NSW Civil and Administrative Tribunal

New South Wales

Case Name:	HZC
Medium Neutral Citation:	[2019] NSWCATGD 8
Hearing Date(s):	1 April 2019
Date of Orders:	1 April 2019
Decision Date:	3 May 2019
Jurisdiction:	Guardianship Division
Before:	Mr M D Schyvens, Deputy President Dr M A Martin, Senior Member (Professional) Ms J Newman, General Member (Community)
Decision:	The guardianship order for HZC made on 13 April 2018 has been reviewed. The order now is as follows: 1. TYC and TXC are appointed jointly as the guardians. 2. This is a continuing guardianship order for a period of three years from 1 April 2019. 3. This is a limited guardianship order giving the guardian(s) custody of HZC to the extent necessary to carry out the functions below. FUNCTIONS: TYC and TXC 4. TYC and TXC have the following functions: a) Advocacy To advocate generally for HZC. b) Accommodation

To decide where HZC may reside.

c) Health care

To decide what health care HZC may receive.

d) Medical/Dental consent

To make substitute decisions about proposed minor or major medical or dental treatment, where HZC is not capable of giving a valid consent.

e) Services

To make decisions about services to be provided to HZC.

f) Restrictive Practices

To give or withhold consent as to whether the following restrictive practices should be used to influence HZC's behaviour :

1. Chemical restraint;
2. Environmental restraint;
3. Mechanical restraint; and
4. Seclusion.

CONDITIONS:

5. The conditions of this order are:

a) Standard Condition

In exercising this role the guardians shall take all reasonable steps to bring HZC to an understanding of the issues and to obtain and consider her views before making significant decisions.

b) Restrictive Practices Conditions

The guardians may only consent to the use of the types of restrictive practices permitted under this order to

	influence HZC's behaviour: (i) as a last resort to prevent HZC harming herself or others; and (ii) in accordance with a behaviour support plan which has been developed by a behaviour support practitioner after having conducted a functional behavioural assessment upon HZC, and which is reviewed regularly (and no less than every 12 months) and/or reviewed as soon as practicable if there is a change in circumstances which requires the plan to be amended.
Catchwords:	GUARDIANSHIP – End of term review of guardianship order –guardianship order renewed. GUARDIANSHIP – Restrictive practices– definition and nature of restrictive practices – categorisation of various restrictive practices – relationship between restrictive practices and NDIS Rules – relevance of definitions in Commonwealth legislation to New South Wales – use of NDIS definitions of restrictive practices in NCAT guardianship proceedings. GUARDIANSHIP – Restrictive practices – use of chemical restraint – relationship between use of chemical restraint and person responsible regime – inadequacy of person responsible regime to facilitate consent to use of chemical restraint – necessity for guardian with restrictive practices function to be appointed in order to make decisions about the use of chemical restraint – importance of consent to use of restrictive practices.
Legislation Cited:	Guardianship Act 1987 (NSW), ss 3(1), 3(2), 4, 14(1), 15(4), 16(1), 33A, 33A(1), 33A(4), 42, Pt 5 National Disability Insurance Scheme Act 2013 (Cth), ss 9, 73J National Disability Insurance Scheme (Restrictive Practices and Behaviour Support) Rules 2018 (Cth), rr 6, 9, 10(2), 18, 20(5), 22, Pt 2.
Cases Cited:	Chapman v South Eastern Sydney Local Health District [2018] NSWSC 1231 MAW v Western Sydney Area Health Service [2000]

	NSWSC 358 MZC [2018] NSWCATGD 34
Texts Cited:	N/A
Category:	Principal judgment
Parties:	HZC (the person) TYC (appointed guardian, mother) TXC (appointed guardian, father) The Public Guardian of NSW
Representation:	N/A
File Number(s):	NCAT 2017/00198184
Publication Restriction:	Decisions of the Guardianship Division of the Civil and Administrative Tribunal have been anonymised to remove any information that may identify any person involved in the Tribunal's proceedings (s 65, Civil and Administrative Tribunal Act 2013 (NSW)).

REASONS FOR DECISION

END OF TERM REVIEW OF GUARDIANSHIP ORDER

Decision Summary

1 We decided to renew the appointment of TXC and TYC as the guardians for their daughter, HZC. HZC, who is 21 years of age and has been diagnosed with a severe intellectual disability with a history of severe global developmental delay, lives in supported accommodation, where service providers assist her in most of her activities of daily living.

2 In the course of that support, HZC's service providers use what are called "restrictive practices," that is, practices which restrict her rights, freedom of movement and access to objects. They do that because at times HZC engages in behaviour which might otherwise cause harm to her or to others.

3 As part of our decision we have decided that the definitions of restrictive practices contained in relatively new Commonwealth legislation, which now applies in the regulation of National Disability Insurance Scheme ("NDIS") service providers in New South Wales, should also be used by this Tribunal when considering matters before us where there is evidence that such

practices are being used on a person with a disability and who is unable to provide their own consent.

4 We have also decided that the use of medications primarily to control someone's behaviour, rather than to treat a diagnosed medical condition, is a matter which requires the consent of a guardian with authority to decide about the use of restrictive practices if the person is unable to provide their own consent. The use of medications in these circumstances should not be categorised as only requiring consent to medical treatment which would permit a person responsible to give consent.

Background

5 HZC lives in fully-supported accommodation in [suburb of greater Sydney], NSW, provided by a registered NDIS service provider.

6 HZC is diagnosed with 1p36 deletion syndrome which is a congenital genetic syndrome associated with a number of medical complications including seizures, cardiac abnormalities, cardiomyopathy, developmental delay, hearing impairments, cleft palate, hypothyroidism and strabismus.

7 Medical reports indicate that as a result, HZC did not develop as she otherwise would have and that she has a severe intellectual disability.

8 It is reported that HZC is limited in her ability to understand and use language to express herself and has difficulty understanding information, particularly when concepts are new, abstract or where several pieces of information are presented to her at once.

9 The opinion of those who treat HZC is that she also has an anxiety disorder, meaning she persistently experiences worry about aspects of her life including her social relationships and daily routine. This causes her distress and disruption to her ability to complete her regular activities. Her anxiety is said to affect her physically in that she experiences restlessness, tension and sleep disturbance which also impacts upon her mood, resulting in irritability and episodes of heightened distress. During those episodes, HZC can behave in a dysregulated, aggressive manner that places her and others at risk of harm.

10 Since 2017, the Tribunal has made and renewed guardianship orders appointing HZC's parents, TXC and TYC, as her guardians; most recently with the authority to make decisions about her accommodation, health care, to consider consent to medical and dental treatment, restrictive practices, the services she receives, and to advocate generally on her behalf.

11 The hearing listed before us was an end of term review of the last guardianship order.

The hearing

12 At the end of these Reasons for Decision is a list of the people who attended the hearing. [Removed for publication.]

13 The Tribunal actively sought HZC's participation in the hearing. HZC was not able to attend due to the difficulty she experiences when dealing with new or unusual situations. We were, however, able to endeavour to engage with her briefly via Skype, from her accommodation, facilitated by TYC. HZC quickly disengaged from that process and did not participate in the balance of the hearing. We were unable to obtain her views about the matters we needed to consider.

What did the Tribunal have to decide?

14 On reviewing the current guardianship order, the Tribunal may renew the order, renew and vary the order, or determine that the order is to lapse.

15 The questions to be considered by the Tribunal are:

- Is HZC someone for whom the Tribunal could make an order because she continues to have a disability which prevents her from being able to make important life decisions? The precise test is referred to below.
- Should the Tribunal make a further guardianship order and if so, what order should be made?
- Who should be the guardian and how long should the order last?

Is HZC someone for whom the Tribunal could renew an order?

16 By s 14(1) of the Guardianship Act 1987 (NSW) ("the Act") we have power to renew a guardianship order for HZC if we are satisfied that she is "a person in need of a guardian".

17 A person in need of a guardian is “a person who because of a disability is totally or partially incapable of managing his or her person”: s 3(1) of the Act. The disability must restrict them in one or more major life activities to such an extent that they require supervision or social habilitation: s 3(2) of the Act.

18 On two previous occasions, the Tribunal, having regard to the evidence before it, concluded that HZC is a person in need of a guardian. Whilst we had no updated medical evidence, we had the benefit of an updated Behaviour and Incident Support Plan, prepared for the support of HZC, which records that there has been no change to HZC’s diagnoses and that, as a result, HZC continues to have challenging behaviours which restrict her in some life activities to the extent that she needs supervision and has a partial inability to manage her person.

19 Everyone who attended the hearing and spoke to this issue, other than HZC who did not comment, agreed that this remains the case.

20 We are satisfied by this evidence that HZC remains a person for whom we could renew the guardianship order if satisfied we should do so. To use the words contained in the Act, HZC is a person in need of a guardian.

Should the Tribunal make a guardianship order and what order should be made?

21 When considering renewing the order, we needed to have regard to the views of HZC, if we were able to obtain them, and those of her parents. We were also required to consider the importance of preserving HZC’s existing family relationships and particular cultural and linguistic environments as well as the practicability of services being provided to her without the need for an order: s 14(2) of the Act.

22 These matters are in no particular order and each is a mandatory consideration. However, we must undertake a balancing exercise in our consideration of these matters. Of course, we also consider any other relevant evidence. In doing so, we are guided by the principles that are set out in s 4 of the Act.

23 HZC remains a particularly vulnerable member of our society. She is a young woman with very complex needs, which have, for some years, required a high

level of supervision and assistance including the use of restrictive practices in the way in which she is provided support. We will say more on this issue, as it is important and has been subject to relevant developments even since the making of the previous order of this Tribunal in April 2018, but for simplicity and clarity we will do so in a later part of these reasons.

24 At the hearing TXC and TYC confirmed that during the last year they have needed to continue to advocate for HZC and to make decisions around her accommodation, so that her support is not compromised by arrangements which they considered not to be in her best interests.

25 Similarly, they confirmed that there have been ongoing health care decisions and medical and dental consents required as, in addition to her other diagnosed conditions, HZC has also suffered a displaced patella which requires ongoing management.

26 Additionally, HZC is treated for anxiety with medications which constitute *major treatment*, as that term is defined in the Act and which require ongoing titration to ensure optimal benefit to HZC whilst minimising any side effects.

27 For those reasons we are satisfied that we should renew the guardianship order, giving the appointed guardians decision making functions in the areas of advocacy, accommodation, healthcare, medical/dental consent, provision of services and the use of restrictive practices. As to the nature of the restrictive practices function, we will refer further to that below.

Who should be appointed and for how long?

28 On previous occasions, the Tribunal has appointed TXC and TYC jointly as their daughter's guardians. They provided reports to the Tribunal regarding their ongoing decision making as guardians during the course of the last order and evidence at the hearing which made it extremely clear that they both maintain a close and ongoing relationship with their daughter and that they are intimately involved in considering and making decisions which are in her best interests. There was no suggestion that they should not be re-appointed. Nor were there other proposed appointees. We were satisfied that they remained appropriate for appointment jointly.

29 We needed to consider how long the order should be renewed for. Commonly, in the past, when considering restrictive practices the Tribunal has limited orders to 12 months.

30 This has been seen as an effective way of ensuring that the person's best interests are met through more regular review of the order and by bringing together all of those involved in supporting the person, including those who propose and implement the restrictive practices, in a way which facilitates ongoing consideration of the restrictive practices with a view to reducing or stopping their use.

31 As we will refer to shortly, there have been recent significant changes in the way restrictive practices are dealt with in NSW so far as they relate to service providers delivering services funded through the NDIS. For reasons we will deal with further it appears that, in circumstances such as these where TXC and TYC have a very clear and intimate understanding and knowledge of their roles as guardians in relation to making decisions about restrictive practices, there is no benefit to HZC in us limiting the order to 12 months. We were satisfied in the circumstances of this matter that it was appropriate to renew the order for three years.

EXPANDED REASONS REGARDING THE RESTRICTIVE PRACTICES USED WITH HZC

A brief history of the nature of restrictive practices, the role of the Tribunal and recent developments regarding the implementation of the NDIS

32 It has long been understood that some members of our society, who receive ongoing support in their activities of daily living, may engage in certain behaviours which involve physical or other risks to themselves and others and that responses need to be developed to reduce or remove those risks.

33 Over time, those behaviours have commonly been described as "challenging behaviours," or more recently, "behaviours of concern" and the practices used to reduce or prevent them have become known as "restrictive practices".

34 The Tribunal has for several years recognised that decision making about the use of restrictive practices is a matter which it should recognise as a specific function which might be assigned to a guardian, so that the guardian's role in

making decisions about such matters is clear and to avoid the use of plenary orders, as required by s 15(4) of the Act.

35 Similarly, over time, through clinical practice the nature of the restrictive practices which are used have been categorised and grouped in such a way as to allow their consistent description. Whilst there is a very broad range of restrictive practices which are used in the support of people with a disability, commonly used and understood terminology has developed.

36 NSW, however, has no legislative definition of restrictive practices or any of the subcategories of restrictive practice which are used in practice. As a result, the decisions of this Tribunal and the former Guardianship Tribunal of NSW have developed alongside clinical practice and have used the descriptions of the various practices that are understood within the disability support sector.

37 Since the advent of the NDIS, though, new Commonwealth legislation has been developed in the regulation of the support provided under the NDIS, particularly as it relates to the use of restrictive practices. The most significant change to the legislative arena brought about by the implementation of the NDIS is the commencement of the NDIS Quality and Safeguarding Framework which underpins the scheme.

38 As noted in *MZC* [2018] NSWCATGD 34 at [29] to [34], under that framework, states and territories are responsible for the authorisation of restrictive practices used by registered NDIS providers and behavioural support practitioners. Section 9 of the *National Disability Insurance Scheme Act 2013* (Cth) defines restrictive practices as “any practice or intervention that has the effect of restricting the rights or freedom of movement of the person with disability”. This is consistent with the common usage of the phrase by the Tribunal.

39 Since 1 July 2018, registered NDIS providers in NSW are regulated by the NDIS Quality and Safeguarding Commission (NDIS Commission) and are responsible to ensure that consent and authorisation is obtained for the use of all restrictive practices.

40 Registered NDIS providers and behavioural support practitioners must now comply with the requirements set by the NDIS Commission, including those outlined in the National Disability Insurance Scheme (Restrictive Practices and Behaviour Support) Rules 2018 (Cth) (the Rules), which commenced on 1 July 2018. The Rules state that a restrictive practice is a **regulated restrictive practice** if it is or involves any of the following (r 6):

> (a) seclusion, which is the sole confinement of a person with disability in a room or a physical space at any hour of the day or night where voluntary exit is prevented, or not facilitated, or it is implied that voluntary exit is not permitted;
>
> (b) chemical restraint, which 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;
>
> (c) mechanical restraint, which is the use of a device to prevent, restrict, or subdue a person's movement for the primary purpose of influencing a person's behaviour but does not include the use of devices for therapeutic or non-behavioural purposes;
>
> (d) physical restraint, which is the use or action of physical force to prevent, restrict or subdue movement of a person's body, or part of their body, for the primary purpose of influencing their behaviour. Physical restraint does not include the use of a hands-on technique in a reflexive way to guide or redirect a person away from potential harm/injury, consistent with what could reasonably be considered the exercise of care towards a person;
>
> (e) environmental restraint, which restrict a person's free access to all parts of their environment, including items or activities.

41 The Notes to r 7 of the Rules state that 'a registered NDIS provider may be liable to a civil penalty if the provider breaches a condition to which the provider's registration is subject (see s 73J of the *National Disability Insurance Scheme Act*)'.

42 Part 2 of the Rules sets out the conditions of registration that apply to all registered NDIS providers who use restrictive practices in the course of delivering NDIS supports. These conditions include requiring the use of restrictive practices to:

- not occur where the relevant State and Territory prohibits such use;
- be undertaken in accordance with State and Territory authorisation processes and a behaviour support plan; and
- be recorded by the provider and reported to the Commissioner.

43 Rule 9 relates to the use of a regulated restrictive practice in a State or Territory 'with an authorisation process (however described)' by a registered NDIS provider in that State. The Notes to r 9 of the Rules state:

> An authorisation process may, for example, be a process under relevant State or Territory legislation or policy or involve obtaining informed consent from a person and/or their guardian, approval from a guardianship board or administrative tribunal or approval from an authorised State or Territory officer.

44 This Commonwealth legislation, and the definitions it contains, is not binding on the Tribunal in its deliberations when considering whether it should appoint a guardian with the function of making decisions about restrictive practices.

45 Notwithstanding that, it would seem to us that there are sound reasons why it would be in the best interests of people with whom restrictive practices are being used in NSW, for there to be some consistency in the way the definitions are applied throughout the quality and safeguards arena and within the Tribunal.

What relevance do the definitions contained in the Commonwealth Legislation have in NSW?

46 The question for us is whether, having regard to the relevance and utility of the definitions in the Commonwealth legislation, is it in the best interests of people to whom the Act applies that the Tribunal uses those definitions? We must consider whether adopting those definitions would ensure that their welfare and interests are given paramount consideration: s 4(a) of the Act.

47 To do so, we must examine the definitions used in the *National Disability Insurance Scheme Act* and the Rules, to determine whether those definitions are:

(1) consistent with the jurisprudence already established by this Tribunal and the former Guardianship Tribunal of NSW in relation to the use of restrictive practices; and

(2) appropriate, on that basis or any other basis, for use by the Tribunal when considering these matters in the future.

48 HZC is subject to forms of restrictive practice across most of the recognised subcategories contained in the Rules. We will deal with each of those individually, in terms of the definitions applied under the Rules, and give our

view as to whether they are appropriate for adoption by this Tribunal in considering the appointment of guardians for restrictive practices.

49 The complications caused by the lack of legislative clarity and legislative comity in this area, though, are clear. The NSW community may well benefit from legislative attention being given to this issue.

Seclusion

50 When HZC's behaviour escalates, she is sometimes locked into part of her accommodation, alone. Staff speak with HZC through a window and remove this restriction when HZC's agitation subsides and they deem it safe to do so.

51 The Tribunal views seclusion as a restrictive practice. The definition of "seclusion" within the Rules as:

> … [T]he sole confinement of a person with disability in a room or a physical space at any hour of the day or night where voluntary exit is prevented, or not facilitated, or it is implied that voluntary exit is not permitted;

is consistent with our view of how the issue should be defined.

52 Until this restriction of HZC's freedom of movement can be removed in a way which is consistent with her best interests, protecting her from both the direct consequence of self-injury and the indirect consequences of injuries she may cause to others, we are satisfied that a guardian needs to remain appointed to consider consent to this restrictive practice

Environmental restraint – Restricted access to food

53 HZC is restricted in her access to food, as her genetic condition causes her to have an abnormally increased appetite, leading to overeating and an inability to self-regulate the frequency and volume of food she consumes. The potential detriment to HZC in doing so relates to the health complications which follow from associated weight gain. HZC has access to a meal plan designed to deliver her an appropriate daily calorie intake and to snacks which are not highly calorific.

54 Even though these are the only foods purchased for HZC, and only one planned day's food is available in her accommodation to her each day, if left to make her own decisions, she would not regulate her eating in this way.

55 The control of what is available for her to eat by others, then, is a form of restrictive practice. In the Rules, it falls within the definition of being an "environmental restraint," in that it:

> … [R]estrict[s] a person's free access to all parts of their environment, including items or activities.

56 The use of ongoing calorie control for HZC in this way is monitored by her parents and treating medical practitioner and reviewed on an annual basis. Again, until it can be discontinued in a way which is consistent with her best interests, we are satisfied that a guardian needs to remain appointed to consider consent to this restrictive practice

Mechanical restraint – Described in the Behaviour and Incident Support Plan as 'Restricted access to cars'

57 The use of devices which may restrict a person's freedom of movement has long been recognised as a form of Restrictive Practice, known as a mechanical restraint.

58 In the Rules, "mechanical restraint" is defined as:

> …[T]he use of a device to prevent, restrict, or subdue a person's movement for the primary purpose of influencing a person's behaviour but does not include the use of devices for therapeutic or non-behavioural purposes.

59 Again, we are satisfied that this appropriately encapsulates the way this issue has been interpreted by the Tribunal and should be adopted as an appropriate definition in those circumstances.

60 When transported by vehicle, HZC has a tendency to behave violently towards the driver. As a result, a Perspex barrier is installed inside the vehicle in which she travels, to prevent her accessing the driver. The safety reasons underlying this restriction are readily apparent. It is, nonetheless, a restrictive practice in that it does restrict HZC's freedom of movement within the vehicle.

61 Until it can be discontinued in a way which is consistent with her best interests, we are satisfied that a guardian needs to remain appointed to consider consent to this restrictive practice.

62 As described above, there are significant advantages in the Tribunal adopting the definitions of the various Restrictive Practices contained in the Rules, where the Tribunal has found that those definitions meet its own understanding

of how those issues should be defined. The use of door safety locks is another example of a mechanical restraint used with HZC.

63 For service providers in New South Wales whose client receives NDIS funding, though, they need to be aware of their obligations not only as it relates to meeting the requirements of the Rules, and ensuring that consent is obtained by a person with appropriate authority, but also the interpretation and application of the Restrictive Practices Authorisation Policy published by the Department of Family and Community Services ("FaCS"), the current version of which is dated June 2018.

64 That policy has a particular bearing on this issue, in that it proposes that service providers are exempt from requiring 'restrictive practices authorisation' where the restrictive practice relates to what is described in that policy as an intervention to manage "Non-Purposeful Risk Behaviour". It is enough to record, for the purpose of this matter, that the policy indicates that

> …[S]trategies used for safe travel purposes are not considered restrictive practices, where the person's actions are deemed to fall into the category of Non-Purposeful Risk."

65 It is important to be clear that this relates only to whether FaCS requires the service provider to go through an authorisation process for restrictive practices of this nature. Presumably, it is intended to ensure that where the practice is narrowly defined, commonly used and unexceptional in practice the full authorisation process will not be necessary

66 This has no bearing, though, on whether consent is required to the use of the practice, even if the full authorisation process is not necessary.

67 Each restrictive practice needs to be consented to (or otherwise) by someone with appropriate authority to make that determination, after it has been through whatever other authorisation process is required under the policy.

68 The importance of the difference between "authorisation," being the process by which the proposed practice is reviewed and recorded against appropriate guidelines by FaCS, and the subsequent consent by an authorised person, cannot be overstated.

69 Therefore, irrespective of whether this restrictive practice requires 'authorisation,' its use also requires the consent of a guardian.

70 Until this restriction of HZC's freedom of movement can be removed in a way which is consistent with her best interests, we are satisfied that a guardian needs to remain appointed to consider consent to this restrictive practice.

Chemical restraint

71 Again, the definition of "chemical restraint" contained in the Rules, as:

> …[T]he 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

is consistent with our interpretation of what is contemplated by the Tribunal when addressing this issue and should be adopted.

72 Whilst HZC is prescribed and administered some regular psychotropic medication for her diagnosed anxiety disorder, it is recognised that she is also given both Seroquel and Diazepam on a regular and PRN or 'as needed basis,' solely to stabilise her behaviour and modify it when it escalates to a challenging level. This is a restrictive practice.

73 The Tribunal on the last two occasions appointed HZC's parents as her guardians with a restrictive practice function, including considering consent to the use of chemical restraint.

74 That is consistent with the practice of this Tribunal in some matters but has not been a universally adopted practice of the Tribunal in the past.

75 In other matters, the Tribunal has expressed the view that consent for the giving of psychotropic medication for the purpose of controlling behaviour can be considered as an issue relating to "medical treatment" therefore falling within the 'person responsible' regime, as that term is defined at s 33A of the Act. Commonly, though, those Tribunals have nonetheless added a requirement that a person consenting to any such treatment only do so in the context of the implementation of a behaviour support plan.

76 The reasoning of those constituted panels of the Tribunal bears examination. Part of their reasoning is that considering chemical restraint as a medical

consent issue, allowing for the application of the person responsible regime, permits no order to be made where a person has someone to act as person responsible. Those panels have expressed the view that this is the least restrictive course and therefore the most appropriate course given that the principles contained in s 4 of the Act.

77 HZC's parents are committed to and thoroughly involved in her support. Even without orders of the Tribunal, they clearly fall within the hierarchy of being persons responsible for HZC as either her carers or relative: ss 33A(4)(c)–(d) of the Act. As we have decided to appoint them with the function of giving or withholding medical and dental consent for HZC, they are clearly both her person responsible: s 33A(4)(a) of the Act. On that basis, we need to examine whether we should include the restrictive practice function of deciding about the use of chemical restraint in our orders or leave it to be dealt with as a medical treatment issue.

78 **The Legislative Ground.** The starting point of our consideration is the definition of medical (and dental) treatment contained in s 33(1)(a) of the Act that, relevantly:

> Medical treatment (including any medical or surgical procedure, operation or examination and any prophylactic, palliative or rehabilitative care) normally carried out by or under the supervision of a medical practitioner.

79 On a broad interpretation, the prescription and administration of psychotropic medication would fall within that definition, but there are other factors which we are satisfied we need to consider, including the broader purpose of Pt 5 of the Act.

80 In other contexts, the Supreme Court has not restricted itself to an examination of the words referred to above when determining the scope of what constitutes medical treatment of a patient: *Chapman v South Eastern Sydney Local Health District* [2018] NSWSC 1231 and *MAW v Western Sydney Area Health Service* [2000] NSWSC 358.

81 Rather, the Court when determining whether conduct was "'treatment," has referred to the broader context of Pt 5, and in *Chapman*, considered "…if the word should be viewed so broadly as to include any external intervention in the patients bodily integrity or processes, divorced from consideration of the

purpose of the intervention": *Chapman v South Eastern Sydney Local Health District* at [42].

82 The Court determined that it should not, finding that the "second of the objects of Pt 5 as stated in s 32(b) is a strong indication that the word "treatment" is used throughout the Part in a sense to which purpose is integral, namely, "the purpose of promoting [the patient's] health and well-being"". The Court was satisfied at [42] that:

> That is a conventional sense of the word in accordance with one of the meanings given in the Macquarie dictionary:
>
> 3.a. the application of medicines, surgery, psychotherapy, etc, to a patient to cure a disease or condition: *asthma treatment*.

83 Further, the Court noted at [44] that:

> [T]hroughout the expanded definitions of major and minor treatment in s 33 of the Act there is no indication that the legislature intended to broaden the concept of treatment for which consent may be given under s 36 of the Act, so as to embrace medical interventions which do not have the purpose of promoting the patient's health or well-being.

84 By definition, chemical restraint, as described in the rules and as adopted by us cannot be said to be to promote the person's health, but arguably could be said to promote their well-being.

85 There is, however another complication in this regard, as one of the mandatory considerations of a person responsible when considering consent to treatment is, as outlined in s 42 of the Act, is:

> The particular condition of the patient that requires treatment.

86 Again, where the adopted definition of chemical restraint specifically excludes the use of medication which is intended to treat a diagnosed condition, it is difficult to see how a person responsible can give consent in those circumstances. It bodes toward the need for the appointment of a guardian with the specific function of dealing with chemical restraint.

87 The Tribunal has adopted this approach in other areas, such as when being asked to give consent to sexual assault examinations for persons unable to give consent, where the Tribunal has found that this is unlikely to constitute "treatment," despite being conducted by a medical practitioner.

88 **The consistency ground.** One of the clear purposes of the Rules is to ensure consistency and conformity in the consideration of restrictive practices. We are concerned that considering chemical restraint differently from other restrictive practices, in terms of the process which needs to be followed to obtain power to give consent to it, is counter-productive to that goal. In our view, consistency in the approach to these practices, particularly where it is regulated as part of a scheme intended to ensure that they are reduced or eliminated, promotes the best interests not only of the population who is subject to these practices as a whole, but to each individual who is subject to their use.

89 **The certainty ground.** Another concern we have with the use of the person responsible regime for consent to chemical restraint is that it creates uncertainty in determining who may give such consent.

90 The hierarchy contained in s 33A(4) of the Act, once one passes beyond an appointed guardian, contemplates the need for a medical practitioner to seek consent from an indeterminate class of persons, which may include “a close friend or relative of the person”.

91 This allows for the consent to be considered by different people at different times, with no requirement for consultation between them or consistency in decision making.

92 There are occasions where this regime may adequately meet the best interests of the person, such as where irregular or infrequent treatment may require consent.

93 The nature of chemical restraint, though, is that it is a significant, often regular, and debilitating intervention which impacts on the self-determinative ability of the person involved and may have a negative impact on other aspects of their health and well-being. The person responsible regime is unsuited to the purpose of regulating it, for that reason.

94 **The consultation ground.** The final concern we raise about considering chemical restraint as a form of medical treatment consent, is that the person responsible regime contemplates the consent being given by a person whose

ability to understand the seriousness of the issue and the complexity of the balance between the protection of the person and their freedoms, is untested.

95 There is also no requirement for anyone to seek the view of the person who the practice is being used on about whether the proposed person responsible is appropriate to make decisions for them.

96 This has the potential to seriously infringe on the person's rights. By dealing with the issue as requiring the appointment of a guardian the person would be given a say, wherever possible, about who they think should make those decisions.

97 For all of the reasons above, we are satisfied that, even if it is possible for the Tribunal to exercise its discretion to treat chemical restraint as a medical treatment issue, it is preferable that it be dealt with by the appointment of a guardian with chemical restraint as a restrictive practice function.

98 Whilst doing so may be an imposition on the freedom of decision making of the person, we are satisfied that the restriction is more illusory than real, where it goes not to whether the restrictive practice is used, but rather who is authorised to consent to it.

99 We decided that each of these functions should be included in the order as categories or restrictive practices to which TXC and TYC may consider providing consent on HZC's behalf.

Conditions on utilising the restrictive practices function

100 Both the Tribunal and the former Guardianship Tribunal of NSW have had a long held practice of placing conditions upon an appointed guardian's ability to authorise the use of restrictive practices. The power to do so is granted in s 16(1)(d) of the Act. The condition has usually been framed such that an appointed guardian may only consent to the use of restrictive practices to address challenging behaviours within the context of a comprehensive positive behaviour plan. Such condition strikes an appropriate balance upon the obligation on the Tribunal to ensure that the welfare and interests of a person under guardianship are given paramount consideration (s 4 (a) of the Act) and

the obligation to ensure that their freedom of decision and freedom of action should be restricted as little as possible (s 4 (b) of the Act).

101 We are of the view that it is appropriate that the Tribunal continue this practice but, in circumstances such as HZC, that is, as recipient of services from NDIS service providers, reframe the condition so that it more closely equates with the primary regulatory requirements imposed by the Rules as they relate to the application of restrictive practices.

102 Accordingly, with reference to the applicable Rules, we impose the following conditions upon HZC's appointed guardians when looking to utilise the authority granted to them to authorise the use of certain restrictive practices upon HZC:

(1) the guardians may only consent to the use of the types of restrictive practices permitted under this order to influence HZC's behaviour:

(a) as a last resort to prevent HZC from harming herself or others; and

(b) in accordance with a behaviour support plan (r 10(2)(a) of the Rules) which has been developed by a behaviour support practitioner (r 18(a) of the Rules) after having conducted a functional behavioural assessment (r 20(5) of the Rules) upon HZC, and which is reviewed regularly (and no less than every 12 months) (r 22(b) of the Rules) and/or reviewed as soon as practicable if there is a change in circumstances which requires the plan to be amended (r 22(a) of the Rules).

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I hereby certify that this is a true and accurate record of the reasons for decision of the Civil and Administrative Tribunal of New South Wales.
Registrar