability for an act done, or omission made, honestly and without negligence under this Act (s 797(1)).

[xciii] Under s 218 of the *Mental Health Act 2013* (Tas), an official does not incur any personal liability for any act done or purported or omitted to be done in good faith in the discharge of their responsibilities, and no civil or criminal proceedings lie against any person for anything done in good faith and with reasonable care in reliance on any order or document apparently given or made under the Act. A liability that would otherwise attach to an official attaches to the employer of the official.

[xciv] While the *Mental Health Care Act 2014* (Vic) includes provisions protecting officials from liability, these good faith exemptions apply only to the Commissioner, and members of the Board of Directors (s 231 and s 337, respectively).

[xcv] S 583 of the *Mental Health Act 2014* (WA) sets out protection from liability when performing functions: An action in tort does not lie against a person other than the State for anything that the person has done in good faith — a) in the performance or purported performance of a function under this Act; or b) in assisting another person in the performance or purported performance of a function under this Act. S 584 provides Protection from liability when detaining person with mental illness (specifically relating to authorised powers pertaining to reasonable suspicion of mental illness at subsection (2): No civil or criminal liability is incurred because the person who has that lawful charge in good faith detains, or continues the detention of, the person who has, or is reasonably suspected of having, a mental illness in order to prevent that person from leaving the particular place.