Chapter 15
Restrictions upon liberty in residential care

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Restrictions upon liberty in residential care

INTRODUCTION

15.1 In this chapter, the Commission considers means of providing appropriate safeguards for people with impaired decision-making ability who are living in certain residential facilities in circumstances that involve substantial restrictions upon their freedom of movement.

15.2 At present, many people who lack capacity to make decisions about their accommodation arrangements live in facilities, such as nursing homes, with the informal consent of a close family member, or other unpaid carer. Some people who live in residential facilities are detained in their ward or room in order to prevent them from leaving and exposing themselves to serious risk, such as that posed by traffic on busy roads. Others are detained in their beds or chairs in order to prevent them from falling and causing serious injury to themselves.

15.3 There is no common law or statutory power permitting the family member or friend to provide substituted consent to these practices. There is no statutory power, nor any clear common law power,1 that permits the staff at the residential facility to undertake these practices. The family members or unpaid carers who are often asked to approve these arrangements act as ‘de facto’ guardians. However, unlike enduring guardians or guardians appointed by the Victorian Civil and Administrative Tribunal (VCAT), there is no formal recognition of their role or scrutiny of informal arrangements involving restraint of liberty.

15.4 The number of people in supported residential care is likely to grow quite substantially over the next two decades as the community ages and life expectancy increases. It will be an ongoing challenge to devise fair, efficient and practical safeguards for the many people who are likely to need someone to decide where they will live and, in some instances, whether they should be detained or restrained for their own welfare. Appointing guardians for all the people who lack capacity to consent to these practices would probably place an unsustainable demand on VCAT and the Public Advocate.

15.5 In 1982, the Cocks Committee2 reported that the family of a person who is unable to make particular decisions can often provide informal consent to various actions without the need for a guardianship order. While the Commission supports the continued use of informal practices in some circumstances, it is necessary to review their continued use when dealing with some practices that involve significant restrictions upon fundamental liberties.

15.6 As discussed in Chapter 4, disability policy and attitudes to legal risk have changed quite substantially in the 30 years since the Cocks Committee reported. It is no longer appropriate to rely on informal consent by family members when dealing with residential decisions that involve total restraint of a person’s liberty. Because liberty is a value of paramount importance in our community, it is strongly arguable that actions involving total loss of liberty should be authorised by a process that involves appropriate checks and balances.

15.7 Many statutes and common law rights protect liberty. They include:

- the Charter of Human Rights and Responsibilities Act 2006 (Vic) (the Charter)3
- the writ of habeas corpus
- the tort of false imprisonment

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1 In some cases, a court may find that the legality of such arrangements rests on the common law doctrine of necessity. This was the approach of the House of Lords in R v Bournewood Community and Mental Health NHS Trust; Ex parte L [1999] 1 AC 458. We discuss the implications of the Bournewood case below.  
• the legislative safeguards under the Disability Act 2006 (Vic) for people with an intellectual disability who are subject to compulsory treatment involving detention
• the legislative safeguards on the use of restrictive interventions, especially restraint and seclusion, for people with a disability as defined under the Disability Act
• the legislative safeguards for people subject to involuntary detention under the Mental Health Act 1986 (Vic)
• the legislative safeguards on the use of restraint and seclusion for people receiving treatment for a mental disorder under the Mental Health Act.

15.8 The Commission’s recommendations in this chapter seek to strike a balance between ensuring there are appropriate safeguards in situations where a person is deprived of their liberty, and avoiding unnecessary administrative burdens for residential care facilities, especially when there is little tangible benefit gained by replacing workable and fair informal arrangements with expensive bureaucratic ones. For this reason, the recommendations in this chapter deal only with safeguards for practices that will result in a total restraint of a person’s liberty. In other instances, people involved in residential care decisions for a person who lacks capacity to consent to their own living arrangements will need to decide on a case-by-case basis whether it is appropriate to rely upon informal consent to those arrangements or whether a personal guardian should be appointed.

15.9 The lack of adequate safeguards for people who are unable to consent to admission to an institution but do not resist that step became an important issue in the United Kingdom following R v Bournewood Community and Mental Health NHS Trust; Ex parte L (Bournewood) in 2005. In 2009, the United Kingdom Government introduced the Deprivation of Liberty Safeguards in response to the European Court of Human Rights’ decision in Bournewood, which found that a man’s informal admission to and subsequent detention in a hospital was a deprivation of his liberty and a violation of article 5(1) of the European Convention for the Protection of Human Rights and Fundamental Freedoms (European Convention).

15.10 The Bournewood case and the Deprivation of Liberty Safeguards are discussed in more detail below.

15.11 It is possible that a similar case could arise in Victoria because the Charter contains a similar provision to article 5(1) of the European Convention. In contrast with the United Kingdom however, where people can bring claims against public authorities under the Human Rights Act 1998 (UK) for breaches of the rights in the European Convention, there is no independent cause of action under the Charter. Any claim under the Victorian Charter concerning circumstances that were similar to those in the Bournewood case would need to be linked to a pre-existing cause of action.
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CURRENT LAW, STANDARDS AND PRACTICES

15.12 Liberty is one of the most important values protected by the common law.\(^\text{14}\) Any interference with a person’s liberty is unlawful unless it is authorised by law.\(^\text{15}\) The common law has developed causes of action—an application for a writ of habeas corpus and the action for false imprisonment—that allow people to test the lawfulness of any deprivation of liberty and that provide remedies when a person is found to have been unlawfully deprived of their liberty.

15.13 Deprivations of liberty are authorised by statute in various circumstances, such as when a person is apprehended or arrested by the police,\(^\text{16}\) or sentenced by a court to a term of imprisonment following conviction for an offence.\(^\text{17}\) Some deprivations of liberty are also authorised by legislation in health and disability settings, such as decisions by an authorised psychiatrist to detain a person with a mental illness in an approved mental health service,\(^\text{18}\) or decisions by the Secretary to the Department of Human Services to authorise restrictive interventions for a person with an intellectual disability.\(^\text{19}\)

15.14 A guardian appointed by VCAT or an enduring guardian with appropriate powers is also able to authorise deprivations of liberty in some circumstances. For example, a guardian with appropriate powers could authorise accommodation arrangements for the represented person which involve that person living in a locked ward or facility, or which permit that person to be strapped in a chair or bed when necessary to safeguard the person’s welfare.

HABEAS CORPUS

15.15 Both habeas corpus and the action for false imprisonment are open to all people who face unauthorised restrictions on their liberty in any settings, except where the deprivation of liberty is authorised by law.

15.16 Habeas corpus is one of the common law’s oldest causes of action\(^\text{20}\) and allows a person to challenge the legality of their deprivation of liberty. It was recently successfully invoked in Victoria in Antunovic v Dawson & Anor (Antunovic).\(^\text{21}\)

15.17 Justice Bell said in that case:

The purpose of the writ is to give a remedy against unlawful restraints on personal liberty, which is not to be narrowly defined. The restraint may be imposed directly or indirectly. It may be partial or total. The question is whether the person imposing the restraint has the lawful custody, power or control of the person being restrained. The liberty protected by common law habeas corpus is broader than the liberty protected by the human right to personal liberty and security in s 21(1) of the Charter. For the purposes of habeas corpus, it is a restraint on personal liberty to imprison or detain somebody and also to impose restrictions on their liberty or freedom of movement which are not shared by the public generally. That freedom is a human right specified in s 12 of the Charter.\(^\text{22}\)

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\(^{14}\) There is a useful discussion of the relevant common law rules in Jeremy Gans, Terese Henning, Jill Hunter and Kate Warner, Criminal Process and Human Rights (2011) Chapter 4.

\(^{15}\) See, eg, Williams v R (1986) 161 CLR 278 (8).

\(^{16}\) Section 459 of the Crimes Act 1958 (Vic) permits members of the police force to apprehend and arrest people in certain circumstances. Other sections of the Crimes Act that allow a person to apprehend another include s 458, which allows a person to apprehend a person found to be committing an offence for the purposes of bringing him or her before a court; and s 463B, which allows a person to use reasonable force to prevent an action that may amount to suicide.

\(^{17}\) Section 6A of the Corrections Act 1986 (Vic) authorises the Secretary of the Department of Justice to detain in custody a person who has been sentenced to a term of imprisonment.

\(^{18}\) Mental Health Act 1986 (Vic) s 12AC.

\(^{19}\) Disability Act 2006 (Vic) s 135.


\(^{22}\) Ibid [113]. Citations omitted from the original.
Although the plaintiff was not subjected to any physical restraint in Antunovic, the Court accepted her evidence that she felt that she was unable to leave the premises in which she was residing without the permission of her psychiatrist. Justice Bell described it as ‘partial not total restraint’ and stated that ‘[b]ecause of the power which the doctor and the unit have over her, Mrs Antunovic feels unable simply to leave the unit and go home’. The Court found that Mrs Antunovic had been unlawfully restrained and ordered her release.

The Victorian case of Skyllas v Retirement Care Australia also involved a writ of habeas corpus sought against an aged care facility on behalf of an elderly woman, Mrs Skyllas, who wished to live in her own home with her son. Justice Byrne ruled that:

As a matter of law the nursing home cannot detain a patient against her wishes and the first defendant did not contend otherwise. This situation assumes that the patient is able to express her wishes and that she has control of her affairs and decision-making processes. Accordingly, on 26 July 2006, I ordered that a writ of habeas corpus issue returnable on 2 August 2006.

When the matter returned before me on that day it appeared that VCAT had on 1 August 2006, appointed the Public Advocate to be plenary guardian of Mrs Skyllas. A representative of the Public Advocate attended Court in response to the writ and I accepted this as sufficient response to the writ, given the health of Mrs Skyllas.

FALSE IMPRISONMENT

False imprisonment is a tort, or civil wrong, that is committed whenever a person directly, and either intentionally, negligently or recklessly, causes the total restraint of the liberty of another person without lawful justification. While false imprisonment is a form of trespass, it is not necessary for there to be actual force or direct physical contact. The tort is committed when a person’s liberty is restrained by means which causes them to submit to their deprivation of liberty.

STATUTORY AUTHORITY TO DEPRIVE LIBERTY

A range of statutes authorise people to deprive others of their liberty in some circumstances. Some of these authorisations concern detention of people with a disability in limited circumstances. These statutory authorisations are usually accompanied by checks and balances that seek to ensure that the powers of detention are exercised fairly and responsibly.

Mental Health Act

The Mental Health Act provides for involuntary treatment and detention of some people with a mental illness in certain circumstances. The Commission examines this scheme more closely in Chapter 24.

The Mental Health Act provides a number of safeguards for involuntary detention and treatment that include:

- the authorised psychiatrist must examine the person within 24 hours after the order is made to determine if the criteria for involuntary treatment are met and either confirm the order or discharge the person.

24 Skyllas v Retirement Care Australia (Preston) Pty Ltd [2006] VSC 409.
25 Ibid [9]–[10]. A guardian was subsequently appointed to make these decisions.
27 Mental Health Act 1986 (Vic) s 8(1)(A) defines a person as mentally ill ‘if he or she has a mental illness, being a medical condition that is characterised by a significant disturbance of thought, mood, perception or memory’. Section 8(2) specifies a number of circumstances that by themselves or in combination will not amount to a mental illness.
28 Mental Health Act 1986 (Vic) pt 3.
29 Ibid s 12AC.
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- appeals against involuntary treatment orders and continued detention under the Act
- compulsory reviews by the Mental Health Review Board.

15.24 The compulsory detention provisions in the Mental Health Act apply only to people being treated in ‘approved mental health services’, which are, in most instances, psychiatric wards in general hospitals.

Disability Act

15.25 The Disability Act establishes a framework for providing support and services to people with disabilities throughout Victoria. Most of the Disability Act’s provisions apply to people with a broad range of disabilities but do not extend to people who have a mental illness or disabilities solely related to ageing. It contains provisions regarding compulsory detention and treatment that apply only to people with an intellectual disability.

15.26 The Senior Practitioner is generally responsible for ensuring that the rights of a person who is subject to restrictive interventions and compulsory treatment under the Disability Act are protected and that appropriate standards are followed.

Safeguards for the use of restrictive interventions for restraint and seclusion include:
- a requirement that disability service providers have approval from the Secretary to use restrictive interventions
- the appointment of an Authorised Program Officer to a disability service provider to ensure that any restrictive intervention is done in a manner that conforms to the requirements of the Act
- a monitoring role for the Senior Practitioner.

15.27 Restraint and seclusion is limited to situations involving risk of harm to the person or other people. It must be the least restrictive treatment of the person as possible in the circumstances. It must be part of a behaviour management plan and only be applied for the period of time that has been authorised by the Authorised Program Officer. Additional criteria apply to the use of seclusion.

15.28 The Authorised Program Officer must ensure that an independent person is available to explain to a person with a disability the treatment that forms part of the behaviour management plan and that the person with a disability knows they can seek a review in VCAT of the decision to include that treatment in the behaviour management plan.

REGULATION OF RESIDENTIAL SERVICES

15.30 Both Commonwealth and Victorian legislation regulate the provision of residential services for people who experience impaired decision-making ability due to a disability.

31 Disability Act 2006 (Vic) s 3 (definition of ‘disability’).
32 Ibid s 152(1)(a).
33 Ibid s 135.
34 Ibid s 139.
35 Ibid s 150.
36 Ibid s 140(a).
37 Ibid s 140(b).
38 Ibid ss 140(c)(i), 141.
39 Ibid s 140(c)(ii).
40 Ibid s 140(c)(iii).
41 Ibid s 140(d).
42 Ibid ss 143(1), 146.
Commonwealth legislation regulates the provision of aged care services while Victorian legislation regulates the provision of supported residential services that are often used by people with an intellectual disability or mental illness.  

15.31 While the legislation contains detailed provisions concerning standards of care, it does not authorise a person to detain or restrain a resident who might be at risk of harm if their liberty was not restrained in some way.

**Aged Care Act 1997 (Cth)**

15.32 The *Aged Care Act 1997* (Cth) applies to all services approved for Commonwealth Residential Care Subsidy. The Aged Care Act enables the development of Accreditation Standards with which a service must comply in order to be eligible for the Residential Care Subsidy.  

15.33 Accreditation Standards prescribe 44 ‘expected outcomes’, generally in quite broad terms, across four areas:  

- **Standard 1:** Management systems, staffing and organisational development  
- **Standard 2:** Health and personal care  
- **Standard 3:** Resident lifestyle  
- **Standard 4:** Physical environment and safe systems.

15.34 Standards are applied through self-assessments by the service and by visits, both announced and unannounced, by teams of assessors.

**Supported Residential Services (Private Proprietors) Act 2010 (Vic)**

15.35 The *Supported Residential Services (Private Proprietors) Act 2010* (Vic) (the SRS Act) applies, subject to some exceptions, to premises where accommodation and personal support are privately provided or offered for a fee or reward.  

15.36 The SRS Act, upon proclamation in 2012, will replace the current regulatory regime for supported residential services provided under the *Health Services Act 1988* (Vic) and the Health Services (Supported Residential Services) Regulations 2001.  

15.37 The SRS Act makes it an offence to operate a supported residential service that is not registered under the Act.  

- It details the rights of residents of supported residential services and puts limits on the restriction of those rights, requiring that:  
  - the restriction is necessary  
  - where there is more than one option available in implementing the restriction, the least restrictive option is chosen.

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43 Clearly, not all people who live in aged care facilities or supported residential services experienced impaired decision-making ability.  
44 *Aged Care Act 1997* (Cth) s 54.2.  
45 Ibid s 42.1.  
46 For full details on the Commonwealth Aged Care Accreditation system, see the website of the Aged Care Standards and Accreditation Agency Ltd <http://www.accreditation.org.au>.  
47 Some premises are excluded. They are where the services provided receive the Commonwealth Residential Care Subsidy, where it is used for residential services under the Disability Act 2006 (Vic); where it is used for an appropriate mental health service under the Disability Act 2006 (Vic), where it is used for an approved mental health service under the Mental Health Act 1986 (Vic); where it is used for services (secure welfare of out of home care) under the Children Youth and Families Act 2005 (Vic); where accommodation and personal support is provided to all residents under a funding and service agreement with State or Commonwealth or a public body where that agreement specifies requirements or standards for the provision of care that are recorded in the Register under the Retirement Villages Act 1986 (Vic); Supported Residential Services (Private Proprietors) Act 2010 (Vic) s 5.  
49 Ibid s 7.  
50 Ibid s 8.
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15.38 The Act also includes provisions about the general operation of supported residential services, detailing:

- residential and service agreements
- support plans
- health and support standards
- medication
- staffing
- complaints
- reporting and records
- management of residents’ money
- security of tenure.

15.39 The Act empowers the Secretary of the Department of Health to monitor services, including powers to enter premises and to direct services to provide documents and answer questions.

AGED CARE ASSESSMENT SERVICE

15.40 An Aged Care Assessment Service (ACAS) assessment is mandatory for an older person who seeks access to Commonwealth-subsidised aged care services, including residential respite, community aged care packages, extended aged care in home packages or flexible care.

15.41 An ACAS assessment occurs as part of the admission process to many aged care facilities in Victoria. However, an ACAS assessment does not specifically address formal substitute decision-making arrangements when a person with impaired decision-making ability is admitted to an aged care residential facility.

The ACAS process

15.42 ACAS assessments generally take place before admission to an aged care facility. In some cases, people who are already in residential care are referred to ACAS for further assessment. This may occur for various reasons, including because the client wants to return home, the facility or family consider there is a need for a move to high-level care, or sometimes because the facility finds it difficult to meet the person’s needs.

15.43 ACAS assessors are independent teams who assess the care needs of older people and identify what kind of care will best meet their needs. Assessment teams are multi-disciplinary and can include medical practitioners, social workers, nurses, occupational therapists and physiotherapists.

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52 Ibid ss 56–8.
54 Ibid s 63.
55 Ibid ss 64–74.
56 Ibid s 75.
57 Ibid ss 76–8.
58 Ibid ss 79–106.
60 Ibid ss 130–155.
62 Consultation with Aged Care Assessment Service in Victoria (28 February 2011).
63 Aged Care in Victoria, above n 61.
64 Ibid.
15.44 There are a number of steps in the ACAS process. They are:

- referral to intake for assessment screening and triaging
- information gathering (involving risk screening and prioritising for response urgency)
- a comprehensive assessment examining physical capability, cognitive and behavioural issues, social environmental factors and physical environmental factors, which is done through the face-to-face component of the assessment
- consultation with the client, and with any family, advocates and relevant professionals, such as the client’s general practitioner. The assessment is holistic and incorporates need, risk and capacity.

15.45 A multidisciplinary discussion will then lead to the development of a ‘care plan’ and the outcome may result in eligibility for Commonwealth-funded programs.

15.46 Decisions about admission to care are made primarily on the basis of risk. People with frequent admissions to hospital are often considered at greater risk and are often recommended for residential aged care.

15.47 Capacity issues do not always arise in an ACAS assessment. If they do arise, various professionals such as a general practitioner, a geriatrician, or a neuropsychologist might assess a person’s capacity to make their own decisions.

15.48 At times, guardianship or administration applications are made in the course of the assessment process. In appropriate cases, ACAS will apply to VCAT for an order. In other cases, ACAS assists family members to make an application.

The ACAS process does not extend to all care facility beds

15.49 People who are living in supported residential services or private retirement villages do not go through the ACAS process for admission to those facilities. However, care and support issues might arise while they are living there and this can trigger an ACAS assessment.

15.50 There are some aged care facilities that have ‘unlicensed’ aged care beds. These beds do not require an ACAS assessment because they are ineligible for a Commonwealth Government subsidy.

THE BOURNEWOOD CASE IN THE UNITED KINGDOM

15.51 The challenges that arise when there is no legal authorisation for actions taken in relation to people with impaired decision-making ability that amount to a deprivation of their liberty were highlighted in the Bournewood case in 2005 and the United Kingdom Government’s response to the decision of the European Court of Human Rights.

15.52 As noted earlier, a similar case could arise in Victoria because of the similarities between the common law rules in both jurisdictions and because there are comparable provisions in the Charter to those in the European Convention.

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65 Consultation with Aged Care Assessment Service in Victoria (28 February 2011).
66 Ibid.
67 Ibid.
68 Ibid.
69 Ibid.
70 Ibid.
71 Ibid.
72 Ibid.
73 R v Bournewood Community and Mental Health NHS Trust; Ex parte L [1999] 1 AC 458; HL v United Kingdom (2005) 40 EHRR 32.
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BACKGROUND TO THE BOURNEWOOD CASE

15.53 HL was a 48-year-old man who was informally admitted to and detained at Bournewood Hospital. He was described by the European Court of Human Rights as a person who ‘has suffered from autism since birth’, as ‘frequently agitated’ with ‘a history of self-harming behaviour’ and as ‘a person who lacks the capacity to consent or object to medical treatment’.74

15.54 No one sought to rely upon any statutory authority for HL’s living arrangements at Bournewood Hospital because the practice at the time was not to invoke any statutory powers when a person in his position was not resisting those arrangements. HL’s former carers, who disagreed with the arrangements made for him at Bournewood Hospital, arranged for proceedings to be taken on his behalf, claiming a writ of habeas corpus and damages for false imprisonment.

15.55 These proceedings were unsuccessful in the United Kingdom. A series of cases culminated in a decision by the House of Lords that any actions taken by hospital staff to detain HL that ‘might otherwise have constituted an invasion of his civil rights, were justified on the basis of the common law doctrine of necessity’.75 At the time of this decision, the only source of statutory authority to detain a person in a hospital in the United Kingdom was the Mental Health Act 1983 (UK)—there was no legislation similar to the Guardianship and Administration Act 1986 (Vic) (G&A Act).

15.56 An application was lodged with the European Court of Human Rights challenging the decision of the House of Lords.

EUROPEAN COURT OF HUMAN RIGHTS DECISION: HL V UNITED KINGDOM76

15.57 The European Court of Human Rights found that the admission of HL to Bournewood Hospital and his subsequent detention was a deprivation of his liberty and a violation of article 5(1) of the European Convention.77 The relevant parts of article 5(1) provide that:

Everyone has the right to liberty and security of person. No one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law.

15.58 The European Convention applies a number of qualifications to the right to liberty. One of the exceptions is “the lawful detention … of persons of unsound mind”.78 However, to be lawful, the detention must be “in accordance with a procedure prescribed by law”.79

15.59 In determining if HL had been unlawfully deprived of his liberty, the European Court of Human Rights considered the following three issues:

- Was HL detained?
- Was HL of unsound mind?
- Was the detention unlawful?

15.60 The European Court found that HL was detained because the health care professionals treating and managing him ‘exercised complete and effective control over his care and movements’.80 He ‘was under continuous supervision and control and was not free to leave’.81

74 HL v United Kingdom (2005) 40 EHRR 32 [1].
75 R v Bournewood Community and Mental Health NHS Trust; Ex parte L [1998] All ER 289, 299.
76 HL v United Kingdom 40 EHRR 32.
77 European Convention.
78 Ibid art 5(1)(e).
79 Ibid art 5(1).
80 HL v United Kingdom (2005) 40 EHRR 32, 792.
81 Ibid 793.
The Court also accepted that HL was of unsound mind.\textsuperscript{82} The remaining question was whether the detention was lawful.

The decision emphasises that the essential objective of article 5(1) of the European Convention is ‘to prevent individuals being deprived of their liberty in an arbitrary fashion’.\textsuperscript{83} The Court stressed that this objective, combined with the general requirement that the detention be ‘in accordance with a procedure prescribed by law’, required ‘the existence in domestic law of adequate legal protections and “fair and proper procedures”’.\textsuperscript{84}

The Court determined that the detention was unlawful because there were insufficient procedural safeguards to guard against arbitrary detention. It emphasised the lack of fixed rules for the admission and detention of compliant people and the strong contrast with the extensive network of safeguards for involuntary patients under the \textit{Mental Health Act 1983} (UK).\textsuperscript{85}

The European Court of Human Rights also determined that there had been a breach of HL’s article 5(4) right to a speedy review of the lawfulness of his detention. Article 5(4) provides that:

\begin{quote}
Everyone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings by which the lawfulness of his detention shall be decided speedily by a court and this release ordered if the detention is not lawful.\textsuperscript{86}
\end{quote}

\textbf{RESPONSE TO THE ‘BOUNEWOOD GAP’ IN THE UNITED KINGDOM}

The decision to admit HL to Bournewood Hospital complied with the Code of Practice under the \textit{Mental Health Act 1983} (UK), which mandated informal admission when a person is mentally incapable of consent but does not object to entering hospital and receiving care or treatment.\textsuperscript{87} The \textit{Bournewood} decision meant, however, that there was a large group of people who were being deprived of their liberty contrary to article 5(1) of the European Convention.

The United Kingdom Government sought to identify which groups of people were affected and in which settings they might be found. In addition to people like HL, who had been admitted to hospital informally, an additional group of people was identified as possibly falling within the ‘Bournewood gap’. This group included many people with dementia who resided in non-hospital settings such as care homes.\textsuperscript{88}

The United Kingdom considered three possible responses to the \textit{Bournewood} decision:

- introduce a new ‘protective care’ system to govern admission and detention procedures as well as reviews of detention and appeals\textsuperscript{89}
- extend the use of detention under the \textit{Mental Health Act 1983} (UK) to the Bournewood group of patients\textsuperscript{90}
- use existing arrangements for guardianship under the \textit{Mental Health Act 1983} (UK).\textsuperscript{91}

\begin{footnotes}
\item[82] Ibid 796.
\item[83] Ibid 799.
\item[84] Ibid.
\item[85] Ibid 800–1.
\item[86] Article 5 of the European Convention on Human Rights is expressed in very similar terms to the right to liberty and security of the person provided by the \textit{Charter of Human Rights and Responsibilities Act 2006} (Vic) s 21(1)–(3), discussed in more detail later in this chapter.
\item[87] See Department of Health (United Kingdom), \textit{Bournewood Consultation: The Approach to be Taken in Response to the Judgment of the European Court of Human Rights in the ‘Bournewood’ Case} (2005) 3 [2.2] (‘Bournewood Consultation’).
\item[88] Ibid 4, 22–3.
\item[89] Ibid 8.
\item[90] Ibid 13.
\item[91] Ibid 14.
\end{footnotes}
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15.68 Following consultations,92 the United Kingdom Government decided to introduce a ‘protective care’ system in the Mental Capacity Act 2005 (UK), which is broadly equivalent to the G&A Act. The Deprivation of Liberty Safeguards came into force on 1 April 2009.93 They seek to ‘provide a proper legal process and suitable protection in those circumstances where deprivation appears to be unavoidable, in a person’s own best interests’.94 They do not cover deprivations of liberty in supported accommodation, a private residence, or for people under the age of 18.95 They do not apply to people detained under the Mental Health Act 1983 (UK).96

15.69 The Deprivation of Liberty Safeguards seek to ensure that people who are or who may be deprived of their liberty in a hospital or care home are identified and that the decision to deprive them of liberty is externally reviewed and authorised, even if the person is not actively seeking liberty. Once a person in this situation is identified, an assessment process is carried out by between two and six assessors who each report separately to the supervisory body that commissions the assessments. If all the requirements are met, an authorisation must be issued. The safeguards are unusual because authority for a person’s deprivation of liberty is provided by a combination of these various clinicians rather than by a court, tribunal or statutory official.97

15.70 The majority of applications in England for authorisations under Deprivation of Liberty Safeguards have been made for people who lack capacity because of dementia. In 2009–10, there were 7157 applications and in 2010–11 there were 8982 applications. Approximately half of the applications were for people who lacked capacity because of dementia.98

15.71 The Commission has been mindful of the complexity and costs associated with the United Kingdom Government’s response to Bournewood—the Deprivation of Liberty Safeguards—when devising recommendations concerning a process of legal authorisation that provides appropriate safeguards when people with impaired decision-making ability who live in residential care facilities are deprived of their liberty.

POTENTIAL APPLICATION OF THE BOURNEWOOD CASE IN VICTORIA

15.72 The Charter of Human Rights and Responsibilities Act 2006 (Vic) (the Charter) protects a person’s right to liberty and security. It provides that:

- every person has the right to liberty and security
- a person must not be subjected to arbitrary arrest or detention
- a person must not be deprived of their liberty except on grounds, and in accordance with procedures, established by law.99

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93 Mental Capacity Act 2005 (UK) c 9, ss 4A, 4B, schs A1, A1A. The new legislative scheme was inserted into the Mental Capacity Act 2005 (UK) c 9 by the Mental Health Act 2007 (UK) c 12, s 50, schs 7, 8, 9.
95 This situation would generally fall under the Children Act 1989 (UK) c 41, s 25. In some situations it would be appropriate to use the Mental Health Act 1983 (UK) c 20: see ibid 12.
96 Mental Health Act 1983 (UK) c 20. The determination of whether someone is ineligible for the safeguards is made under the Mental Capacity Act 2005 (UK) c 9, sch 1A. For a recent discussion of the problematic relationship between the Mental Health Act 1983 (UK) c 20 and the ineligibility provisions for the Deprivation of Liberty Safeguards contained in the Mental Capacity Act 2005 (UK) c 9, sch 1A see Neil Allen, ‘The Bournewood Gap (As Amended?)’ (2010) 18 Medical Law Review 78.
97 The Commission will publish a background paper on its website about Deprivation of Liberty Safeguards in the UK and safeguards in other jurisdictions.
99 Charter of Human Rights and Responsibilities Act 2006 (Vic) ss 21(1)–(3).
It also provides that any person deprived of liberty by arrest or detention is entitled to apply to a court for a declaration or order regarding the lawfulness of their detention. The court must make a decision without delay and order the release of the person if it finds that the detention is unlawful. This Charter entitlement mirrors the common law right to challenge the lawfulness of detention by seeking a writ of habeas corpus.

These provisions in the Charter have very similar wording to the right to liberty in article 5 of the European Convention that was central to the European Court’s decision in Bournewood.

Given the similarities between article 5 of the European Convention and section 21 of the Charter, it is possible that Charter proceedings against a ‘public authority’ in relation to a person without capacity who is effectively detained in a hospital or nursing home without formal authorisation could produce a similar result to the Bournewood case.

It is important to note that the Charter, unlike the European Convention, specifies that a person cannot bring an action against a public body based solely on a Charter right but must rely on an existing cause of action. In such proceedings—such as an application for a writ of habeas corpus or an action based on false imprisonment—it is possible to seek a remedy for a breach of a Charter right.

It is also important to note that the Charter, unlike the European Convention, does not oblige governmental action to secure compliance with the rights set out in the Charter.

Various steps have been taken in a number of comparable jurisdictions to provide safeguards for various practices when people who lack capacity are admitted to or deprived of their liberty while living in residential care facilities by establishing processes that enable various people to authorise these actions.

The Commission will publish a background paper on its website about relevant safeguards operating in England and Wales, Queensland, and the Canadian provinces of Ontario, British Columbia and the Yukon.

Many people and organisations suggested that there should be specific laws regulating the admission and potential detention of a person in a residential facility when the person lacks capacity to consent to these steps.

Aged Care Crisis submitted that:

older people who are perceived to have cognitive impairment are the only group of people who can be placed in locked facilities, against their will, without any reasonably accessible procedures for appeal. Clearly, people must be kept safe but we are aware of several instances where the basic human right, not to be kept locked away or otherwise restrained without due process, has been disregarded. We can think of no other group of people where this situation would be regarded as acceptable.

100 Ibid s 21(7).
101 The definition of ‘public authority’ in s 4 of the Charter of Human Rights and Responsibilities 2006 (Vic) is broad. Section 4(1)(c) includes entities that are exercising functions of a public nature on behalf of the state or a public authority.
103 European Convention art 1.
104 For eg, Submissions CP 19 (Office of the Public Advocate), CP 21 (Action for More Independence & Dignity in Accommodation), CP 29 (STAR Victoria), CP 48 (Centre for the Advancement of Law and Mental Health—Monash University), CP 56 (Disability Discrimination Legal Service), CP 57 (Aged Care Assessment Service in Victoria), CP 66 (Victorian Equal Opportunity and Human Rights Commission), CP 69 (Australian Medical Association (Victoria)), CP 71 (Seniors Rights Victoria) and CP 75 (Federation of Community Legal Centres (Victoria)).
105 Submission CP 38 (Aged Care Crisis). Emphasis in the original.
15.82 Another submission raised specific concerns about deprivations of liberty involving people in hospitals with post-traumatic amnesia. It was noted that ‘the lack of prescribed safeguards surrounding the authorisation and long-term use of … restrictive practices in general hospital wards is in strong contrast to the extensive network of safeguards for involuntary patients under Victoria’s mental health legislation’. It was argued that deprivations of liberty, seclusion and restrictive practices limit a person’s Charter rights and extensive procedural safeguards are required for these situations. Those safeguards should include:

- that limits on rights should only be permissible following independent and impartial decision making, which take into account the nature of the right and whether the limitation is reasonable and proportionate in the individual circumstances
- access to an independent and impartial court or tribunal appeal or review mechanism
- specific exclusion of treatment that involves deprivations of liberty, seclusion or the long-term use of restraints from the definition of ‘medical treatment’.

THE REFORM OPTIONS PROPOSED IN THE CONSULTATION PAPER

15.83 The Commission identified five possible reform options in the consultation paper for dealing with deprivations of liberty in residential care facilities. They were:

- no change—retain the current system of relying primarily upon informal arrangements
- use existing guardianship mechanisms to appoint substitute decision makers
- introduce a new scheme of safeguards similar to the Deprivation of Liberty Safeguards scheme in the United Kingdom
- extend protection through existing legislation, such as the Disability Act
- expand the decision-making powers of automatic appointees (the person responsible under section 37 of the G&A Act) with additional safeguards.

15.84 Support for the options suggested in the consultation paper fell primarily into two categories: those who supported the introduction of a new scheme of safeguards similar to the Deprivation of Liberty Safeguards scheme, and those who supported the expansion of automatic appointment provisions with additional safeguards.

15.85 There was little support for the options of using existing guardianship mechanisms or of extending the reach of existing legislation such as the Disability Act.

15.86 The option of continuing to rely upon informal arrangements received limited support. Some submissions considered that the current informal processes are sufficient. It was noted that there are a number of processes that may be applicable to admission to residential aged care, in particular, assessment by ACAS.

106 Submission CP 86 (Anne Kennedy).
107 Ibid.
108 For eg, Submissions CP 8 (Leonie Chirgwin), CP 19 (Office of the Public Advocate), CP 66 (Victorian Equal Opportunity and Human Rights Commission) and CP 84 (Law Institute of Victoria—Supplementary Submission).
109 For eg, Submissions CP 21 (Action for More Independence & Dignity in Accommodation), CP 73 (Victoria Legal Aid), CP 27 (Catholic Archdiocese of Melbourne), CP 29 (STAR Victoria), CP 33 (Eastern Health), CP 43 (Alfred Health), CP 48 (Centre for the Advancement of Law and Mental Health—Monash University), CP 56 (Disability Discrimination Legal Service), CP 57 (Aged Care Assessment Service in Victoria) and CP 71 (Seniors Rights Victoria).
110 For eg, Submission CP 35 (Ursula Smith), who supported this option.
111 For eg, Submission CP 23 (Dr Kristen Pearson) (note the comments in this submission specifically excluded the situation of younger people).
112 Submission CP 23 (Dr Kristen Pearson).
Current processes involve assessment by ACAS, and frequently involve input from health professionals (including medical, social work, nursing, case managers etc) as well as oversight from family members/carers/friends and from the admitting facility.113

15.87 One response noted that the assessment processes undertaken by ACAS are driven by the need to determine the level of Commonwealth funding for the person in question.114

15.88 Eastern Health’s submission suggested that there is no need for specific laws if the person lacks capacity but everyone agrees to place the person in residential care.115 It considered that laws would be ‘too heavy handed’, especially if there is no conflict about the decision.116

Expansion of automatic appointment provisions with safeguards

15.89 Many submissions supported the option of allowing family members and carers to authorise some deprivations of liberty in their capacity as the automatically appointed person responsible for providing substitute consent to medical treatment. Reasons given for supporting an extension to the powers available under the automatic appointment scheme included:

• to provide stricter controls and greater scrutiny117
• to provide certainty about who can make the decision and avoid delays118
• to help protect against de facto decision making by service providers.

15.90 The Public Advocate, who did not support this option overall, noted that it would have the advantage of avoiding an excessively high administrative burden.119

15.91 The submission of Victoria Legal Aid stated that:

VLA often receives phone calls from persons living in aged care facilities who feel they are ‘trapped’ in these facilities by family members who do not wish them to return home. Although this problem in itself cannot be solved through the expansion of s 37 of the [G&A] Act, this would at least create stricter controls and a more transparent process.

15.92 Aged Care Assessment Service in Victoria submitted that:

This process informally occurs now where the next of kin/family are asked to accept responsibility for a decision, or carer/family declare they are unwilling to retain a role in caring for the person at home, thus decision is made for residential care. Currently there is no scrutiny of this process.

The additional dilemma exists where people have no recognised relationships as defined in ‘person responsible’ e.g. marginalised people. The ACAS–OPA protocols and the Department of Health and Ageing support alternative arrangements that should be considered when changing this law.120

15.93 The Catholic Archdiocese of Melbourne supported giving the person responsible power to make accommodation decisions where those decisions are relevant to the health care available to the person in combination with additional safeguards.121

113 Ibid.
114 Consultation with Royal District Nursing Service (9 March 2011).
115 Submission CP 33 (Eastern Health).
116 Ibid.
117 For eg, Submissions CP 57 (Aged Care Assessment Service in Victoria) and CP 73 (Victoria Legal Aid).
118 For eg, Submission CP 43 (Alfred Health).
119 Submission CP 19 (Office of the Public Advocate).
120 Submission CP 57 (Aged Care Assessment Service in Victoria).
121 Submission CP 27 (Catholic Archdiocese of Melbourne).
Restrictions upon liberty in residential care

Additional safeguards for automatic appointees

15.94 In the consultation paper, the Commission suggested that additional safeguards could be needed if the automatic appointment scheme were expanded to permit the person responsible to make decisions about residential care.122 A range of possible safeguards was identified. They were:

- The person responsible should not be able to exercise their powers without medical certification that the represented person lacks capacity and is at risk of harm.
- Before making a decision, the person responsible should be required to consider and formally acknowledge the benefits of the placement for the person, whether a less restrictive alternative exists and the duration of the practice.
- The person responsible should be required to reconsider regularly if this form of accommodation is still necessary.
- The represented person or any interested party should be able to challenge the consent given by the person responsible and have the decision reviewed by VCAT.
- The person responsible’s consent should be deemed insufficient if the represented person is actively refusing, or resisting, admission to the facility, or was resisting staying there or actively requesting to leave the facility, thereby requiring a decision by VCAT to appoint a guardian to authorise the represented person’s continuing residence in the facility.
- The Public Advocate should be notified that the person responsible has made a decision about accommodation. The Public Advocate could be permitted to undertake random audits of the way that these decision makers have exercised their powers and responsibilities and conduct an annual review of the ongoing need for these arrangements.
- The automatic appointment process would not apply if an admission or detention procedure under another piece of legislation was applicable, such as under the Disability Act or the Mental Health Act.
- There should be restrictions on the types of residential facility for which an automatic appointee’s consent would be sufficient.

15.95 A number of organisations considered that all the possible safeguards were appropriate and necessary.123 Seniors Rights Victoria submitted that the introduction of these safeguards, combined with an education program for medical professionals would be important because:

current practice in relation to medical decision-makers often involves an element of ageism, in that elderly spouses are regularly discounted by staff at medical facilities or carers when a person responsible is needed. This, combined with the potential for a conflict between the represented person and family members in relation to decisions to admit the older person into care, increases the risk of abuse and the need for the types of safeguards discussed in the Consultation Paper.124

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122 These safeguards are detailed on pages 283 and 284 of the consultation paper.
123 For eg, Submissions CP 21 (Action for More Independence & Dignity in Accommodation), CP 57 (Aged Care Assessment Service in Victoria), CP 71 (Seniors Rights Victoria) and CP 75 (Federation of Community Legal Centres (Victoria)).
124 Submission CP 71 (Seniors Rights Victoria).
15.96 Action for More Independence & Dignity in Accommodation also considered that all the safeguards are necessary and supported allowing the person responsible to make decisions about residential care only with these safeguards in place. It strongly supported the safeguard that any person should be able to challenge the consent given by the person responsible. It submitted that this safeguard should be strengthened beyond the situation where a represented person is actively resisting, refusing admission or asking to leave as:

this relies on a person being capable of resisting staying in a facility or actively requesting to leave. Many people are not capable of such active resistance either due to the level of their disability or fear of the consequences of resisting. We would add to this safeguard that VCAT can find the person responsible consent to be insufficient if the person admitted is displaying any behaviour which would indicate they are unhappy about going to or staying in the facility.125

15.97 In contrast, other community responses argued that requiring VCAT to appoint a guardian in these circumstances might be an overly burdensome and impractical safeguard.126 Autism Victoria submitted:

What person if anxious would not actively resist moving their place of residence? This would be unreasonable for carers to keep caring for a person with limited decision making capacity in their own home beyond what they can cope with. Carers’ wishes have to be equally considered.127

15.98 Some submissions suggested that an appropriate additional safeguard would be an ACAS assessment for a recommendation about the type of care that would be suitable to help ensure that there is not a more appropriate placement available.128

15.99 Victoria Legal Aid suggested that, in formulating a safeguard that related to the type of residential facility, it was important that:

consideration should be given to allowing automatic consent for admission to certain types of residential facilities only in certain situations (such as moving a person aged over 80 into an aged care facility). Where it is proposed to place a represented person in a residential facility in circumstances where they do not fall within the primary eligibility criteria for that facility (eg a person aged under 65 in a residential aged care facility), VLA suggests that automatic consent should not be sufficient and that VCAT should be required to determine whether there is any more appropriate placement reasonably available. The VCAT determination should be required prior to any such move taking place.129

15.100 The Public Advocate did not support the option that an automatic appointee be empowered to make these decisions. However, should this option be adopted, her submission supported the introduction of the safeguards proposed by the Commission.130 The Public Advocate did not support safeguards that involved the Public Advocate being notified of the use of these powers by automatic appointees, suggesting that the administrative burden of this task outweighed its usefulness. The Public Advocate observed that ‘it is the times the Public Advocate is not notified that would be the situations of greatest concern’.131 The Law Institute of Victoria also noted that the Public Advocate may not have the resources or capacity to perform this role or the jurisdiction to act under the Aged Care Act 1997 (Cth). It was suggested that the Office of the Senior Practitioner might be better placed to perform this role.132

126 Submissions CP 24 (Autism Victoria) and CP 35 (Ursula Smith).
127 Submissions CP 24 (Autism Victoria).
128 For eg, Submissions CP 57 (Aged Care Assessment Service in Victoria) and CP 73 (Victoria Legal Aid).
129 Submission CP 73 (Victoria Legal Aid).
130 Submission CP 19 (Office of the Public Advocate).
131 Ibid.
132 Submission CP 84 (Law Institute of Victoria—Supplementary Submission).
15.101 The Public Advocate proposed two additional safeguards:

- The Public Advocate should be advised when a person is consistently objecting to an accommodation decision.
- The Public Advocate should receive and investigate complaints about the exercise of power by persons responsible. In appropriate cases, the Public Advocate would be able to apply to VCAT for an order removing the person responsible from having decision-making authority.\(^{133}\)

15.102 The Public Advocate also suggested legislative articulation of the principles that should guide facilities which utilize those restrictions that may be considered to be deprivations of liberty.

Such legislative articulation would put the onus on facilities to name restrictive practices as such, and to justify their use by pointing to the absence of less restrictive options.\(^{134}\)

15.103 The Law Institute of Victoria did not support the option of extending the use of automatic appointment provisions with additional safeguards. However, the submission did consider what safeguards would be required if this did occur. The submission proposed that medical certification should take the form of a statutory declaration and there should be guidance to practitioners as to matters to consider. It also suggested that certification should be built into ACAS processes and should not be an additional state-based requirement.\(^{135}\)

15.104 The Law Institute of Victoria noted that oversight by an impartial authority or judicial body would require significant resources. It suggested ‘a staged approach … whereby initial resources are committed to undertaking a scoping of the need for independent oversight’.\(^{136}\) Although the submission raised concerns about the Public Advocate’s capacity to undertake a monitoring role, it suggested that as an interim measure the Public Advocate ‘could undertake a monitoring role with powers to investigate any abuses for the purpose of seeking guardianship or administration’.\(^{137}\) It considered that the Public Advocate would require a substantial increase in resources to perform this role.

### Residential facilities to be included

15.105 Some submissions considered the facilities that should be covered by an automatic appointment scheme.\(^{138}\)

15.106 The Public Advocate suggested:

> The residential facilities to which an expanded person responsible scheme might apply would include all government funded and supported accommodation settings as well as all government regulated settings. It would not apply to those facilities that are subject to higher-level safeguards, such as those accommodation settings where people are detained under disability or mental health legislation.\(^{139}\)

15.107 Action for More Independence & Dignity in Accommodation submitted that it should only apply to ‘the types of residential facility … where the person will receive a level of health and personal care’.\(^{140}\)

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133 Submission CP 19 (Office of the Public Advocate).
134 Ibid.
135 Submission CP 84 (Law Institute of Victoria—Supplementary Submission).
136 Ibid.
137 Ibid.
138 For eg, Submissions CP 19 (Office of the Public Advocate), CP 24 (Autism Victoria), CP 33 (Eastern Health), CP 35 (Ursula Smith), CP 47 (Dr Michael Murray) and CP 59 (Carers Victoria).
139 Submission CP 19 (Office of the Public Advocate).
15.108 Aged Care Assessment Services Victoria considered that ‘[a]ny residential facility that can meet the level of care required by the person should fall within this scheme’. However, it considered that:

[an] exception to the facilities that fall within this scheme should be psychogeriatric units as they are specialised and most restrictive in their care. Under the Mental Health Act a Consultant Psychiatrist can also recommend accommodation as part of a Treatment Order.

Problems with use of automatic appointment provisions

15.109 A number of organisations did not support extending the automatic appointment scheme, even with safeguards, to permit the person responsible to make accommodation decisions that involve a deprivation of liberty.

15.110 The major reasons for this opposition were:

• Medical treatment decisions currently made under the person responsible scheme are governed by medical professional norms, whereas accommodation decisions may not be.

• Medical treatment decisions currently made under the person responsible scheme are generally discrete short-term decisions, whereas accommodation decisions may involve ongoing responsibility for decisions.

• Medical treatment decisions currently made under the person responsible scheme are generally focused on a single issue, whereas decisions about a person’s accommodation may involve multiple factors leading to insufficient focus on considerations about limitations on freedom.

• The person responsible may not be the most appropriate person to make this decision and automatic appointments may inappropriately prioritise some family relationships over others.

• There is potential for a conflict of interest between the person responsible and the person to whom the decision relates.

• It is inappropriate to give decisions that are currently made informally, and have the potential to compromise the rights of a person with a disability, elevated legal status.

15.111 The Law Institute of Victoria expressed concern that the proposed safeguard of requiring a person responsible to sign a declaration confirming that they have considered all relevant matters might become a formality without practical effect.

15.112 A number of submissions considered that the existing person responsible hierarchy would be appropriate if the scheme was extended with safeguards to allow decisions about accommodation involving deprivations of liberty.

141 Submission CP 57 (Aged Care Assessment Service in Victoria).
142 Ibid.
143 For eg, Submissions CP 19 (Office of the Public Advocate), CP 65 (Council on the Ageing Victoria), CP 66 (Victorian Equal Opportunity and Human Rights Commission) and CP 84 (Law Institute of Victoria—Supplementary Submission).
144 For eg, Submissions CP 19 (Office of the Public Advocate) and CP 84 (Law Institute of Victoria—Supplementary Submission).
145 For eg, Submissions CP 66 (Victorian Equal Opportunity and Human Rights Commission) and CP 86 (Anne Kennedy).
146 For eg, Submissions CP 19 (Office of the Public Advocate), CP 65 (Council on the Ageing Victoria), CP 84 (Law Institute of Victoria—Supplementary Submission).
147 For eg, Submissions CP 19 (Office of the Public Advocate), CP 84 (Law Institute of Victoria—Supplementary Submission).
148 For eg, Submissions CP 19 (Office of the Public Advocate) and CP 84 (Law Institute of Victoria—Supplementary Submission).
149 For eg, Submissions CP 19 (Office of the Public Advocate), CP 65 (Council on the Ageing Victoria) and CP 84 (Law Institute of Victoria—Supplementary Submission).
150 Submission CP 84 (Law Institute of Victoria—Supplementary Submission).
151 For eg, Submissions CP 21 (Action for More Independence & Dignity in Accommodation), CP 24 (Autism Victoria), CP 33 (Eastern Health) and CP 35 (Ursula Smith).
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15.113 Submissions from the Public Advocate and the Law Institute of Victoria suggested that the hierarchy would need to ensure that enduring guardians or guardians with accommodation powers took priority over other individuals.\textsuperscript{152}

**Deprivation of liberty safeguards**

15.114 A number of community responses supported the introduction of a modified version of the deprivation of liberty safeguards model used in England and Wales.\textsuperscript{153}

15.115 The Victorian Equal Opportunity and Human Rights Commission said that the strictest possible safeguards were required rather than a simple solution to ensure that decisions are reasonable, proportionate and justified as required by the Charter. The commission observed that while deprivation of liberty safeguards may be extremely resource intensive, this type of approach is the only way to protect the rights of the people concerned.\textsuperscript{154}

15.116 The Public Advocate considered the deprivation of liberty safeguards introduced in England and Wales to be ‘unduly administratively burdensome’ but supported a simplified version of the scheme.\textsuperscript{155}

**THE COMMISSION’S VIEWS AND CONCLUSIONS**

15.117 Many Victorians now live in supported residential care and, as discussed in Chapter 4, the number of people living in these facilities will increase substantially over the next few decades. Some of these people are unable to make their own accommodation decisions because they have impaired decision-making ability due to a disability. It appears that family members and carers often make decisions about living arrangements for these people informally. In some instances, VCAT appoints a guardian to make place of residence decisions for a person who is reluctant to move from home or hospital into supported residential care.

15.118 The Commission is not proposing any changes to these practices even though the existing informal arrangements clearly lack any legal foundation. The circumstances in Victoria are not the same as those in England and Wales where statutory processes—the Deprivation of Liberty Safeguards—now apply to people who lack the capacity to consent to living in publicly funded supported residential care facilities. These statutory processes were the United Kingdom Government’s response to the European Court of Human Rights decision in Bournewood and to the requirement in the European Convention on Human Rights that the United Kingdom Government take action to secure the rights breached in Bournewood.

15.119 The Victorian legal environment is different. There has been no local equivalent to the Bournewood decision and the Victorian Charter does not oblige the Government to take action to secure any rights when a court finds that they have been breached. Failure to act in these circumstances would have political rather than legal consequences.

15.120 The Commission does not believe that there is widespread support for new formal processes to govern place of residence decisions for every person who lacks the capacity to consent to living in supported residential care. The existing combination of informal arrangements and formal decisions by VCAT-appointed guardians in some difficult cases appears to operate reasonably well for the moment. However, the Commission urges the Attorney-General to keep the practice of relying upon informal agreement under attention as the number of people with impaired decision-making capabilities continues to increase.

\textsuperscript{152} Submissions CP 19 (Office of the Public Advocate) and CP 84 (Law Institute of Victoria—Supplementary Submission).

\textsuperscript{153} For eg, Submissions CP 19 (Office of the Public Advocate) and CP 66 (Victorian Equal Opportunity and Human Rights Commission).

\textsuperscript{154} Submission CP 66 (Victorian Equal Opportunity and Human Rights Commission).

\textsuperscript{155} Submission CP 19 (Office of the Public Advocate).
ability who move to supported residential care increases. The Public Advocate is well placed to advise the Attorney-General of the need for any change to the current arrangements.

15.121 Some of the people who live in supported residential care and who lack the capacity to consent to their own living arrangements experience substantial restraints upon their movements that are not authorised or regulated in any way. The Public Advocate has pointed to ‘the need for Victoria (and indeed Australia) to better regulate the means by which people with disabilities are subjected to some degree of “deprivation of liberty” or are subjected to unregulated or under-regulated restrictive interventions’.156

15.122 The Commission believes that it is necessary to devise appropriate means of regulating deprivations of people’s liberty while they are living in supported residential care. While there is no evidence of substantial numbers of people making applications for a writ of habeas corpus or taking action for false imprisonment, many existing practices are not ‘legislatively authorised and subject to review’.157 Nonetheless, it is important to protect the interests of vulnerable people and to ensure that they are deprived of their liberty only in circumstances where it has been authorised for their own welfare. There should also be appropriate checks and balances in place to ensure appropriate use of these powers. These things are not happening now.

15.123 The Commission has not identified any means of regulating these practices in other jurisdictions that it recommends for adoption in Victoria. The English and Welsh Deprivation of Liberty Safeguards are not supportable. Extending the authority of a person responsible for providing consent to medical treatment to making deprivation of liberty decisions for a person in supported residential care is not an attractive option because of the potential for too many conflicts of interests and because it values liberty too lightly. While the appointment of a guardian has theoretical appeal, it is not a practical solution to an issue of increasing magnitude. The reasons for rejecting these options are examined in more detail below.

PROBLEMS WITH THE UNITED KINGDOM APPROACH

15.124 The Commission believes that introducing a Victorian version of the Deprivation of Liberty Safeguards scheme would be extremely expensive and administratively burdensome.

15.125 While rigorous, the English and Welsh process is particularly complex, time-consuming and resource intensive. The Commission understands that some assessments take much longer than originally anticipated, leading to increased costs.158 Annual assessments take at least 10 hours and sometimes up to 18 hours.159 These detailed assessments, which require at least two assessors, also have the potential to cause a great deal of stress to the person concerned.160

15.126 There are also inconsistencies in the application of Deprivation of Liberty Safeguards across England and Wales. Some areas have a high number of applications, whereas others have very few,161 perhaps because of differing views about the meaning of ‘deprivation of liberty’.162

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156 Submission CP 19 (Office of the Public Advocate).
157 Ibid.
158 Consultation with Office of the Public Guardian (United Kingdom); Social Care Institute for Excellence and Department of Health (United Kingdom) (17 November 2010).
160 Deprivation of Liberty Safeguards: Code of Practice, above n 94, 41.
162 See Peter Lepping, Rajvinder Singh Sambhi, Karen Williams-Jones, ‘Deprivation of Liberty Safeguards: How Prepared Are We?’ (2010) 36 Journal of Medical Ethics 170–1 on the difficulties associated with identifying a deprivation of liberty and the issue of whether the motive of the detaining authority is relevant in assessing whether a deprivation of liberty has occurred.
Chapter 15

Restrictions upon liberty in residential care

15.127 The Deprivation of Liberty Safeguards have been criticised by a respected commentator as being ‘complex, voluminous, overly bureaucratic and difficult to understand’ and were described as a ‘significant and costly error’.163

PROBLEMS WITH THE AUTOMATIC APPOINTMENT OF ONE DECISION MAKER

15.128 Many responses to the consultation paper referred to the risks associated with extending the reach of the scheme for automatically appointing a substitute decision maker for medical treatment decisions to residential care decisions. This proposal would enable the person responsible to consent to the living arrangements in a supported residential facility for a person who is unable to make their own decision about these matters without any additional oversight.

15.129 The Commission accepts that there is a greater risk of a conflict of interest for a person responsible when making residential care decisions than when making medical treatment decisions because a person responsible might benefit from deciding that a family member should live in supported residential care in circumstances that involve a deprivation of their liberty. In addition, while medical treatment decisions under the automatic appointment provisions are regulated by the professional considerations that govern medical practice, there are no equivalent controls when making decisions about living arrangements that involve a total restraint of liberty.

USE OF GUARDIANSHIP

15.130 The Commission considers that people should be encouraged to appoint an enduring personal guardian to make decisions about living arrangements with the power to authorise restrictions upon their liberty that promote their health or safety. To avoid doubt, new guardianship legislation should indicate that it is possible for a person to give an enduring personal guardian the power to authorise deprivations upon liberty of the person when living in supported residential care that promote their health or safety.

15.131 The Commission believes that when the tribunal appoints a personal guardian for a person with the power to make decisions about residential care it should consider whether to include an express power to authorise deprivations of liberty. To avoid doubt, new guardianship legislation should expressly permit the tribunal to give a personal guardian this power.

15.132 While it is important that personal guardians are clearly permitted to authorise deprivations of liberty for a person’s health or safety as part of residential care arrangements, it is unlikely that guardianship will be an effective means of dealing with most instances in which these practices occur because of the numbers of people involved.

**RECOMMENDATIONS**

**Legal procedures for decisions involving restrictions upon liberty**

232. New guardianship legislation should permit a person with capacity to appoint an enduring personal guardian to make decisions for them about supported residential care that include authorising a restriction upon liberty in order to promote the health or safety of the person.

233. New guardianship legislation should permit the tribunal to appoint a personal guardian to make decisions about supported residential care, for a person who satisfies the criteria for the appointment of a personal guardian, that include authorising a restriction upon liberty in order to promote the health or safety of the person.

**A NEW COLLABORATIVE AUTHORISATION PROCESS**

15.133 The Commission believes that a new collaborative mechanism should be devised for regulating deprivations of liberty of people who are living in supported residential care and who lack the capacity to consent to restrictive living arrangements that are used to promote their health or safety. This mechanism should be as efficient as possible bearing in mind the significance of depriving a person of their liberty, even for their own welfare.

15.134 This new mechanism should complement the steps available under existing guardianship laws. It should continue to be possible for people to rely upon the authorisation of a personal guardian for these practices when an appointment has been made prior to the time at which restrictive living arrangements appear necessary or when there is disagreement about the need for them. This new mechanism should replace the informal arrangements that are currently relied upon in many instances. It would also overcome the need to apply to VCAT for the appointment of a personal guardian to authorise restraints upon liberty when a number of people with an interest in the wellbeing of the person concerned believe that some restrictive living arrangements are necessary.

15.135 The Commission believes that the new mechanism should have the following features. It should:

- describe how the decision about a restriction upon liberty will be made if the person concerned is objecting but lacks capacity to make the decision
- describe how this decision should be made if the person does not have the capacity to make it but appears compliant
- describe the facilities in which the procedure can be used
- include principles to guide how and when this procedure should be used
- include principles to guide how decisions should be made collaboratively
- describe the situations in which the decision must be referred to the tribunal.

**RECOMMENDATION**

**A new collaborative authorisation process**

234. New guardianship legislation should establish a collaborative mechanism for authorising restrictions upon the liberty of people who are living in supported residential care and who lack the capacity to consent to restrictive living arrangements that are used to promote their health or safety.
Restrictions upon liberty in residential care

RELEVANT FACILITIES

15.136 The Commission believes that new guardianship legislation should identify the supported residential facilities in which it is permissible to rely upon the proposed collaborative process to authorise restrictions upon the liberty of a person who lacks the capacity to make their own decisions about these matters when those restrictions are imposed for their health or safety. The collaborative process would obviate the need for a guardianship application when there was no guardian with the necessary powers to authorise these restrictions and it would provide the facilities in question with clear legal authority to take actions that are now undertaken informally, sometimes in circumstances that might expose them to legal risk.

15.137 Many Victorians live in facilities that provide supported residential care. Some people living in these facilities experience significant restrictions upon their movements—such as being locked or effectively locked in premises, or being strapped or wrapped into chairs—in order to protect them from harm. As discussed earlier in the chapter, many of these facilities, especially those with residents that receive some form of public funding for their accommodation, are closely regulated by the Commonwealth and Victorian governments. The proposed collaborative process should be available for use in facilities that are effectively regulated. It is not appropriate that the process should be available for use in other supported residential facilities that operate under limited regulation. Those facilities should be obliged to comply with existing laws that govern deprivations of liberty.

15.138 The Commission believes that the Victorian Government should identify the supported residential facilities in which it is permissible to rely upon the proposed collaborative process to authorise restrictions upon liberty. This matter will involve collaboration with the Commonwealth Government because of its significant role in the area of aged care accommodation.

RECOMMENDATION

Relevant facilities

235. New guardianship legislation should describe the residential facilities in which the collaborative mechanism for authorising restrictions upon liberty can be used.

IDENTIFYING A RESTRICTION UPON LIBERTY

15.139 The restrictions upon liberty that should be capable of being authorised by the proposed collaborative mechanism are those which would otherwise be unlawful. This means that it should be possible to use the mechanism to authorise actions that would in the absence of legal authority cause a person to succeed in an action for false imprisonment or would result in an order for release in habeas corpus proceedings.

15.140 While the manner in which ‘restrictions upon liberty’ is described in new guardianship legislation is ultimately a matter for Parliamentary Counsel, the Commission suggests there may be benefit in an approach that does not seek to define ‘restrictions upon liberty’ in detail but which permits the use of practices that would be unlawful unless authorised.
15.141 While this suggested approach is legally useful because it renders lawful actions that would otherwise be unlawful, it provides insufficient guidance to people who work in supported residential facilities about the practices that fall within the proposed collaborative mechanism. As noted earlier, one of the many difficulties associated with the English Deprivation of Liberty Safeguards has been the lack of clarity about what constitutes a deprivation of liberty in a residential setting.

15.142 It could be beneficial to highlight in legislation some common practices and activities that do not amount to a restriction upon liberty which requires authorisation. For example, if a person is restricted to a particular location because of their own physical limitations, rather than because of measures taken by the residential facility, this would not be a ‘restriction of liberty’.

15.143 The Commission proposes two means of assisting people to identify those practices that amount to a restriction upon liberty. First, the Commission recommends that the Public Advocate should be required to develop guidelines in consultation with appropriate professional groups that identify practices undertaken in supported residential facilities that are a restriction upon liberty and that should be authorised when imposed without consent. Secondly, any person should be permitted to apply to the tribunal for advice about whether a particular practice is a restriction upon liberty that requires authorisation.

**RECOMMENDATIONS**

**Identifying a restriction upon liberty**

236. New guardianship legislation should describe those restrictions upon liberty that can be authorised by use of the collaborative mechanism.

237. The Public Advocate should develop guidelines in consultation with appropriate professional groups that identify practices undertaken in supported residential facilities that are a restriction upon liberty and that should be authorised when imposed without consent.

238. Any person with a genuine interest in the personal and social wellbeing of a person living in a relevant facility should be permitted to apply to the tribunal for directions about whether a particular action is a restriction upon liberty that requires authorisation.

**GUIDELINES FOR FACILITIES**

15.144 The Commission believes that new guardianship legislation should require relevant residential facilities to identify when a person living at that facility is experiencing, or is likely to experience, a restriction upon their liberty which requires authorisation. This step can be taken by following a statutory process.
Chapter 15

Restrictions upon liberty in residential care

RECOMMENDATIONS

Guidelines for facilities

239. New guardianship legislation should require relevant residential facilities to identify when a person is experiencing, or is likely to experience, a restriction upon liberty in their facility and take steps to seek authorisation for this restriction upon liberty.

240. New guardianship legislation should include a process to guide facilities that engage in practices that involve restrictions upon liberty:

(a) Facilities should identify any restrictive practices that may be used for a particular individual and consider whether less restrictive options are available.

(b) Restrictive practices should not be used for the convenience of staff.

(c) Any restrictions used should be in place for the shortest possible time.

(d) Facilities should inform the health decision maker of any changes to accommodation arrangements that are likely to result in a restriction upon liberty or before using different restrictive practices.

A COLLABORATIVE AUTHORIZAION PROCESS

15.145 The Commission believes that relevant supported residential facilities should be permitted to rely upon a three-person collaborative authorisation process when the living arrangements for a person who lacks the capacity to make their own decisions about accommodation involve restrictions upon their liberty that are imposed for their own health or safety. The people who should be permitted to participate in the collaborative authorisation process are:

- the person in charge of the residential facility
- a medical practitioner or other health practitioner approved by regulation
- the person’s health decision maker.\(^{165}\)

15.146 The requirement that three people participate in the collaborative decision-making and authorisation process seeks to reflect the significance of allowing anyone other than a court or tribunal to authorise the deprivation of a person’s liberty. It also seeks to address concerns that two of three nominated people who will usually be involved in the on-going care of a person with these living arrangements might sometimes experience conflicts of interest.

15.147 The appearance of a conflict of interest is often just as important as an actual conflict when dealing with significant issues. Sometimes a person who is a health decision maker might appear to benefit if a family member or person for whom they care is unable to leave a supported residential facility in which they are living. Sometimes the staff at the facility might appear to benefit if the movements of some of the people for whom they care are restricted. In these circumstances, apparent and actual conflicts of interest are minimised by having a shared decision-making process. In order to ensure shared responsibility for decisions, it should not be possible for anyone to have more than one role in the process.

\(^{165}\) In Chapter 5, the Commission proposes the term ‘health decision maker’ replace the term ‘person responsible’ used in Part 4A of the Guardianship and Administration Act 1986 (Vic) and that this person continue to be an automatically appointed substitute decision maker for medical treatment decisions.
**Person in charge of the facility**

15.148 The first person in the collaborative decision-making process should be the person in charge of the facility. A valuable feature of the Deprivation of Liberty Safeguards in England and Wales is the duty on the residential facility to identify people who are or are likely to be deprived of their liberty and to initiate the authorisation process.

15.149 The person in charge of the facility should also be responsible for arranging for the second person in the collaborative decision-making process—a medical practitioner or other approved health practitioner—to assess the person’s capacity and to consider whether the restriction upon liberty is necessary for the person’s health or safety.

15.150 The person in charge of the facility should also be responsible for providing the third person in the collaborative decision-making process—the health decision maker—with information that:
- identifies the circumstances in which the proposed restriction of liberty is to be used
- identifies the duration of the proposed restriction of liberty, and
- indicates why the proposed restriction upon liberty is necessary for the health or safety of the person.

**Medical practitioner or other approved health practitioner**

15.151 The second person in the collaborative decision-making process is a medical practitioner, or other health practitioner approved by regulation, who would be required to make two assessments. They are, first, whether the person has the capacity to make their own decision about the restrictive living arrangements in question and, secondly, whether the restriction upon liberty is necessary for the health or safety of the person.

15.152 In order to maintain the integrity of the process, the legislation should provide that the medical practitioner should not have a financial interest in the residential facility.

15.153 When determining whether the restriction upon liberty is necessary for the health or safety of the person, the medical practitioner should be required to consider whether:
- the relevant restrictive practices that amount to a restriction of liberty are necessary to prevent harm to the person
- the restrictions are proportionate, reasonable and justified in the circumstances
- the benefits of the restrictions outweigh the risk of negative consequences to the person
- there are less restrictive options available.

**Health decision maker**

15.154 The third person in the collaborative decision-making process is the health decision maker. The health decision maker must agree to the proposed restriction upon liberty.

15.155 Many people thought that the hierarchy of automatic appointees for restriction of liberty decisions should be the same as the hierarchy for medical treatment decisions. The Commission agrees with this view. The scheme would be unworkable in practice if there were different hierarchies of automatic appointees for medical treatment and restriction of liberty decisions.
A role for the Public Advocate as health decision maker

15.156 In Chapter 13, the Commission recommends that the Public Advocate become the substitute decision maker of last resort for significant medical treatment decisions. The Commission believes that the Public Advocate should also become the health decision maker of last resort for the collaborative authorisation process.

RECOMMENDATIONS

A collaborative authorisation process

241. The collaborative mechanism for authorising restrictions upon the liberty of people who are living in supported residential care and who lack the capacity to consent to restrictive living arrangements that are used to promote their health or safety should require the approval of three people, who are:

(a) the person in charge of the residential facility
(b) a medical practitioner or other health practitioner approved by regulation
(c) the person’s health decision maker.

242. If a person is eligible for more than one role they may only act in one of the decision-making roles.

243. A person is not eligible to act in the role of health decision maker or medical practitioner if they have a financial interest in the residential facility.

The person in charge of the residential facility

244. The person in charge of the residential facility should be responsible for identifying a proposed or current restriction upon liberty for someone living within the facility.

245. In these circumstances the person in charge of the residential facility should arrange for a medical practitioner (or other approved health practitioner) to assess the person’s capacity and to consider whether the restriction upon liberty is necessary for the person’s health or safety. The person in charge of the facility should provide the health decision maker with a report that:

(a) identifies the circumstances in which the proposed restriction upon liberty is to be used
(b) identifies the duration of the proposed restriction upon liberty
(c) explains how the proposed restriction upon liberty is necessary for the health or safety of the person.
The medical practitioner

246. The medical practitioner (or other approved health practitioner) should be required to undertake two assessments:

(a) whether the person has the capacity to consent to the restriction upon their liberty
(b) whether the restriction upon liberty is necessary for the health or safety of the person.

247. When deciding if the restriction upon liberty is necessary for the health or safety of the person, the medical practitioner must determine whether:

(a) the relevant restrictive practices that amount to a restriction of liberty are necessary to prevent harm to the person
(b) the restrictions are proportionate, reasonable and justified in the circumstances
(c) the benefits of the restrictions outweigh the risk of negative consequences to the person
(d) there are any less restrictive options available.

The health decision maker

248. The health decision maker must agree to the proposed restriction upon liberty.

249. The hierarchy of health decision makers for restriction upon liberty decisions should be the same as the hierarchy for medical treatment decisions. If no-one is available to undertake this role, the Public Advocate should be the health decision maker in the collaborative authorisation process.

250. When deciding whether to agree to the proposed restriction upon liberty, the health decision maker should be required to consider the following matters:

(a) the assessments by the medical practitioner
(b) whether the restriction upon liberty is necessary for the health or safety of the person
(c) whether there are any less restrictive options available.

SAFEGUARDS

Applications to VCAT

15.157 There will be circumstances in which it is not appropriate to use the collaborative process to authorise restrictions upon the liberty of a person living in supported residential care or when there should be external review of the collaborative authorisation process.

15.158 The collaborative authorisation process should not be used when the person concerned consistently resists and opposes restrictions upon their liberty. In these circumstances, an application should be made to the tribunal to consider whether it is necessary to appoint a guardian to make decisions about restrictive living arrangements. If the collaborative authorisation process has been used to authorise restrictions and the person concerned consistently resists and opposes restrictions upon their liberty, the matter should also be referred to the tribunal for decision. The three people who participated in the authorisation process should be obliged to refer the matter to VCAT if they become aware that the person concerned is consistently resisting and opposing restrictions upon their liberty.
Restrictions upon liberty in residential care

15.159 The person whose liberty is restricted, or any person with a genuine interest in their wellbeing, should be permitted to apply to the tribunal for consideration of the matter—including use of the collaborative process to authorise those restrictions—or to refer the matter to the Public Advocate with the request that she investigate the matter and decide whether to apply to the tribunal for the appointment of a guardian.

**RECOMMENDATIONS**

**Applications to the tribunal**

251. The collaborative mechanism for authorising restrictions upon the liberty of people who are living in supported residential care should not be used in circumstances where the person concerned consistently resists and opposes restrictions upon their liberty.

252. If the collaborative authorisation process has been used to authorise restrictions upon the liberty of a person, the three people who participated in the authorisation process should be obliged to refer the matter to the tribunal if they become aware that the person concerned is consistently resisting and opposing restrictions upon their liberty.

253. A person living in supported residential care in circumstances where they are experiencing restrictions upon their liberty or any person with an interest in their wellbeing should be permitted to apply to the tribunal for consideration of these circumstances or inform the Public Advocate of their concerns and request that she investigate the matter.

**Duration of authorisations**

15.160 It is difficult to determine an appropriate period for the duration of any restrictions upon liberty that are authorised by use of the collaborative process. As indicated earlier, the Commission has sought to strike a balance between protecting vulnerable people and avoiding expensive and unhelpful bureaucratic obligations.

15.161 While the authorisation should not operate indefinitely, it should be reviewed at appropriate intervals and renewed when necessary. The Commission believes that an authorisation should be first reviewed within 12 months. Thereafter, it should be possible to make authorisations for a period of up to five years depending upon the circumstances of the particular case.

15.162 The Public Advocate should issue guidelines to assist people involved in the collaborative authorisation process to determine the appropriate period for any authorisation of a restriction upon liberty.
RECOMMENDATIONS

Duration of authorisations

254. Any authorisation of restrictions upon the liberty of people who are living in supported residential care made by use of the collaborative mechanism should not operate for more than 12 months in the first instance.

255. The continuing need for those restrictions should be reviewed within the 12-month period if the three people involved in the process believe that the authorisation should be extended.

256. Any review of the authorisation should follow the same process as the initial authorisation.

257. It should be possible to renew any authorisation for a period of up to five years.

258. The Public Advocate should issue guidelines to assist people involved in the collaborative authorisation process to determine the appropriate period for any authorisation of a restriction upon liberty.