



Victorian
Law Reform
Commission

People with Intellectual Disabilities
at Risk: A Legal Framework for
Compulsory Care
Report

Victorian Law Reform Commission

GPO Box 4637
Melbourne Victoria 3001
Australia
DX 144 Melbourne, Vic

Level 10
10-16 Queen Street
Melbourne Victoria 3000
Australia

Telephone +61 3 8619 8619
Facsimile +61 3 8619 8600
TTY 1300 666 557
1300 666 555 (within Victoria)
law.reform@lawreform.vic.gov.au
www.lawreform.vic.gov.au

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Preface

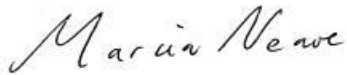
The recommendations in the Report are intended to provide a transparent and accountable legislative framework to regulate situations in which people with an intellectual disability may be detained or treated without consent. The Report recommends that similar legislation should be phased in to deal with people who have a cognitive impairment, such as acquired brain injury and autism spectrum disorder.

Production of the Report has been a team effort. Chris Dent, and Ian Parsons were involved in the consultation process and prepared early drafts of the Final Report. I thank them for their work. Padma Raman, CEO of the Commission also made a substantial contribution to early drafts. Dominique Saunders, Special Counsel at Russell, Kennedy provided advice throughout the project and she and Matthew Carroll, Acting CEO of the Victorian Law Reform Commission assisted in refining recommendations and in drafting sections of the Report during the final stages.

I am grateful for the assistance provided by Leah Bloch, an intern at the Commission who took responsibility for footnote checking and also contributed practical insights from her experience in caring for people with an intellectual disability. As always production of the Report was facilitated by a dedicated and efficient team, including Kathy Karlevski, Lorraine Pitman, and Simone Marrocco. Julie Bransden, the Commission's librarian, prepared the bibliography.

In addition to those participating in our consultation process, a number of people with relevant expertise shared their views with the Commission on various aspects of the project. They included Penny Armytage, (now Secretary, Department of Justice) Carmel Benham, Manager, Legislation Policy and Review, DHS, John Billings, Deputy President VCAT, Julian Gardner, Public Advocate, Dr Bill Glaser, John Lesser President, Mental Health Review Board of Victoria, Tracey O'Halloran, Manager, Multiple and Complex Needs Initiative, DHS, Arthur Rogers, Director, DHS, Sue Tait, President of the Intellectual Disability Review Panel, and Dr Ruth Vine, Director of Mental Health, DHS, and. I am grateful for

their help in thinking through the complex issues covered in this Report. The recommendations in the Report are, of course, those of the Commission.



Marcia Neave
Chairperson

ACKNOWLEDGMENTS

ADVISORY COMMITTEE

Mr John Billings, Deputy President, VCAT

Mr Julian Gardner, Public Advocate, Office of the Public Advocate

Dr Bill Glaser

Mr John Lesser, President, Mental Health Review Board of Victoria

Ms Dominique Saunders, DisAbility Services Legislation Policy and Review,
Russell Kennedy

Ms Sue Tait, President, Intellectual Disability Review Panel

Dr Ruth Vine, Deputy Chief Psychiatrist, Metropolitan Health & Aged Care
Division, Department of Human Services

Contributors

Authors	Professor Marcia Neave AO Chris Dent Ian Parsons Dominique Saunders
Editors	Valina and Tony Rainer
Victorian Law Reform Commission	
<i>Chairperson</i>	Professor Marcia Neave AO
<i>Commissioner</i>	Judith Peirce
<i>Part-time Commissioners</i>	Paris Aristotle AM Her Honour Judge Jennifer Coate The Honourable Justice David Harper Professor Felicity Hampel SC Professor Sam Ricketson Dr Iain Ross
<i>Chief Executive Officer</i>	Matthew Carroll
<i>Operations Manager</i>	Kathy Karlevski
<i>Policy and Research Officers</i>	Susan Coleman Kate Foord Nicky Friedman Angela Langan Hilary Little Siobhan McCann Victoria Moore Priya SaratChandran
<i>Project Officer</i>	Simone Marrocco
<i>Librarian</i>	Julie Bransden
<i>Administrative Officers</i>	Lorraine Pitman

Terms of Reference

The Victorian Law Reform Commission will:

1. Review existing provisions for the compulsory treatment and care of persons with an intellectual disability who are at risk to themselves and the community; and
2. Make recommendations on the development of an appropriate legislative framework for that compulsory treatment and care.

The legislative framework should include, amongst other things:

- the principles and objectives under which compulsory treatment and care would occur;
- the process for approving a facility where compulsory treatment and care can occur;
- the process for admission to such a facility;
- the process for routine and independent review that results in an enforceable decision;
- the process that a person can access to initiate a review;
- the definition of restraint and seclusion, the situations in which it can be applied and relevant reporting requirements; and
- whether there is a need for community based compulsory treatment and care.

In undertaking this reference, the Commission should have regard, amongst other things, to:

- the relevance of the legislative framework to people with other cognitive impairment such as acquired brain injury and dual disability (mental illness and intellectual disability)
- the relevance of whether a court order is present or not; and
- the process of transfers within the criminal justice system and between the criminal justice system and disability services.

Abbreviations

ABI	Acquired Brain Injury
AC	Appeal Cases (United Kingdom)
ACT	Australian Capital Territory
ch(s)	Chapter(s)
cf	compare
cl	clause
CLR	Commonwealth Law Reports
CMIA	<i>Crimes (Mental Impairment and Unfitness to be Tried) Act 1997</i> (Victoria)
DHS	Department of Human Services
DOJ	Department of Justice
DSA	<i>Disability Services Act 1991</i> (Victoria)
eg	for example
GAA	<i>Guardianship and Administration Act 1986</i> (Victoria)
HCA	High Court of Australia
HL	House of Lords
ibid	In the same place (as the previous footnote)
ie	that is
ICCPR	International Covenant on Civil and Political Rights
IDPSA	<i>Intellectually Disabled Persons' Services Act 1986</i> (Victoria)
IDRP	Intellectual Disability Review Panel
IQ	Intelligence Quotient
ITRP	Intensive Residential Treatment Program
J	Justice (JJ pl)
MHA	<i>Mental Health Act 1986</i> (Victoria)

MHRB	Mental Health Review Board
n	footnote
NSW	New South Wales
OPA	Office of Public Advocate
OPP	Office of Public Prosecutions
para	paragraph
pt(s)	part(s)
s	section (ss pl)
SA	South Australia
sch(s)	schedule(s)
SFS	Statewide Forensic Service
VCAT	Victorian Civil and Administrative Tribunal

Summary

WHAT PROBLEMS DOES THE REPORT ADDRESS?

This Report deals with two types of decisions that affect people who have an intellectual disability or a cognitive impairment (for example an acquired brain injury or an autism spectrum disorder). First, it deals with decisions to detain people without their consent in a prescribed facility, so that they can be provided with services and programs in order to reduce a significant risk that they may seriously harm others.

Secondly, it deals with decisions about restrictive care practices that affect the freedom of people who have an intellectual disability. The practices that are considered in the Report include ‘mechanical restraint’, (for example using a belt to restrain a person to prevent self-injury or injury to others), ‘chemical restraint’, which involves prescribing a person drugs to change that person’s behaviour, and ‘seclusion’, which involves locking a person in a room apart from other people. These practices are currently used to prevent a person from harming him or herself or others. In April 2002 restraint or seclusion measures were applied to 1285 people using Department of Human Services (DHS) services. It is likely that this figure is underestimated.

The Report does not deal with ordinary medical treatment decisions, which are adequately covered by the *Guardianship and Administration Act*.

In 2001 the *Report of the Review Panel Appointed to Consider the Operation of the Disability Services Statewide Forensic Service* (the Vincent Review), which was chaired by Justice Frank Vincent, drew attention to deficiencies in the legislative and administrative framework for monitoring and controlling use of detention and restrictive practices affecting people with an intellectual disability. The recommendations in the Report are intended to provide a transparent and accountable system that protects rights and liberties but also to safeguard people with a disability, and the community, against the risk of serious harm.

Recommendations on detention apply to detention of people with either an intellectual disability or a cognitive impairment. Recommendations that propose controls on use of restrictive practices apply only to people with an intellectual disability. However the Report recommends that a similar framework be phased in for people with a cognitive impairment.

DETENTION DECISIONS

PROBLEMS WITH THE CURRENT LAW

At present a small number of people with an intellectual disability who exhibit behaviour that may seriously harm others, for example predatory sexual behaviour towards children, are detained in facilities such as Statewide Forensic Services (SFS). SFS provides programs to assist people with an intellectual disability to modify their behaviour.

Some people are placed in SFS following conviction for a criminal offence, but remain there after their sentence expires. A detained person's guardian may agree to the detention, or the person may consent to remaining there.

The Vincent Review said that a more transparent process for authorising detention should be introduced. The appointment of a guardian is an unsatisfactory means of authorising detention. Guardians face a conflict of interest if they are asked to agree to a person living in a secure facility, to prevent such person harming others. Where detention is based on 'consent' of the detained individual, the consent may not be real, because of the person's disability.

RECOMMENDATIONS

The Report:

- establishes statutory criteria for detention, permitting it only as a last resort, when the significant risk that the person will seriously harm others cannot be reduced by less restrictive measures;
- requires preparation of a detention plan, indicating the services and programs that will be provided to the person during detention and how the person will benefit from them;
- requires approval of detention by a Victorian Civil and Administrative Tribunal (VCAT) panel comprising a judge and a person with expertise in the area of intellectual disability or cognitive impairment;
- provides that the term of a detention order cannot exceed five years; and
- requires VCAT to review detention orders every six months.

SENIOR CLINICIAN

The Report proposes creation of an Office of Senior Clinician, which is independent from, but resourced by, DHS. The Office of Senior Clinician will report annually to the Minister who must table the Report in parliament. The functions of the Office of Senior Clinician will include arranging for assessment of people proposed to be detained, and making applications for detention to VCAT.

RESTRICTIVE CARE DECISIONS

PROBLEMS WITH THE CURRENT LAW

Section 44 of the *Intellectually Disabled Persons' Services Act 1986* imposes some controls on the use of restraint and seclusion. Except in an emergency, restraint and seclusion can only be used where it is authorised in the person's individual program plan and approved by an authorised officer of the Department of Human Services. These requirements must be satisfied even where the person has a guardian who has consented to use of restraint or seclusion.

Use of restraint and seclusion must be reported to the Intellectual Disability Review Panel each month. A person can appeal to the Intellectual Disability Review Panel against use of restraint and seclusion.

It is widely agreed that the Act does not adequately control use of restraint and seclusion. The Intellectual Disability Review Panel lacks capacity to monitor these practices, and cannot make binding decisions. The right to seek review of a decision to use restraint and seclusion is of limited use to people with an intellectual disability.

RECOMMENDATIONS

The Report:

- proposes detailed statutory criteria for use of mechanical and chemical restraint and seclusion;
- requires DHS to arrange for the preparation of a care plan for the person, indicating how particular measures will be used to manage the person's behaviour;
- requires the care plan to be approved by the Office of Senior Clinician; and
- requires the Office of Senior Clinician to review care plans providing for restraint and seclusion annually.

Provision is made for emergency use of restraint and seclusion.

The Report also proposes the adoption of statutory criteria regulating use of physical restraint, and requires the Office of Senior Clinician to develop guidelines indicating the circumstances in which a service provider should have a locked door policy.

It recommends that an annual medical report should be prepared for all people receiving services under the *Intellectually Disabled Persons' Services Act 1986* (IDPSA) and provided to the Office of Senior Clinician.

INTERACTION BETWEEN THE CRIMINAL JUSTICE SYSTEM AND THE HUMAN SERVICES SYSTEM

PROBLEMS WITH THE CURRENT LAW

CRIMES (MENTAL IMPAIRMENT AND UNFITNESS TO BE TRIED) ACT 1997

Under the *Crimes (Mental Impairment and Unfitness to Be Tried) Act 1997* (CMIA) a court can find that people are unfit to stand trial or should not be convicted of an offence because of their mental impairment. If they are found not guilty, the court can make a custodial supervision order committing them to custody in a prison or another appropriate place, or a non-custodial supervision order releasing them on conditions specified by the court. Although the defence of mental impairment applies to people who are tried for offences in the Magistrates' Court, magistrates cannot make supervision orders, and must discharge a person who is found not guilty because of mental impairment, even if the person is in need of care because of an intellectual disability and behaves in a way that exposes others to risk of harm.

JUSTICE PLANS

People with an intellectual disability may, upon being found guilty of an offence punishable by imprisonment or a fine greater than \$500, may be placed on a community based order. As a condition of a such order they may be required to comply with the provisions of a justice plan. The justice plan may include a condition requiring them to reside at the SFS facility or in a locked residential facility or to participate in a program designed to modify their behaviour.

Because justice plans are linked to community based orders they cannot last for more than two years. It may take longer than this to assist a person with an

intellectual disability to change their behaviour, so they do not re-offend. Justice plans cannot be used for people with a cognitive impairment who have committed offences.

SENTENCING LIMITATION

Under the *Sentencing Act 1991* a court can order that a person with a mental illness who has been convicted of an offence is assessed, detained and treated in an approved mental health facility, instead of a prison. The court does not have an equivalent power to order that a person with an intellectual disability or cognitive impairment is detained in a facility which provides treatment and care to people with a disability, instead of in a prison.

EXPIRY OF SENTENCES

A person with an intellectual disability or cognitive impairment may have a continuing need for care or treatment after their sentence in prison expires. Some people who were originally living at SFS under a justice plan or other court order remain there after their sentence because they agree to do so or their guardian consents on their behalf.

RECOMMENDATIONS

The Report recommends that where a magistrate finds a person with an intellectual disability or cognitive impairment is not guilty because of mental impairment, the magistrate should be able to refer the person to the Office of Senior Clinician. If the Office of Senior Clinician believes that the provision of services could reduce the likelihood of the person re-offending the Office may recommend to DHS that services be provided to the person. If the Office of Senior Clinician believes that the person's behaviour poses a significant risk of serious harm to others, the Senior Clinician can apply to VCAT for a detention order.

The Report also recommends that justice plans should be extended to people who have a cognitive impairment, but that operation of this provision should be deferred for two years to allow for the development of appropriate services for people with a cognitive impairment.

It is recommended that the *Sentencing Act 1991* should be amended to give the court power to direct DHS to prepare a care plan for a person with an intellectual disability or cognitive impairment, indicating the services that will be provided to the person in prison to reduce the risk that he or she will re-offend.

Alternatively the court may order that the person serves their sentence in a prescribed facility instead of in jail. An order of this kind cannot be made unless the person would otherwise have received a prison sentence. The term of detention in the prescribed facility cannot exceed the term of imprisonment that the person would otherwise have received.

The Report proposes that the Office of Senior Clinician should be able to apply to VCAT for an order authorising that people be detained after their sentence expires if their behaviour is likely to pose a significant risk of serious harm to others. Detention orders cannot last for more than five years. If a person is detained after serving a sentence the total period of imprisonment and detention cannot be longer than five years.

OVERSEEING THE OPERATION OF THE SYSTEM

The Office of Senior Clinician will play a major role in ensuring that people with an intellectual disability receive an appropriate standard of care. The Commission believes that the Office should be established as a statutory body that is independent from, but works in collaboration with DHS. Functions of the Office of Senior Clinician shall include

- developing guidelines dealing with a range of issues;
- receiving and monitoring annual medical reports and reports on the use of restraint and seclusion affecting people with an intellectual disability;
- functioning as a central records agency for detention plans and care plans; and
- developing mechanisms to monitor the performance of service providers.

The Office of Senior Clinician will have power to visit premises and to obtain access to records and to undertake audits of care practices in facilities.

Where guidelines will affect the cost of service provision the Report recommends that they be developed jointly by DHS and the Office of Senior Clinician and approved by the Minister of Community Services.

Finally, the Report recommends the establishment of an independent complaints handling system to receive, investigate, mediate and resolve complaints about service provision to people with an intellectual disability or cognitive impairment. Because DHS is currently reviewing disability legislation the Commission does not express a view as to whether a new complaints-handling body should be established or whether this task should be undertaken by an existing body, such as the Health Services Commissioner.

Recommendations

1. The legislation that regulates detention and restrictive practices should contain principles to guide its interpretation.
2. These principles should refer to:
 - ? safeguarding rights and liberties of people who have intellectual disability or cognitive impairment;
 - ? ensuring that information about rights is provided to these people, their families and guardians;
 - ? preventing exploitation and abuse;
 - ? maximising social participation and ensuring that people who have an intellectual disability or cognitive impairment can develop to their fullest capacity;
 - ? recognising that the liberties of a person may have to be restricted, in order to assist them to modify their behaviour so that they are less likely to harm others and can be encouraged to develop to their full capacity;
 - ? ensuring that detention and restrictive practices benefit the person who is required to participate in care and treatment;
 - ? ensuring that such measures are imposed in a manner that is the least restrictive of the person's freedom and action as is possible in the circumstances; and
 - ? ensuring that decisions that restrict the liberty of a person are reviewable and made in a transparent manner and that decision-makers are accountable for decisions.
3. People should only be subjected to detention or restrictive practices where this form of treatment will benefit them.
4. 'Benefit' should be defined in terms of maximising people's quality of life and increasing their opportunity for social participation. Beneficial treatment includes, but it is not limited to, assisting people to reduce their risk of self harm and harm to others.

5. A person may be detained if:
 - ? the person has an intellectual disability;
 - ? the person has previously exhibited a pattern of violent or dangerous behaviour that has harmed others seriously or exposed another person to significant risk of serious harm;
 - ? it is necessary to detain the person because there is a significant risk that otherwise he or she will seriously harm others;
 - ? the risk that the person may harm others cannot be substantially reduced by using other less restrictive measures;
 - ? a detention plan has been prepared, indicating the services and programs that will be provided during the period that the person is detained and providing for transition between detention and the person being cared for in a less restrictive environment;
 - ? the services that will be provided under the plan will benefit the person by reducing the risk that he or she will harm others; and
 - ? the person is unable or unwilling to consent to living in a prescribed facility and to participating in a program to reduce the risk of harming others.
6. A detention plan should include:
 - ? the programs that will be provided to the person during the period of detention and how they will benefit him or her;
 - ? any restrictive practices that it is proposed to apply to the person while in voluntary detention;
 - ? a proposed process for the person's transition between detention and living in the community, including provision for leaves of absence; and
 - ? the proposed duration of the order.
7. Before a detention plan is prepared, the Office of Senior Clinician must consult with the person and the person's primary carer or guardian.
8. A copy of the detention plan should be provided to the person, the primary carer and the facility in which the person will be detained.
9. An Office of Senior Clinician should be established as an independent statutory authority resourced by the Department of Human Services and reporting annually to the Minister for Community Services.

10. The Annual Report of the Office of Senior Clinician should be tabled in Parliament.
11. The Office of Senior Clinician should be responsible for overseeing detention of people with an intellectual disability who are at significant risk of causing serious harm to others. The Office of Senior Clinician shall:
 - ? receive requests for the assessment and the development of detention plans;
 - ? prepare guidelines as to the other matters which should be included in detention plans;
 - ? arrange for assessments and the development of a detention plan to benefit persons whom it is proposed to detain;
 - ? arrange appropriate facilities to receive persons on detention orders;
 - ? make applications to the relevant body for the approval of detention plans and the making of detention orders.
12. Applications for detention orders should be made by the Office of Senior Clinician, acting on its own initiative or on the request of an appropriate person.
13. The following persons should be able to request the Senior Clinician to apply for a detention order for a person with an intellectual disability:
 - ? the Public Advocate;
 - ? an authorised officer of the Department of Human Services;
 - ? a clinician or other health care professional who has been involved in caring for the person;
 - ? a guardian or family member of the person with a cognitive disability; and
 - ? a senior police officer, who is authorised to do so.
14. The Senior Clinician should be able to initiate an application for a detention order without a request from a third party.
15. The Victorian Civil and Administrative Tribunal (VCAT) should have power to:
 - ? authorise and review decisions for the detention of a person with an intellectual disability whose behaviour creates a significant risk of serious harm to others; and
 - ? approve a detention plan for a person who is subject to a detention order

16. Before making a detention order, VCAT must be satisfied that the criteria set out in Recommendation 5 are satisfied.
17. VCAT should determine whether it is necessary to detain a person because there is a significant risk that if not detained the person will harm others, on the balance of probabilities.
18. The Office of Senior Clinician should be responsible for arranging for a panel of experts to assess a person who is subject to an application for a detention order, and for providing a report to VCAT.
19. The assessment panel should include a person with appropriate professional qualifications, and a person with experience in behaviour modification programs and direct care of people with an intellectual disability.
20. The panel should be required to prepare a report for VCAT on:
 - ? whether there is significant risk that the person not detained will seriously harm others;
 - ? the matters that should be included in the detention plan; and
 - ? the benefits to the person that will result if the detention plan is implemented.
21. Applications for detention orders should be heard by a panel that includes a Supreme or County Court judge and at least one other member with knowledge and experience in one of the following areas:
 - ? psychology (with specialisation in intellectual disability);
 - ? psychiatry;
 - ? neurophysiology;
 - ? direct care of people with an intellectual disability;
 - ? pharmacology; or
 - ? disability advocacy.
22. Section 94 of the Victorian Civil and Administrative Tribunal Act 1998, which allows VCAT to seek the assistance of an expert, should apply to detention proceedings.
23. VCAT should be funded sufficiently to allow it to commission independent expert advice about the need for detention.

24. Section 62 of the Victorian Civil and Administrative Tribunal Act 1998 should be amended to allow a person with an intellectual disability to be represented in detention proceedings by a lawyer, a disability advocate, or any other person approved by the Tribunal.
25. VCAT should have power to order that a person with an intellectual disability is represented by an advocate.
26. An advocate in detention proceedings should be obliged to act in the best interests of the client.
27. Section 148 of the Victorian Civil and Administrative Tribunal Act 1998, which allows an appeal from VCAT to the Supreme Court on points of law, should apply to detention decisions made by VCAT.
28. Detention orders should be reviewed by VCAT at least every six months.
29. A VCAT order, authorising detention, may contain provisions requiring review of the original decision within a shorter period.
30. An application may be made to VCAT for a reassessment of a decision authorising detention within the six month period, or the shorter period required by VCAT. The application may be made by the person with an intellectual disability, a family member or guardian, or a person providing services or care to the person.
31. VCAT should have the power to reject an application for review.
32. The person affected by the proceedings must be present at the hearing, except where VCAT orders that the person should not appear because appearance would be detrimental to the person's health or wellbeing.
33. VCAT hearings should be open to the public, unless VCAT otherwise directs. An application may be made by a party to the proceedings or the party's representative, to have the hearing closed.
34. If the hearing is closed, VCAT may permit a family member of the person, or any other person with a direct interest in proceedings to be present during the whole or any part of the hearing.
35. The person who will be affected by a detention decision has the right to be heard and to inspect any relevant documents, except where:
 - ? inspection of documents would cause serious harm to the person's health, safety or wellbeing;
 - ? this would expose another person to a risk of serious harm;

- ? involve the unreasonable disclosure of information relating to the personal affairs of any person; or
 - ? breach a confidentiality provision imposed by a person who supplied information that is contained in the documents or document.
36. Any other person with a direct interest in a detention decision has the right to be heard.
 37. The term of a detention order cannot exceed five years. An order cannot be received beyond the five year period.
 38. The Office of Senior Clinician may apply to VCAT for an assessment order or an emergency detention order, either on the initiative of the Office or on the request of an authorised police officer or a clinician.
 39. An assessment order should only be able to be made in circumstances where it is necessary to detain the person for the purposes of assessment, because there is a significant risk of serious harm being caused to other members of the community. A judicial member of VCAT can authorise the detention of a person for the purposes of assessment, for a period of up to 14 days.
 40. In the case of an emergency, where the person's behaviour has created an extreme risk of harm to others, an ordinary member of VCAT can authorise a detention order for up to 72 hours. The person must be released at the end of that period, unless a judicial member authorises detention for the purposes of assessment, for a period of up to 14 days.
 41. Escorted leaves of absence may be authorised by the person in charge of the prescribed detention facility. All escorted leaves of absence must be reported to the Office of Senior Clinician on a quarterly basis.
 42. The Office of Senior Clinician shall prepare and publish guidelines indicating when escorted leave should be permitted and the qualifications and skills required for escorts.
 43. The detention plan may provide for unescorted leaves of absence from a facility. The criteria for authorising an unescorted leave of absence should be contained within the detention plan.
 44. Unescorted leave must be endorsed by the person in charge of the facility after there has been an assessment of the person's current behaviour. If leave allowed for in the plan is not permitted this must be reported to the Office of Senior Clinician.

45. Interstate transfers may be approved to and from other states that have provisions allowing detention on similar grounds to those recommended above.
46. The police or a prescribed person should be authorised to detain people who abscond while subject to a detention order and to return them to the facility specified in the detention plan.
47. The provisions for authorisation and review of detention should apply to people of 17 years of age or older, who satisfy the relevant statutory criteria.
48. The legislative framework controlling restrictive practices should apply to people who receive services or participate in programs under the Intellectually Disabled Persons' Services Act 1986.
49. Clear criteria regulating use of the following restrictive practices should be set out in the IDPSA or in regulations under that Act.
50. The restrictive practices that should be regulated are:
 - ? mechanical restraint of a person for behavioural control purposes, for example using straps on a person who is behaving aggressively;
 - ? prescribing medication for behavioural control purposes (chemical restraint);
 - ? seclusion of the person, for example locking a person in an area apart from others;
 - ? physical restraint of a person for behavioural control purposes, for example holding a person down; and
 - ? locking doors to prevent a person leaving a facility or an area within the facility.
51. Mechanical restraint should be defined as use of a mechanical device to prevent, restrict or subdue movement of a person's body for the primary purpose of behavioural control.
52. The definition should exclude mechanical restraint used for therapeutic purposes (such as where leg braces are used on a person with cerebral palsy to limit muscular contractions), and mechanical restraint used to enable a person to be transported safely.
53. Chemical restraint should be defined as the use of a chemical substance to control or subdue a person's behaviour.

54. It should exclude a drug prescribed:
- ? by a general practitioner for the sole purpose of treating a physical illness or condition;
 - ? by a psychiatrist for the sole purpose of treating a mental illness; and
 - ? a drug prescribed to control a person's behaviour so that person can receive treatment for a physical illness or condition (for example an anaesthetic drug).
55. Seclusion should be defined as:
- ? the confinement of a person alone at any hour of the day or night in a room, the door and window of which cannot be opened by the person from the inside; or
 - ? the confinement of a person alone at any hour of the day or night in a room in which the doors or windows are locked from the outside.
56. The IDPSA should provide that mechanical or chemical restraint or seclusion (as defined in Recommendations 51–5) may only be used where:
- ? this is necessary to prevent the person from physically harming himself or herself or any other person; or
 - ? this is necessary to prevent a person persistently destroying property, or destroying property in a way that will pose a risk of serious harm to others; and
 - ? the particular form of restraint or seclusion used is the least restrictive means of preventing the person from physically harming himself or herself or any other person or destroying property; and
 - ? use of restraint and seclusion on the particular occasion has been authorised by the person in charge of the service.
57. Where it is proposed that provision of services to a person with an intellectual disability may require the use of mechanical or chemical restraint and seclusion:
- ? a care plan must be prepared that indicates how the proposed form of restraint or seclusion will be used in managing the person's behaviour;
 - ? the care plan must indicate how the use of restraint or seclusion will benefit the person; and
 - ? the care plan proposing use of these measures must be approved by the Office of Senior Clinician, who must be satisfied that the statutory criteria apply.

58. Where restraint or seclusion have not been authorised in a care plan that has been approved by the Senior Clinician, they can be used in an emergency where:
 - ? the measure is necessary to prevent the person from seriously injuring himself or herself or any other person;
 - ? the particular form of restraint or seclusion used is the least restrictive means of preventing the person from doing such serious harm; and
 - ? use of restraint or seclusion has been authorised by the person in charge of the service.
59. Where restraint or seclusion is used in an emergency the Office of Senior Clinician must be notified within 48 hours.
60. In addition to the functions that are recommended to be conferred on the Office of Senior Clinician in Chapter 4, the Office should be responsible for:
 - ? approving care plans, including provision for restraint or seclusion;
 - ? conducting an annual review of care plans that provide for use of restraint and seclusion to determine whether the plans should be changed;
 - ? receiving reports on emergency use of restraint or seclusion; and
 - ? monitoring use of restraint and seclusion.
61. Before a care plan is approved, DHS must consult with the person and the person's primary carer or guardian.
62. A copy of the care plan must be provided to the person, the primary carer and any association or organisation that provides the person with services.
63. Where DHS has prepared a care plan that provides for restraint and seclusion, the Office of Senior Clinician should have power to request additional information from DHS or to direct a more detailed assessment of the person's needs, before approving the care plan.
64. The Office of Senior Clinician must annually review plans that contain provisions for restraint and seclusion. In situations where the Office declines to authorise a care plan providing for use of restraint and seclusion, the Office shall liaise with the service provider to make arrangements as to how the person should be managed.
65. The Office of Senior Clinician must establish a system for monitoring the use of restraint and seclusion.
66. VCAT should have jurisdiction to review care plans providing for restraint and seclusion for persons with an intellectual disability.

67. The following persons may apply for a review:
 - ? the person to whom the plan applies;
 - ? a family member or guardian of that person; or
 - ? the Office of the Public Advocate.
68. The membership of the VCAT panel and the procedures applied by VCAT in reviewing care plans providing for restraint and seclusion should be the same as those recommended for VCAT reviews of detention plans.
69. Physical restraint should be defined as the use of any part of a person's body to prevent, restrict, or subdue movement of the body or part of a body of an person with an intellectual disability.
70. The IDPSA should provide that physical restraint may only be used
 - ? in an emergency situation that makes it necessary to restrain a person with an intellectual disability in order to discharge the duty of care that is owed to the individual, to other residents, or to staff members, or to prevent serious harm to another person.
 - ? where provision is made for the routine use of physical restraint in a care plan, because it is necessary to prevent the person from self-harming or causing serious harm to another person, a care plan providing for routine use must be approved by the Office of Senior Clinician.
71. When physical restraint is permitted under Recommendation 70 the person applying it must use the minimum force necessary for the purpose for which it is used.
72. The person applying physical restraint should cease to do so as soon as it is no longer necessary to prevent the person from harming him or herself or causing serious harm to another person.
73. VCAT should have jurisdiction to review a care plan that provides for routine use of physical restraint.
74. A locked door policy should be defined as
 - ? the regular locking of external doors and windows while clients and staff are inside the building, which restricts the entrance and exit of clients;
 - ? the regular locking of doors and windows, which confines a client to a particular part of a building or premises.
75. The Senior Clinician should develop guidelines indicating the circumstances in which a service provider may adopt a locked door policy.

76. Service providers should be required to provide an annual report to the Office of Senior Clinician about practices affecting access to and exit from premises.
77. The Senior Clinician should monitor service providers' practices relating to the locking of doors and windows and should have power to instruct service providers to change practices relating to client's access to and exit from premises.
78. The IDPSA should require preparation of an annual medical report for all people receiving services under the IDPSA.
79. The medical report should be provided to the Office of Senior Clinician.
80. Where the person is being prescribed drugs for the treatment of a mental illness, the Senior Clinician may request the Chief Psychiatrist to assess the person, to determine whether the provisions for involuntary treatment for mental illness should apply to that person.
81. Where the person is being prescribed drugs for the purposes of treatment of a physical condition the Senior Clinician should have power to refer the matter to the Office of the Public Advocate, who may decide that an application should be made to appoint a guardian for the person.
82. Cognitive impairment should be defined as a significant and long-term disability in comprehension, reasoning, learning or memory that is the result of any damage to, or any disorder, imperfect or delayed development, impairment or deterioration of the brain or mind.
83. The proposed framework for regulating detention should not apply to people whose cognitive impairment is solely due to mental illness.
84. The proposed framework for regulating detention should not apply to people with a personality disorder, unless the personality disorder is accompanied by damage to, or any disorder, imperfect or delayed development, impairment or deterioration of the brain or mind.
85. The legislative criteria and approval process for detention orders should apply to people with a cognitive impairment, as well as to people with an intellectual disability.
86. The VCAT panel constituted to hear a detention application for a person with a cognitive impairment shall include a person with professional expertise or experience in caring for people with cognitive impairments.
87. The Office of Senior Clinician should develop legislative criteria and a process for developing, approving and regularly reviewing care plans that allow people with a cognitive impairment to be restrained or secluded.

88. The process for developing, approving and regularly reviewing care plans that allow people with a cognitive impairment to be restrained or secluded should be phased in over a three year period.
89. In the meantime the Office of Senior Clinician should establish and publicise a system to require quarterly reporting of use of restraint and seclusion.
90. Recommendation 126 which requires service providers to provide the Senior Clinician with an Annual Report about their practices in relation to access to and exit from premises, should apply to service providers which provide facilities for people with cognitive impairments.
91. Aged care facilities should not be required to report on use of restraint and seclusion and practices in relation to locking of doors.
92. The Crimes (Mental Impairment and Unfitness to be Tried) Act 1997 should be amended to allow facilities prescribed for people subject to detention orders to be 'appropriate places' to receive persons subject to custodial supervision orders.
93. Where a magistrate finds a person with an intellectual disability or mental impairment is not guilty because of a mental impairment under s 20 of the Crimes (Mental Impairment and Unfitness to be Tried) Act 1997, the Magistrate may refer the person to the Office of Senior Clinician.
94. The Office of Senior Clinician shall consider whether the person is eligible for services under the Intellectually Disabled Persons' Services Act 1986 or the Disability Services Act 1991 and whether the provision of such services could reduce the likelihood of the person re-offending.
95. Where the Office of Senior Clinician believes that the provision of services would reduce the likelihood of the person re-offending, the Office may recommend to DHS that such services be provided to the person.
96. Where the Office of Senior Clinician is of the view that the person's behaviour poses a significant risk of serious harm to others, the Senior Clinician shall arrange for the assessment of the person to determine whether an application for detention should be made.
97. If a Magistrate refers a person to the Office of Senior Clinician, the Office must file a report with the Court within 14 days of the referral, indicating any steps which are being taken in relation to the person.
98. The Sentencing Act 1991 should be amended to make justice plans available to offenders with a cognitive impairment.

99. Operation of this provision should be deferred for two years, to allow for development of appropriate services for people with cognitive impairments who commit offences.
100. DHS should ensure that service providers are aware that offenders must comply with justice plans.
101. Where a change in program provision occurs, which would prevent the offender complying with the conditions of a justice plan, DHS should be required to refer the matter to the Secretary to the Department of Justice, or in the case of a justice plan entered into as a condition of an adjourned undertaking, to Victoria Police.
102. Where a change in program provision has prevented the offender from complying with the justice plan, the offender may request the Secretary to the Department of Human Services to advise the Secretary to the Department of Justice.
103. Where the matter is referred to the Secretary to the Department of Justice, or to the Victoria Police, the Secretary or Victoria Police must consider whether an application should be made to the court under section 82 of the Sentencing Act 1991 for a change to the provisions of the justice plan.
104. The Sentencing Act 1991 should be amended to allow the court to refer a person with an intellectual disability or cognitive impairment, who has been found guilty of an offence, and is to be sentenced to a term of imprisonment, to DHS, for an assessment and the development of a care plan, indicating the services that will be provided to the person during his or her period of imprisonment.
105. Where the court refers a person to DHS, a care plan must be prepared for the person indicating the services that are to be provided to the person during his or her imprisonment, for the purposes of reducing the risk that the person will re-offend.
106. The Court shall not make a care plan order unless the court is satisfied that the proposed care plan will reduce the risk that the person will re-offend.
107. Where a person with an intellectual disability or cognitive impairment has been found guilty of an offence, the court may order that the person serves his or her sentence in a prescribed facility instead of in jail (this is known as a security order).

108. The Court may not make a security order unless:
 - ? a detention plan has been prepared by DHS indicating how the person will be cared for and the services that will be provided to the person in the secure facility;
 - ? the court is satisfied that the services which will be provided to the person in the prescribed facility will reduce the risk that the person will re-offend; and
 - ? but for the person's intellectual disability or cognitive impairment, the court would have sentenced the person to a term of imprisonment.
109. The term of the security cannot exceed the period of imprisonment to which the person would have been sentenced had the care and treatment order not been made.
110. A security order can only be made where the services that the person needs to reduce the possibility that he or she will re-offend cannot be effectively provided within a prison environment.
111. Provision should be made to allow prisoners with a cognitive impairment to be transferred to an appropriate residential institution for the whole or a part of their sentence.
112. Leaves of absence, not exceeding six months, for offenders sentenced to security orders, or for offenders transferred from prison to an appropriate facility, should be approved by the Secretary to the Department of Justice.
113. Before granting leave, the Secretary to the Department of Justice must be satisfied that the safety of members of the public is not endangered by the granting of leave and that the Office of Senior Clinician has been consulted.
114. Special leave, not exceeding 24 hours, for offenders sentenced to security orders should be approved by the Office of Senior Clinician.
115. Before granting leave, the Office of Senior Clinician must be satisfied that there are special circumstances justifying the granting of leave and that the safety of members of the public will not be endangered by the granting of leave.
116. If the Corrections Victoria Commissioner or the Adult Parole Board considers that a person's behaviour is likely to pose a significant risk of serious harm to others after the expiry of his or her prison sentence or care and treatment order, they may refer the person to the Office of Senior Clinician.

117. The Office of Senior Clinician shall consider whether the person should be assessed, to determine whether they meet the criteria for the making of a detention order.
118. If an assessment is made, the Office of Senior Clinician must consider whether an application should be made to VCAT for a detention order.
119. The duration of a detention order that is to take effect when a person is released from prison must take into account any period of time that a person has spent on a care and treatment order whilst in prison and the cumulative total of the two orders must not exceed five years.
120. All guidelines prepared by the Office of Senior Clinician should take account of the principles in Chapter 3 of this Report. They should also:
 - ? emphasise the importance of obtaining the consent of people with an intellectual disability or cognitive impairment to treatment and care, wherever possible;
 - ? prescribe standards of treatment and care which take account of cultural factors that affect people who are being cared for; and
 - ? ensure that people receiving treatment and care and their families and guardians receive information about their rights, including information about their opportunity to make complaints and to seek a review of care decisions.
121. Minimum standards for prescribed facilities should be developed jointly by the Office of Senior Clinician and DHS and should be approved by the Minister of Community Services.
122. Stakeholders, including service providers and disability advocacy groups, should be consulted about proposed minimum standards.
123. Facilities prescribed for people subject to detention orders should be proclaimed by the Governor-in-Council.
124. Minimum standards for staff employed by service providers under the IDPSA should be developed jointly by the Office of Senior Clinician and DHS and be approved by the Minister for Community Services.
125. The Office of Senior Clinician should be responsible for monitoring compliance with minimum staffing standards.

126. Where a person with an intellectual disability is subjected to restraint and seclusion in accordance with their care plan, this must be recorded by the service provider. Service providers must forward an annual report to the Office of Senior Clinician on all persons in their care, indicating all instances of use of restraint and seclusion.
127. Where emergency use of restraint and seclusion is reported to the Office of Senior Clinician, the Office of Senior Clinician may direct that use of restraint and seclusion should cease, either immediately or after an alternative method of care is put in place. Before giving such a direction the Office of Senior Clinician must consult with the service provider about alternative means of managing the person's behaviour.
128. Providers of services under the DSA should be required to record all instances of use of restraint and seclusion affecting people with cognitive impairments.
129. Providers of services under the DSA should report quarterly to the Office of Senior Clinician on all instances of use of restraint and seclusion.
130. The Office of Senior Clinician should function as a central records agency for detention plans and care plans.
131. The Office of Senior Clinician should be resourced with the computer infrastructure to enable all reports and records from service providers to be submitted and monitored electronically and to permit systems to be established for monitoring particular care practices.
132. The Office of Senior Clinician should develop mechanisms to monitor the performance of service providers.
133. The Office of Senior Clinician should have power to visit and inspect premises, to obtain access to records of service providers, to inspect documents and to see any person who is receiving care.
134. Service agreements should permit the Secretary of the Department of Human Services to amend the agreement or impose additional conditions on the service provider to ensure compliance with guidelines and appropriate standards of care.
135. The Office of Senior Clinician should have power to report breaches of service agreements, failure to comply with guidelines or directives of the Office of Senior Clinician or inappropriate service practices, to the Secretary of the Department of Human Services.

136. Where the service provider has consistently failed to comply with guidelines or directives of the Office of Senior Clinician or to provide an acceptable level of care, the Secretary should consider whether the service agreement should be amended or rescinded.
137. In the case of persistent breaches with guidelines or failure to comply with directives of the Office of Senior Clinician the Secretary of the Department of Human Services may recommend to the Minister that approval of a prescribed facility should be rescinded.
138. Community visitors must respond to a request to be seen by a resident or her or his representative within 14 days of being advised of the request. The community visitor must respond to the request by visiting the person who made the request or by notifying, in writing, the Office of the Public Advocate of the reasons for not visiting the person who made the request.
139. Where the community visitor notifies the Office of the Public Advocate of the reasons for not visiting the person who made the request, the Office of the Public Advocate should send copies of these reasons to the person, the person's guardian, if any, and to the Office of Senior Clinician.
140. If the Office of the Public Advocate does not consider the community visitor's reasons for not making a requested visit are sufficient then the Office may request the responsible Minister to direct a community visitor to visit the facility.
141. An independent complaints handling system should be established to receive, investigate, mediate and resolve complaints with respect to detention and use of restrictive practices, and other aspects of service provision for people with an intellectual disability or cognitive impairment.

Chapter 1

Introduction

SCOPE OF THIS REFERENCE

1.1 On 21 December 2001 the Attorney-General asked the Victorian Law Reform Commission to review the existing provisions for the ‘compulsory treatment and care’ of persons with an intellectual disability who are at risk to themselves and the community, and to make recommendations for an appropriate legislative framework for compulsory care.

DEFINITIONS

1.2 The expression ‘compulsory treatment and care’ in the terms of reference refers to treatment of people without the real consent of the person concerned. People who have an intellectual disability may not have capacity to consent to treatment and care. In this situation a guardian may be appointed to make decisions for them, or a relative or carer may make decisions on their behalf. In other cases the person may have the capacity to consent but may not be given any opportunity to do so. For example they may be given medication to take without realising that they are able to refuse to do so. Sometimes care is provided against the stated wishes of the person. For example a person may be told they cannot leave the place where they are living unless they are accompanied by a member of staff. The term ‘compulsory care’ is intended to cover all these situations.

1.3 The term ‘intellectual disability’ is used in this Report in the same way as it is defined in the *Intellectually Disabled Persons’ Services Act 1986* (IDPSA). Under that Act, a person is considered to have an intellectual disability if she or he has an IQ of 70 or less.¹

1 Section 3 of the Act defines ‘intellectual disability’ in relation to a person over the age of five, as the concurrent existence of
(a) significant sub-average general intellectual functioning; and
(b) significant deficits in adaptive behaviour—
each of which become manifest before the age of 18 years.

WHY DID THE COMMISSION RECEIVE THIS REFERENCE?

1.4 The issue of ‘compulsory care’ was referred to the Commission by the Attorney-General at the request of the then Minister for Community Services, the Hon Christine Campbell MP. This request was based on a recommendation made by a Review Panel, established by the Minister for Community Services, to consider the operation of the Disability Services Statewide Forensic Service (SFS), which is a service operated by the Victorian Department of Human Services (DHS) to provide intensive care and treatment to people with an intellectual disability who exhibit dangerous or anti-social behaviour.

1.5 The report of the Review Panel (the Vincent Report),² which was released in September 2001, drew attention to the lack of a clear statutory framework for compulsory treatment and care. The present law is inadequate because it does not provide clear guidelines on when compulsory treatment is allowed or on how decisions to treat people without consent should be monitored and reviewed. The Auditor-General, in the 2000 *Report on Services for People with an Intellectual Disability*,³ also highlighted the need to tighten the framework protecting the rights of people with an intellectual disability. The Vincent Report recommended that the Attorney-General should refer this matter to the Victorian Law Reform Commission.

1.6 Although the terms of reference arose out of the Vincent Report, which focused on the position of people with an intellectual disability whose behaviour places others at risk, the Commission was also asked to consider the relevance of any proposed legislative framework to people with other forms of cognitive impairment, for example acquired brain injury.

COGNITIVE IMPAIRMENT

1.7 We use the term ‘cognitive impairment’ to cover a range of conditions that affect a person’s mental functioning. People with cognitive impairments include people with an acquired brain injury, with an autism spectrum disorder, or with a dual disability (mental illness and intellectual disability) where the injury or

2 *Report of the Review Panel Appointed to Consider the Operation of the Disability Services Statewide Forensic Service* (2001). Justice Frank Vincent was Chair of the Review Panel.

3 Auditor-General Victoria, *Services for People with an Intellectual Disability* (2000) 43–9.

disorder affects their reasoning ability. The expression is defined more precisely in Chapter 6.

CURRENT LEGISLATIVE FRAMEWORK

1.8 Problems with the current legislative framework for compulsory care are discussed in detail in Chapter 2. However in this introductory chapter we provide a brief overview of the legislation that is relevant to this Report.

1.9 The central provisions that guide the provision of services for people with a disability in Victoria are the:

- *Intellectually Disabled Persons' Services Act 1986* (IDPSA); and
- *Disability Services Act 1991* (DSA).

Both pieces of legislation are primarily concerned with the provision of services on a voluntary basis to people who are eligible to receive those services.

1.10 The IDPSA was enacted at a time when people were moving from institutional care into care in the community.⁴ The legislation was intended to ensure recognition of the rights of people with an intellectual disability to services, whilst emphasising support for a reasonable quality of life and the person's capacity for physical, social, emotional and intellectual development.

1.11 Consistently with this philosophy, the Act provides that certain principles should apply in the provision, management, development and planning of services. These principles affirm:

- that the rights of people with an intellectual disability are the same rights as other members of the community;
- that services should promote the inclusion and participation of people with an intellectual disability in the life of the community;
- that services should support a reasonable quality of life; and
- that generic community services should be available and where necessary made accessible to people with an intellectual disability.

1.12 In Victoria, the *Disability Services Act 1991* was introduced in response to the first Commonwealth-State Disability Agreement. The DSA binds Victoria to

⁴ See the comments in Submission 22, Victorian Bar, para 1.3.

principles and objectives for providing services that are consistent with the Commonwealth *Disability Services Act 1986*. The objects of the Commonwealth Act are to assist people with disabilities to participate fully, be integrated as members of the community and achieve increased independence, employment opportunities and self-esteem. The definition of ‘disability’ covers intellectual, physical, sensory or psychiatric impairment (or any combination of these).

1.13 The *Equal Opportunity Act 1995* (Vic) and the *Disability Discrimination Act 1992* (Cth) are also relevant to this reference. These Acts aim to eliminate discrimination on the grounds of disability and to promote the rights of people with a disability to equality of opportunity.

1.14 The Report also considers the effect of the *Guardianship and Administration Act 1986* (GAA) which provides, among other things, for the appointment of a guardian or administrator for people with a disability who are unable to make reasonable judgments for themselves.

CONTEXT OF THE REPORT

1.15 It is estimated that around 217,100 Victorians have some form of mental or behavioural disorder.⁵ Of these, about 40,000 have an intellectual disability.⁶ Many people with an intellectual disability have the same diversity of experiences, relationships and lifestyles as others in the community. The same is true of persons with other forms of cognitive impairment. However, persons with intellectual disabilities or cognitive impairment sometimes behave in ways that place themselves or others at risk of harm. Such behaviour may occur because the person lacks appropriate support,⁷ because of other environmental factors, or because of some aspect or aspects of the person’s disability or impairment.

1.16 Occasionally, such behaviour takes the form of serious and predatory criminal conduct that severely endangers people. An intellectual disability or cognitive impairment may prevent someone from fully understanding the consequences of his or her behaviour or may impede the person from changing his or her behaviour to avoid such consequences. For example, a person may sexually

5 Australian Bureau of Statistics, *Disability and Long Term Health Conditions, Australia, 1998: Disability, Ageing and Carers* (2000) 17.

6 Auditor-General Victoria, *Services for People with an Intellectual Disability* (2000) 3.

7 Submission 27, Victoria Legal Aid 1.

assault a child in a situation where intellectual disability prevents the disabled person from understanding appropriate sexual behaviour.

1.17 Such conduct will often be dealt with under the criminal justice system. The court can make a range of sentencing orders, which are discussed in more detail in Chapter 2.⁸ However the criminal justice system, with its focus on punishment, is often not the most effective way of dealing with the harmful behaviour of a person with either an intellectual disability or a cognitive impairment. In particular, there is no guarantee that sentencing a person for a criminal offence will prevent recurrence of behaviour that is related to the particular disability, or that it will reduce the risk of harm to others.

1.18 In other instances where a person with an intellectual or cognitive disability is charged with a criminal offence, the court may find that the person is either unfit to stand trial or not guilty because of his or her mental impairment. In this situation the supreme or county court can make supervision orders requiring the person to be detained in a secure place or released on conditions supervised by the court.⁹

1.19 Not all criminal behaviour comes to the attention of the police. Even if it does, the police may decide not to charge the person with an offence. In either situation, however, those responsible for caring for the person may wish to take steps to prevent the person from self-harming or harming others. In these circumstances, it is not uncommon for an application to be made for a guardian to be appointed so that the guardian can decide where the person should live. The guardian may decide that the person should live in a secure place. Alternatively, the person may 'consent' to living in a secure place, without necessarily understanding that he or she is free to leave. If this occurs the person is, in effect, detained to prevent harm, without having been convicted of any offence.

1.20 Only a few people with an intellectual disability or cognitive impairment act in a way that puts others at risk. More commonly, the person's behaviour needs managing because the person lacks insight into his or her behaviour or cannot control it. In many instances this behaviour has to be managed in the place in which the person is living. For example, a person in a community residential unit or in a day care program may sometimes need to be confined to his or her room to

8 See paras 2.33–56.

9 See paras 2.47–51.

prevent the person hitting members of staff or other residents. The person may not be able to leave a residential unit alone because he or she does not understand the risk of injury from traffic. The person may be prescribed drugs to prevent him or her behaving aggressively.

1.21 Decisions of the kind described above limit the ability of the person to live freely within the community. Such decisions are potentially discriminatory because, as a general principle, people can only be deprived of their liberty if they have been convicted of a criminal offence. In particular, both parliament and the courts have usually taken the view that people cannot be detained, or have their freedom of movement restricted, on the basis of a prediction that they may harm themselves or others.

1.22 A notable exception to this general proposition exists in the case of people with a mental illness. Such people can be involuntarily detained and treated when they appear to be mentally ill, and require treatment because they are unable to consent, or refuse to consent, and treatment is required for their own health and safety or for the protection of members of the public. A detailed statutory framework regulates detention and treatment of people who are mentally ill.¹⁰

1.23 The IDPSA places some restrictions on the use of ‘restraint’ and ‘seclusion’ measures within facilities and programs to which that Act applies.¹¹ However these

10 *Mental Health Act 1986* s 8(1).

11 *Intellectually Disabled Persons’ Services Act 1986* s 44. Seclusion is defined in s 44 as ‘sole confinement of an eligible person at any hour of the day or night in a room of which the doors and windows are locked from the outside.’ Restraint is not defined in the act, but has been interpreted in various ways. Disability Services, Department of Human Services, *Restraint and Seclusion—Policy: January 2001—Amended September 2002*, (2002) 4, defines chemical restraint as the use of any chemical substance ‘to control or subdue a person’s behaviour’ and mechanical restraint as ‘mechanical devices used to prevent, restrict or subdue movement of any part of the person’s body.’ The DHS policy emphasises that for both, restraint must be the ‘intent or primary purpose’ of the use of the substance or device, thereby excluding devices and substances used for therapeutic purposes. The Intellectual Disability Review Panel, *Guide to Completing Monthly Form for Restraint and Seclusion Monitoring (RASM) System* (2000), jointly produced by IDRP and DHS, sets out the same definitions, incorporating the requirement of ‘primary intention’ into the actual definition. However, the Intellectual Disability Review Panel, *Restraint and Seclusion: Notes for Authorised Program Officers Under the Intellectually Disabled Persons’ Services Act 1986* (2001), also jointly produced by IDRP and DHS, omits the ‘primary purpose’ qualification from its otherwise similar definitions. However this policy excludes ‘any drug prescribed to treat a medical condition or as an adjunct to a surgical or diagnostic procedure,’ and ‘any therapeutic device used as an adjunct to medical or surgical treatment or used to assist or support the person gain increased bodily movement or prevent muscle contractions.’ It is unclear whether the variation in these definitions has any practical effect.

provisions do not protect people with an intellectual disability or other cognitive impairment to the same extent as the safeguards that apply to involuntary detention and treatment of people with a mental illness.

1.24 The absence of such a framework makes it difficult to ensure that an appropriate balance is maintained between two sets of competing interests: the rights and liberties of persons with an intellectual disability or other cognitive impairment on the one hand, and the need to protect them or others from harm on the other. This concern was the genesis of the present reference to the Commission.

TWO TYPES OF DECISIONS

1.25 The terms of reference do not define the concept of ‘compulsory care and treatment’. This expression could cover a very broad range of care and treatment decisions. It was clearly intended to cover decisions that severely affect a person’s liberty, such as confinement within a secure facility.¹² It was also intended to cover decisions to physically restrain or to medicate a person in order to prevent that person harming others. However, it could be interpreted to cover decisions that have a less significant effect on the person’s freedom, such as a decision to conduct ordinary dental work on a person with an acquired brain injury who lacks the capacity to consent to that treatment.

1.26 The reference is also potentially very broad because it does not comprehensively define cognitive impairment. It could cover care decisions affecting an extremely large number of people, including for example, people with Alzheimer’s disease¹³ and other forms of dementia. Accordingly it has been necessary for the Commission to limit the scope of the work. For the purposes of this reference the Commission will not consider issues of detention for people with dementia who reside in aged care facilities. There are already some controls in place for aged care services and the care of people with dementia. These are discussed again below.¹⁴

12 Victorian Law Reform Commission, *People with Intellectual Disabilities at Risk: A Legal Framework for Compulsory Care* Discussion Paper (2002) 71.

13 Known more formally as dementia of Alzheimer’s type: American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* (4th ed, Text Revision, 2000) 154.

14 See para 2.20.

ROUTINE MEDICAL TREATMENT

1.27 The present law allows some decisions to be made on behalf of people who cannot consent to treatment on their own behalf because of their disability. For example, some people have a guardian appointed to make decisions about their health care and accommodation¹⁵ and the *Guardianship and Administration Act* allows ‘a person responsible’¹⁶ such as a guardian, carer, spouse or close relative, to make medical treatment decisions for people who lack capacity to consent to treatment.¹⁷ The Commission believes that the current system, under which decisions about routine medical treatment can be made by carers, families and guardians of people with intellectual disabilities or cognitive impairments is appropriate and that legislative reform is not required in this area.

THE FOCUS OF THIS REPORT

1.28 Instead of proposing a new framework to regulate all decisions that may be made without the consent of a person with an intellectual disability or cognitive impairment, the Commission has decided to focus its work on two types of decisions.¹⁸ These are:

- detention of people to reduce the risk that they may seriously harm others; and
- decisions that substantially limit people’s freedom and that are part of the process of caring for them, in order to prevent them harming themselves or others. We call these ‘restrictive practices’. The expression is intended to cover decisions to restrain people through physical or chemical means, to seclude them, or to substantially restrict their freedom of movement in order to prevent them harming themselves or others.

1.29 Both the Vincent Review¹⁹ and the Auditor-General’s Report²⁰ highlighted deficiencies in the current legislative framework for regulating detention and

15 *Guardianship and Administration Act 1986* Pt 4.

16 *Ibid* Pt 4A.

17 VCAT must consent to the carrying out of ‘special procedures’ for example, termination of pregnancy.

18 The terms of reference explicitly refer to ‘admission to...facility[ies]’ (which may be read as referring to detention) and ‘restraint and seclusion.’

19 *Report of the Review Panel Appointed to Consider the Operation of the Disability Services Statewide Forensic Service* (2001). Justice Frank Vincent was Chair of the Review Panel.

20 Auditor-General Victoria, *Services for People with an Intellectual Disability* (2000).

restraint and seclusion. The Commission has chosen to focus on these forms of compulsory care because detention and restrictive practices are often used to protect third parties, as much as to protect the individual. Decisions of this kind require a balance to be found between protecting other members of the community from harm and safeguarding the rights of the person whose freedom is affected.

DETENTION

1.30 The Report covers decisions to detain people with an intellectual or other cognitive impairment without their consent in a prescribed facility, where the purpose of confinement is to provide them with therapeutic or rehabilitative services, in order to reduce a significant risk that they may seriously harm others.

1.31 As discussed above, some people falling into this category are currently dealt with in the criminal justice system. In other cases, a guardian makes the decision that they should live in a secure place where they cannot harm others, or they consent to living in such a facility, without having a clear understanding that they have an option to refuse to do so.

1.32 The Statewide Forensic Service (SFS) is a disability services program operated by the Department of Human Services (DHS). It provides an intensive treatment residential program (ITRP) for a small number of people with an intellectual disability who exhibit dangerous behaviours. Participants in the program are held initially in a locked residential facility operated by SFS. The aim of the program is to modify their behaviour so that they can eventually live in the community without posing a risk to either themselves or to others.

1.33 While many of the people in SFS have been confined to the facility under a court order, this is not the case for all residents. People placed in SFS under a court order, may agree to remain there after the expiry of the court order, or a guardian may be appointed to make this decision on their behalf.²¹ In these situations there may not have been any external scrutiny of the decision that they should continue to be detained. The Vincent Review was critical of the current processes for dealing

21 At the time of the Vincent Report, of a total of 16 residents, six had consented to living at SFS and two clients' guardians had consented on their behalf; *Report of the Review Panel Appointed to Consider the Operation of the Disability Services Statewide Forensic Service* (2001) 10.

with such matters and recommended that the Victorian Law Reform Commission should consider legislative reform of the processes.²²

1.34 Chapter 2 of this Report identifies inadequacies in the current framework for regulating these kinds of decisions. In Chapter 4 we make proposals for a new legislative framework, and in Chapter 6 we consider how this framework should apply to people with a cognitive impairment.

RESTRICTIVE PRACTICES

1.35 The Report also deals with restraint, seclusion and other decisions that restrict people's freedom (restrictive practices) that are made in the course of caring for them, in order to prevent self harm or harm of others. Such restrictive practices include physical restraint (for example by holding down) and limiting people's freedom of movement, for example by locking the doors in the place where they are living, so that they cannot enter and leave as they choose.

RESTRAINT

1.36 People's freedom may be affected by the use of physical or chemical restraints. The IDPSA regulates use of 'restraint' for behavioural control purposes, but does not define this expression. The Disability Services Policy on Restraint and Seclusion²³ currently defines restraint as 'the use of any chemical substance or mechanical means whereby the movement of any part of a person's body is restricted or subdued'. Mechanical restraint refers to 'manual methods or mechanical devices used to prevent, restrict or subdue movement of any part of a person's body'. For example, the restriction of people's movement by using straps to keep them in a chair would come within this definition.

1.37 Chemical restraint refers to 'any chemical substance used to control or subdue a person's behaviour'. The Policy excludes prescription of drugs by a medical practitioner for the primary purpose of treating a physical illness or condition, or the prescription of drugs by a psychiatrist for the purpose of treating a mental illness. If, however, the primary purpose of the prescription is to control

22 *Report of the Review Panel Appointed to Consider the Operation of the Disability Services Statewide Forensic Service* (2001) 12–4.

23 Disability Services, Department of Human Services, *Restraint and Seclusion—Policy: January 2001—Amended September 2002*, (2002), 4. For more detailed discussion of current definitions of these practices see paras 5.20–40

the person's behaviour, for example by reducing his or her sexual drive or aggression, it comes within the definition.

SECLUSION

1.38 Seclusion is defined in section 44 of the IDPSA as the sole confinement of a person, at any hour of the day or night, in a room of which the doors and windows are locked from the outside. The Policy also covers 'any situation where a person is confined in a room on his/her own and the door cannot be opened by the person from the inside'. This covers the situation where the person cannot leave the room because his or her disability prevents the person from opening the door, even though the door is not locked. The purpose of seclusion is usually to protect the person or others from harm.



CASE STUDY

James is an intellectually disabled man who lives in a community residential unit with six other people. He has difficulty controlling his emotions and from time to time he is violent to staff members and other residents. He has got into several fights and because he is quite small he has been badly hurt on a couple of occasions. Staff have found that if they place him in his room for a few hours and do not allow him to mix with other residents he usually calms down.

1.39 The recent Auditor-General's *Report on Services for People with an Intellectual Disability* found that 'there are weaknesses in the operation of safeguards related to the use of restraint and seclusion, including a lack of understanding by some providers of their responsibilities [and] limited definitions of what constitutes restraint and seclusion.'²⁴ The Auditor-General's Report recommended that consideration be given to strengthening and clarifying the legislation which regulates restraint and seclusion.²⁵

24 Auditor-General Victoria, *Services for People with an Intellectual Disability* (2000) 6. The definitions of restraint and seclusion are discussed in paras 5.23–6. Both involve some reasonably significant restrictions on the freedom of the person with the disability.

25 Ibid 43–9.

1.40 Chapter 5 of this Report recommends the strengthening of the IDPSA provisions which currently regulate the use of restraint and seclusion of people with an intellectual disability. It also proposes controls on other restrictive practices, such as locking doors to prevent people leaving premises where they are living.



CASE STUDY

Bill is a 30 year old man with a severe intellectual disability. Some years ago he lit a number of fires in the garden of the residence in which he is living and on the second occasion he burnt his hands severely. The community residential service in which Bill lives locks the door so that Bill cannot go outside without someone accompanying him.

1.41 Chapter 6 proposes the phasing in of a similar system to regulate use of restrictive practices in relation to people with cognitive impairments other than intellectual disability.

OUR PROCESS

1.42 In May 2002 the Commission published a Discussion Paper, *People with Intellectual Disabilities at Risk: A Legal Framework for Compulsory Care*, which sought responses to the issues raised by the terms of reference. We also produced an Easy English version of the Discussion Paper and an audio version of the Easy English publication to ensure that people with disabilities had the opportunity to comment on our proposals. These publications were produced with the assistance of a reference group of people with intellectual disabilities. As part of the consultation process we organised a number of forums for people with intellectual disabilities, advocates and service providers. These forums were held in Melbourne and in regional centres including Morwell and Warrnambool.

1.43 The Commission received 29 submissions from individuals and organisations, including organisations such as DHS, the Office of the Public Advocate, Statewide Forensic Services and the Intellectual Disability Review

Panel.²⁶ We also met with individuals and organisations on an informal basis to discuss issues raised by the terms of reference.

1.44 The issues raised in the consultation process have informed the development of this Report. The Commission also established an expert Advisory Committee to provide advice on our recommendations.²⁷

OTHER REVIEWS

1.45 While the Commission was conducting its research and consultation process DHS has been working on a review of current disability services legislation in Victoria. DHS has published a *Discussion Paper*²⁸ and submissions on this Paper are currently being considered.

1.46 During the period of our work DHS has also been undertaking a project on *Responding to People with Multiple and Complex Needs*. A report on Phase One of the Project was published in August 2003. The goal of the project was to provide a better system for dealing with the needs of a small group of DHS clients who ‘may experience combinations of mental illness, intellectual disability, acquired brain injury, behavioural difficulties, family dysfunction and drug and alcohol abuse’.²⁹ This project arose from a perceived inadequacy in the way in which services have been provided and coordinated for clients who have multiple disabilities and impairments, whose behaviour requires considerable resources to manage, and who often move in and out of the criminal justice system. The recommendations in the report are intended to ensure better assessment of the needs of people in this group, and a more integrated system of service delivery for those who present with complex problems and who receive services from DHS.³⁰

1.47 DHS has identified 208 people across Victoria who fall into this group. Because some of these people had an intellectual disability³¹ there is an overlap

26 See Appendix 1 for the list of Submissions.

27 See page viii for the composition of the Advisory Committee.

28 Disability Services Division, Department of Human Services, *Review of Disability Legislation in Victoria* (2003).

29 Department of Human Services, *Responding to People with Multiple and Complex Needs Phase One Report* (2003) 3.

30 Ibid.

31 Ibid 18. The Report indicates that 175 of them had mental health issues and 104 had disabilities (82 had both). The number of those with an intellectual disability was not identified in the Report.

between this project and our reference. Some of the people being considered in the Complex Needs project may also be subject to the framework recommended in this Report. The Commission has been kept informed of progress on both DHS projects throughout the period of this reference.

STRUCTURE OF THE REPORT

1.48 This structure of this Report is as follows.

- Chapter 2 of this Report discusses the problems with the present law.
- Chapter 3 discusses the principles which we propose should underpin the legislative framework for detention and the use of restrictive practices in caring for people with an intellectual disability or cognitive impairment.
- Chapter 4 sets out a legislative framework for detention of people with an intellectual disability, including the process by which involuntary decisions are made and how they can be reviewed.
- Chapter 5 sets out a framework for regulating the use of restrictive practices in the course of caring for people with an intellectual disability.
- Chapter 6 considers the extent to which the proposed legislative framework should apply to people with a cognitive impairment.
- Chapter 7 makes proposals to improve the response of the criminal justice system to people with an intellectual disability or cognitive impairment.
- Chapter 8 provides a framework for overseeing the operation of the system, and makes recommendations for systematic monitoring of service providers and for complaints handling.

Chapter 2

Problems with the Current System

INTRODUCTION

2.1 In Chapter 1 we referred to the lack of an adequate legislative framework regulating decisions to detain people without consent or to use restrictive practices. We also briefly described the current legislation that applies to the treatment and care of people with intellectual disabilities and cognitive impairments. The *Discussion Paper*³² examined the legislative framework and identified:

- inadequacies in human services legislation;
- inappropriate use of guardianship to authorise detention of people with an intellectual disability;
- gaps in the criminal justice system; and
- poor interaction between the criminal justice and human services systems.

2.2 Our consultations confirmed the existence of these problems. They are described in more detail below.

HUMAN SERVICES LEGISLATION

CURRENT PROVISIONS

2.3 Unlike most other jurisdictions throughout Australia and internationally, Victoria has separate legislative regimes dealing with the provision of services for people with intellectual disabilities and people with a mental illness. Services for people with an intellectual disability are provided under the *Intellectually Disabled Persons' Services Act 1986* (IDPSA) or the *Disability Services Act 1991* (DSA). Some services for people with a cognitive impairment are provided under the DSA.

32 See Victorian Law Reform Commission, *People with Intellectual Disabilities at Risk: A Legal Framework for Compulsory Care* Discussion Paper (2002) 11–41.

Services for people with a mental illness are provided under the *Mental Health Act 1986* (MHA). The MHA is the only one of these three pieces of legislation that makes detailed provision for care and treatment without the person's consent.³³

2.4 The IDPSA and the DSA deal with the provision of services at the request of clients, their carers or guardians and the manner in which they are delivered. Because the IDPSA and DSA deal with the provision of services to people on a voluntary basis, they do not contain general provisions authorising detention of people whose behaviour creates a risk of harm to others.

2.5 However, the IDPSA does contain provisions authorising use of the restrictive practices of restraint and seclusion.³⁴ Controls on these practices are discussed below. The IDPSA provisions do not authorise on-going restrictions of liberty, but reflect the legislative policy that restraint and seclusion should only be used intermittently in limited circumstances. There are no provisions in the DSA allowing restraint or seclusion.

2.6 Decisions about the priority of services for people with a disability are made according to need and are necessarily influenced by resource constraints.³⁵ The Commission was told that these constraints may result in a person's rights and freedoms being restricted, in situations where a better-resourced service might be able to avoid use of restrictive practices. For example, a poorly funded service may adopt a locked door policy because it does not employ sufficient staff to allow residents who wish to go out to be accompanied by a staff member.

2.7 In practice, a person with an intellectual disability or cognitive impairment may be detained or subjected to restrictive practices in a number of situations. First, a person may be treated as if he or she has consented to treatment and care when this is not actually the case. For example

- a person may 'agree' to take medication that has the effect of modifying behaviour, without understanding the effects of the medication, or while being under the impression that it has another purpose; and
- a person may 'agree' to live in a place that he or she is not free to enter and leave.

33 The objects of the *Mental Health Act 1986* include 'to provide for the care, treatment and protection of mentally ill people who do not or cannot consent to that care, treatment or protection': s 4.

34 For the definition of these practices paras 5.23–7.

35 Auditor-General Victoria, *Services for People with an Intellectual Disability* (2000) 4.

2.8 Secondly, a guardian may agree to a person living in a particular place in order to prevent the person harming others. Finally, a person may be restrained or secluded under section 44 of the IDPSA.

SECTION 44 OF THE IDPSA

2.9 As we have mentioned above, the IDPSA contains some safeguards in relation to the use of restraint and seclusion of people with an intellectual disability. These safeguards apply to people who are registered and receiving services defined under the Act. These include services provided in a residential institution, residential program, registered service, by contracted service providers or in a non-residential service. The IDPSA requires the preparation of general service plans for people eligible to receive services under the Act.³⁶ A general service plan is a comprehensive plan prepared for a person with an intellectual disability. It 'specifies the areas of major life activity in which support is required and the strategies to be implemented to provide that support'.³⁷

2.10 The general service plan is prepared in consultation with the person who will receive the services, their primary carer and other appropriate people.³⁸ A copy of the plan must be provided to the person, the primary carer and any association or organisation which provides services to the person.³⁹

2.11 An individual program plan is prepared for a person with an intellectual disability and specifies the activities and methods to be used to achieve the goals in areas identified in the person's general service plan. As for general service plans, consultation with the person and his or her primary carer is required, and a copy of the plan must be used to the person and, unless the person objects, to his or her primary carer.⁴⁰

36 *Intellectually Disabled Persons' Services Act 1986* s 9. The person requesting an assessment for eligibility may require the Secretary to prepare a general service plan, within a reasonable time. If a request has not been made and the person with the intellectual disability is seeking admission or has been admitted in an emergency to a residential service, a registered service, a contracted service provider, a residential program or a non-residential program the Secretary must ensure that a plan is prepared within 60 days.

37 *Ibid* s 3.

38 *Ibid* ss 9(4) and (5). A person may object to the primary carer being consulted and if the Secretary is satisfied the person has the capacity to object and the primary carer is not the person's guardian, the Secretary must not consult with the primary carer.

39 *Ibid* s 9(6).

40 *Ibid* s 11(4).

2.12 Under section 44, mechanical or chemical means of restraint can only be used if the following requirements are met:

- it is necessary to prevent a person from injuring himself or herself or any other person, or to prevent the person persistently destroying property;
- the use and form of restraint is authorised in the person's individual program plan, and approved by the authorised program officer;⁴¹ and
- in the case of an emergency the restraint is authorised by the person in charge.

Restraint can only be used for the period authorised in the individual program plan or authorised by the person in charge.

2.13 A person can be kept in seclusion only if it is part of the person's individual program plan or, in the case of an emergency if it

- is necessary for the protection, safety or wellbeing of the person or other persons with whom they would otherwise be in contact; and
- is authorised by the person in charge and notified to the authorised program officer without delay.

2.14 Where restraint or seclusion is used, a service provider must report it to the Intellectual Disability Review Panel (IDRP) on a monthly basis.⁴² However there is no legislative requirement or authorisation for the IDRP to monitor or act on the reports⁴³ other than to table an annual report in Parliament. In April 2001–02, 1285 people eligible for services under the IDPSA were reported to the IDRP as having been subject to restraint or seclusion, which amounts to 17% of people receiving services under the IDPSA.⁴⁴

2.15 There is no requirement to report restrictive practices which do not come within the definition of restraint and seclusion. For example, when a person is regularly placed in a locked room in which others are present this does not have to be reported. Similarly, because the definition of chemical restraint excludes drugs prescribed for medical treatment purposes, there is no requirement to report such prescribing practices.

41 Ibid s 44(1): An authorised program officer means a person authorised by the Secretary.

42 Ibid s 44(9).

43 Auditor-General Victoria, *Services for People with an Intellectual Disability* (2000) 45.

44 Intellectual Disability Review Panel, *Annual Report 2001–2002*, (2002) 41.

2.16 An application for review of a decision to use restraint or seclusion can be made to the IDR. ⁴⁵ The IDR, however, has no power to make binding decisions and is not fully independent from DHS. ⁴⁶ A number of Departmental staff sit on the Panel as sessional members. ⁴⁷ In practice, it appears that clients and their families are not routinely advised of their right to seek a review ⁴⁸ and it is very rare for people to seek review of decisions. In 2001–2002 the IDR received 238 inquiries, ⁴⁹ nine applications for review and completed five hearings. ⁵⁰

2.17 There are no similar provisions regulating use of restraint and seclusion by persons providing services under the DSA.

CRITICISMS OF THE OPERATION OF SECTION 44

2.18 The Auditor-General's Report on *Services for People with an Intellectual Disability* criticised the way that the section 44 provisions were applied in practice. ⁵¹ These criticisms related to:

- variations in the levels of information and justification which Authorised Program Officers required before they approved the use of restraint and seclusion;
- 'regular renewal of individual program plans specifying the use of restraint and seclusion, and the accompanying formal approval with little evidence of formal review of the effectiveness or continued appropriateness of the strategy, an absence of consultation with family members and in some cases, little evidence of a review of the Individual Program Plan itself'; ⁵²

45 *Intellectually Disabled Persons' Services Act 1986* s 51(f), s 52.

46 Under s 52 of the *Intellectually Disabled Persons' Services Act 1986* the Panel has the power to make recommendations to the Secretary of DHS with respect to particular decisions made under the Act, including decisions to use restraint and seclusion. The Secretary may reject any recommendations made by the Panel.

47 Intellectual Disability Review Panel, *Annual Report 2001–2002*, (2002) 30.

48 Auditor-General Victoria, *Services for People with an Intellectual Disability* (2000) 48. The research of the Auditor-General also suggested that there was a general reluctance on the part of the families to complain: *ibid.* Over 2,500 potentially reviewable decisions were made in 1999–2000 on general service plans and eligibility assessments, which were only two of the seven types of reviewable decisions made by the Department: *ibid.* 47.

49 Intellectual Disability Review Panel, *Annual Report 2001–2002*, (2002) 27.

50 *Ibid.* 14.

51 Auditor-General Victoria, *Services for People with an Intellectual Disability* (2000) 44.

52 *Ibid.*

- lack of awareness among service providers about the need to seek approval for, or report the use of, restraint and seclusion; and
- failure of the provisions to cover some types of restrictive practices, that substantially affect the rights of people with an intellectual disability. In particular the Report referred to situations in which a person was placed in a room or other area that he or she was unable to leave and to the lack of any time limit on the period during which a person can be placed in seclusion.

2.19 The limited safeguards that apply to the use of restraint and seclusion under the IDPSA do not apply to people who do not receive, or are not eligible for, services under that Act.⁵³ The Auditor-General's Report commented that 'this can lead to a situation where an individual is protected while living in a service for people with an intellectual disability, but if moved to another setting such as a nursing home, may no longer be entitled to the same standard of protection'.⁵⁴

2.20 People with other cognitive impairments such as acquired brain injury or autism spectrum disorder may receive services under the DSA, which does not regulate use of restraint and seclusion measures. Some of these people may be housed in hostels and nursing homes that receive funding under the *Aged Care Act 1997* (Cth), which introduced new funding and accountability arrangements for Commonwealth funded residential care services. The accreditation standards for residential aged care, which apply under the Commonwealth contain some general principles relevant to the use of restraints. In addition, the Commonwealth Department of Health and Ageing has published *Standards and Guidelines for Residential Aged Care* which make specific provisions about the use of physical restraints.⁵⁵ These standards may provide some limited protection for residents, including younger people with acquired brain injury, who are housed in nursing

53 The *Intellectually Disabled Persons' Services Act 1986* has been criticised for its limited coverage. It has been argued that a 'broader definition should ensure that persons with autism or acquired brain injury, now excluded under the Act, would be included. Similarly, persons whose intellectual disability is not manifest before the age of 18 or because they cannot demonstrate that the condition was manifest before the age should be covered': Loula Rodopoulos, 'Justice for Everyone' in Anthony Shaddock et al (eds), *Intellectual Disability & the Law: Contemporary Australian Issues* (2000) 11, 15.

54 Auditor-General Victoria, *Services for People with an Intellectual Disability* (2000) 44

55 Victor Harcourt, 'Physical Restraints in Residential Aged Care' (2001) 75 (10) *Law Institute Journal* 73; see also Australian Society for Geriatric Medicine, *Physical Restraint Use in the Elderly*, Position Statement No.2.

homes. However, concerns have been raised about the inappropriate use of psychotropic medications and physical restraints in such facilities.⁵⁶

2.21 Unlike the aged care sector, which regulated by the *Aged Care Act 1997* (Cth) and the Aged Care Principles,⁵⁷ there is no accreditation process under either the IDPSA or the DSA.

PROBLEMS WITH CURRENT PROVISIONS

2.22 The Commission's view is that the current human services framework does not adequately protect the rights of people with either an intellectual disability or cognitive impairment. The problems that exist include:

- no legislative framework regulating detention;
- inadequate legislative provisions to control use of restrictive practices by service providers;
- no effective process for regular monitoring of the use of these practices or auditing the way that service providers use these practices; and
- no independent review process for decisions that may substantially limit the freedom of people with intellectual disabilities or other cognitive impairments.

2.23 The Discussion Paper noted the discrepancies between the system for involuntary detention and treatment of people with mental illness⁵⁸ and that which applies to people with intellectual disabilities and other cognitive impairments. In our consultations, however, we observed there was some cynicism about the effectiveness of the current provisions and processes for involuntary treatment of people with mental illnesses. If it is the case that these safeguards do not always work for this group of people,⁵⁹ the current arrangements for people with

56 See, for example, NSW Department of Health, *Review of the Nursing Homes Act 1988* Issues Paper (2000) 35–6.

57 Section 96-1 of the *Aged Care Act 1997* (Cth) enables the Minister to make up to 23 Principles that are required or permitted under the Act, or that the Minister considers are necessary or convenient to carry out or give effect to a Part or section of the Act. The Minister has made 21 Principles under the Act. See <<http://www.health.gov.au/acc/legislat/legindex.htm>> @ 7 October 2003.

58 Victorian Law Reform Commission, *People with Intellectual Disabilities at Risk: A Legal Framework for Compulsory Care*, Discussion Paper (2002) 17–20.

59 For example, Submission 16, Mental Health Legal Centre, 2, suggests that the review provisions in the *Mental Health Act 1986* are inadequate.

intellectual disabilities or other cognitive impairments are even more open to abuse, because detention and restrictive care practices are less regulated and open to scrutiny.

GUARDIANSHIP

2.24 In some situations, the guardian of a person may consent to the person being detained or may consent to the use of restrictive practices to control the person's behaviour.⁶⁰ For example, a guardian may agree to the prescription of sedatives in order to control a person's aggressive behaviour, may decide that a person should be placed in a community residential unit or a residential institution⁶¹ that provides long term care, or may agree to the person's admission to Statewide Forensic Services (SFS).

2.25 Guardians are appointed under the *Guardianship and Administration Act 1986* (GAA) following an application to the Victorian Civil and Administrative Tribunal (VCAT).⁶² A member of the person's family, a friend, another member of the community or the Public Advocate may apply to VCAT for appointment as a guardian. A guardianship application may also be made when a person with an intellectual disability or cognitive impairment is being released from prison after serving a sentence for an offence, because it is believed that the person should be placed in a residential facility to prevent him or her harming others.

2.26 The purpose of appointing a guardian is to provide a substitute decision-maker for people who, because of a disability,⁶³ cannot make decisions on their own behalf. A guardianship order can only be made if VCAT is satisfied that the person in respect of whom the application is made has a disability that covers an 'intellectual disability, mental disorder, brain injury, physical disability or dementia'.⁶⁴ The person must also be unable, by reason of the disability, to make reasonable judgments in respect of all or any of the matters relating to their person

60 For example, pt 4A of the *Guardianship and Administration Act 1986* outlines the provisions for the authorisation of medical and other treatment.

61 These include institutions at Colanda and Sandhurst.

62 Ibid s 19(1). The application is heard in the specialist guardianship list of the human rights division of the Tribunal (Victorian Civil and Administrative Tribunal Rules 1998 r 2.03).

63 In s 3 of the *Guardianship and Administration Act 1986*, 'disability' in relation to a person means intellectual impairment, mental disorder, brain damage, physical disability or dementia.

64 Ibid s 3.

or circumstances.⁶⁵ The appointment must be in the best interests of the person with the disability.⁶⁶ The order may limit the powers of the guardian to particular life areas (a ‘limited guardian’), such as housing or health care.⁶⁷ Alternatively, the guardianship order may give the guardian the same decision-making powers that a parent would have over his or her child (a ‘plenary guardian’).⁶⁸

2.27 If the person is receiving services under the IDPSA, the use of restraint and seclusion is authorised in the circumstances provided in the Act, whether or not a guardian has agreed to the use of these measures. If the restrictive practice falls outside the definition of restraint and seclusion,⁶⁹ or if the person is not receiving services under the IDPSA (for example because the person has an acquired brain injury rather than an intellectual disability) a guardian may agree to the use of restrictive practices. However some people are subjected to such restrictive practices without any guardian being appointed.

PROBLEMS IN RELYING ON GUARDIANS TO CONSENT TO DETENTION OR USE OF RESTRICTIVE SERVICE PRACTICES

DETENTION

2.28 Two views have been expressed as to whether guardians should be able to agree to detention on behalf of a person. Some argue that there is an irreconcilable tension between the statutory duty of a guardian to act in the best interests of the person with a disability and the need to protect the community against harm.⁷⁰ On this view, the conflict of interest faced by the guardian makes it inappropriate for the guardian to take account of issues of community safety. On the other hand, it may be argued that, in cases where the person is likely to seriously harm others, a guardian can decide that detention *is* in the person’s best interests because it would

65 Ibid s 22(1).

66 Ibid s 22(3).

67 Ibid s 25.

68 Ibid s 24.

69 If the dosage of a sedative does not amount to chemical restraint then it does not have to be reported to the IDR (if the person has not been assessed as being eligible under the IDPSA there is no need for reporting at all). See paras 5.9–11 and 5.24–6 for some of the problems raised by the use of chemical restraint. For general provisions regarding the consent by guardians to medical and other treatment see Ibid pt 4A.

70 Submission 9, Astrid Birgden 1.

be against the person's best interests to be convicted and sentenced for an offence.⁷¹ This is the view of the President of the NSW Guardianship Tribunal who argues that '[m]embers of the community, either with or without disabilities, are at risk from the unacceptable behaviours of....people. They need protection from the actions of such people. The perpetrators of those actions need protection from the consequences of what they have done'.⁷² It is desirable for the law to clarify whether or not guardians should be able to consent to detention.

2.29 The Commission's view, which is discussed in more detail in Chapter 4, is that guardians should not be able to consent to a person being detained in a secure facility. Generally, the law does not allow detention of people because there is a risk that they may harm others. Because detention without the detainees' consent of people who have not been convicted of a criminal offence is a very severe restriction on their liberty, it is in the interests of the community as a whole that such decisions should be made in accordance with transparent criteria and should be open to scrutiny and monitoring. The guardian of a person with a mental illness cannot consent to that person's involuntary detention or treatment. It is therefore anomalous that people with an intellectual disability or cognitive impairment are not similarly protected.

RESTRICTIVE PRACTICES

2.30 There is also a lack of clarity about the role of guardians in consenting to the use of restrictive practices.⁷³ At present, a person with an intellectual disability may be subjected to restraint and seclusion that is authorised under the IDPSA, without a guardian being appointed. For people with other cognitive impairments a guardian may agree to use of restraint and seclusion and other restrictive practices, or these may be used without a guardian being appointed.⁷⁴

71 Submission 5, Victorian Civil and Administrative Tribunal 1.

72 Nick O'Neill, 'Capacity to be Criminal, the Criminal Justice System and the Protection of Adults with an Intellectual Disability for the Benefit of Themselves and Others' in Anthony Shaddock et al (eds), *Intellectual Disability and the Law: Australian Contemporary Issues* (2000) 119–20.

73 According to the Victorian Government, *Report of the Review Panel Appointed to Consider the Operation of the Disability Services Statewide Forensic Service*, Justice Frank Vincent, Chair (2001) 12, the *Guardianship and Administration Act 1986* is 'under-developed in relation to the compulsory treatment and care of people with an intellectual disability'.

74 Submission 14, Intellectual Disability Review Panel, suggests that only about five people in the State may be compelled by guardians to participate in a residential or treatment program 4.

2.31 Where a person cannot live independently unless in supported accommodation, it may be appropriate to require the person to satisfy the standards of behaviour required in that place, whether it is a community residential unit or an institution. To enable the person to do this, it is arguable that a properly appointed guardian should have the power to agree to restrictive practices that allow the person to live in a particular place.⁷⁵

2.32 On the other hand, the involvement of guardians may create a similar conflict of interest to that which applies in making detention decisions. For example, a guardian may be placed in an invidious position if asked to consent to the medication of a person, where this does not provide a direct benefit to that person but is intended to prevent him or her from harming other people in the residential facility, because staff shortages make adequate supervision of residents difficult. Similar difficulties arise where people are confined primarily because they are difficult to manage and there are no other ways in which they can be supervised. In Chapter 5 we discuss whether guardians should be able to agree to the use of restrictive practices and propose a number of safeguards on the use of these practices.

CRIMINAL JUSTICE LEGISLATION

2.33 Under the criminal justice system, a person with an intellectual disability or cognitive impairment who actually harms someone can, like anyone else, be charged and convicted of an offence under the criminal law. In the DHS Report on *Responding to People with Multiple and Complex Needs*, 71% of the 208 people identified as having such needs had past or current contact with juvenile justice or adult correctional services. One hundred and four of the 208 individuals had some type of disability including an intellectual disability.⁷⁶ An intellectual disability or cognitive impairment is likely to make it harder for a person to understand and protect his or her interests in dealings with the police and the courts.⁷⁷

75 Nick O'Neill 'Capacity to be Criminal, the Criminal Justice System and the Protection of Adults with an Intellectual Disability for the Benefit of Themselves and Others' in Anthony Shaddock et al (eds) *Intellectual Disability and the Law: Australian Contemporary Issues* (2000) 119, 124.

76 Operation Division, Victorian Government Department of Human Services, *Responding to People with Multiple and Complex Needs: Phase One Report*, (2003) 6, 18.

77 Jim Simpson, Meredith Martin and Jenny Green, *The Framework Report: Appropriate Community Services in NSW for Offenders with Intellectual Disabilities and Those at Risk of Offending* (2001) para 4.2.

2.34 If a person with an intellectual disability or cognitive impairment is convicted of an offence involving harm or threatened harm to others, sentencing options include⁷⁸ a term of imprisonment, a community based order, or in the case of a person with an intellectual disability, a community based order combined with a justice plan.⁷⁹

IMPRISONMENT

2.35 Some persons with intellectual disabilities or cognitive impairments who are convicted of offences are sentenced to a term of imprisonment. Research into the sentencing outcomes for people with an intellectual disability who appear before the courts has not yet been carried out in any rigorous way in Victoria. However, research conducted elsewhere indicates that there is an enormous over-representation of people with an intellectual disability within the prison system.⁸⁰ It is likely that there is a similar over-representation of such persons in Victoria. Many of these persons will have committed minor offences that do not place others at risk of harm. People with cognitive impairments may also be over-represented in the prison system.

2.36 The Port Phillip Prison has a specialist protection unit (the Marlborough Special Unit) for male prisoners with intellectual disabilities. On 2 October 2003 there were 30 sentenced prisoners and five remand prisoners in the Unit.⁸¹ However some people with intellectual disabilities and cognitive impairments are held elsewhere in the prison system.

2.37 One explanation for the over-representation of people with an intellectual disability in the prison system may be the lack of suitable services for their care and management within the community. Such persons may move backwards and

78 This is not an exhaustive list of sentencing options. For a discussion of the broad range of sentencing options that are available see Richard Fox and Arie Freiberg, *Sentencing: State and Federal Law in Victoria* (2nd ed) (1999) Chs 7–10.

79 Other options include dismissal, discharge or adjournment of the charges. Conditions may be imposed on some of these orders: *Ibid* Ch 7.

80 One NSW study has shown that while the incidence of intellectual disability in the general population is 2–3%, at least 12–13% of the NSW prison population has an intellectual disability: New South Wales Law Reform Commission, *People with an Intellectual Disability and the Criminal Justice System*, Report 80 (1996) para 2.5.

81 Information provided by Corrections Victoria.

forwards between the criminal justice system and informal care networks provided by neighbours and family members.

TRANSFER FROM A PRISON TO A RESIDENTIAL INSTITUTION

2.38 Where a person who is eligible for services under the IDPSA is convicted of an offence and sent to prison, such person may be transferred to a residential institution as a 'security resident' under section 21 of the IDPSA. A security order can be made only if an individual program plan has been prepared for that person and the Secretary to the Department of Justice considers that it is in the best interests of the person or the community. In making this decision, the Secretary must consider the risk to which the person would be exposed if detained in prison, whether the person would be more appropriately placed in a residential institution, whether programs are offered by the residential institution which are designed to reduce the likelihood of the person committing further criminal offences, and any other matters the Secretary considers relevant.⁸²

2.39 The Intellectual Disability Review Panel, which is constituted under the IDPSA, must review the case of a resident within 12 months of that person becoming a security resident and thereafter review it at 12 month intervals.⁸³ The Minister for Community Services may terminate the order on the recommendation of the Secretary of DHS, or the Intellectual Disability Review Panel, in which case the person will be transferred to a prison. Otherwise, the order terminates when the sentence of imprisonment expires.

2.40 The submission from the Victorian Bar said that Criminal Bar Association members report that in their experience intellectually disabled offenders are typically incarcerated in 'protection' units within prisons, rather than transferred to other facilities.

[i]ntellectually disabled persons are rarely transferred to residential facilities once incarcerated. The Association has not been able to access data in regards to this, however, anecdotally, it simply does not appear to happen.⁸⁴

82 *Intellectually Disabled Persons' Services Act 1986* s 21(7).

83 *Ibid* ss 28(a), 36.

84 Submission 22, Victorian Bar, para 8.2.

COMMUNITY BASED ORDERS

2.41 Community based orders are available as a non-custodial sentencing option for the court if a person is found guilty of an offence punishable by imprisonment or a fine greater than \$500; the court has received a pre-sentence report; and the person agrees to comply with the order. An order can last for up to two years.⁸⁵

2.42 Section 37 of *Sentencing Act 1991* defines *core* conditions of the order, including that:

- no further offences, punishable by imprisonment, be committed during the period of the order;
- the offender report to a specified community correctional services centre within two working days of receiving the order;
- the offender notify an officer at the centre of any change of address or employment within two working days; and
- the offender not leave the State without permission and obey the lawful directions of community correctional services officers.

2.43 Additional program conditions may be attached. These can include requirements that the person attend educational or other programs, submit to medical, psychological or psychiatric assessment as directed by the Regional Manager, live in a particular place, or participate in the services specified in a justice plan.⁸⁶

JUSTICE PLANS

2.44 If the situation is one in which the court can impose a community based order and the person has an intellectual disability, the court may order that the person complies with the provisions of a justice plan.⁸⁷ A justice plan is provided by Disability Services on the request of the court after a person has pleaded guilty or has been found guilty of an offence and is intended to assist the court in sentencing by recommending services designed to reduce the likelihood of re-offending. The justice plan can last for up to two years, or the period for which the

85 *Sentencing Act 1991* ss 36, 110.

86 *Ibid* s 38.

87 *Ibid* ss 80–3.

person would have been sentenced, whichever is the shorter⁸⁸ and must be reviewed by the Secretary of DHS no later than one year after the sentence is imposed.⁸⁹ A justice plan can require that the person live in a particular place or comply with a particular care regime or both. For example, the person may be required to live in a community residential unit where his or her behaviour can be supervised.

2.45 Where the behaviour of a person with an intellectual disability involves danger to others, the justice plan may require the person to reside within SFS for as long as deemed appropriate by the SFS and to participate in all programs and groups recommended by the SFS. Typically, the justice plan may state that:

The strict environment controls imposed by placement within the [SFS] will assist (the person) with behaviour management and assist him develop internal controls necessary to reduce the likelihood of him re-offending. He will also be provided with the opportunity to continue to participate in treatment groups and sessions to address offence related issues and ... program development to reduce the likelihood of re-offending and to increase the client's ability to live in a less restrictive environment and further ... the person will participate in psychoeducational, psychotherapeutic and educative programs aimed at addressing offence related behaviour and general psychological development in addition to assisting to develop pro-social skills.⁹⁰

2.46 Justice plans only apply to people eligible for services under the IDPSA. They are not available to people with other cognitive impairments such as people with an acquired brain injury.

CRIMES (MENTAL IMPAIRMENT AND UNFITNESS TO BE TRIED) ACT 1997

2.47 In other instances where a person with an intellectual disability or cognitive disability is charged with a criminal offence, the court may find that the person is either unfit to stand trial or not guilty because of his or her mental impairment under the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (CMIA).

88 Ibid s 80.

89 Ibid s 81.

90 Victorian Government, *Report of the Review Panel Appointed to Consider the Operation of the Disability Services Statewide Forensic Service*, Justice Frank Vincent, Chair (2001) 7–8.

2.48 A person found unfit to stand trial, can be remanded to a prison or other appropriate place for a specified period.⁹¹ If the person is found not guilty because of impairment, the court can order that the person be released, or it can make a custodial supervision order committing the person to custody in a prison or another appropriate place. For people with intellectual disabilities (forensic residents) an ‘appropriate place’ is a service, institution or program under the IDPSA. An order cannot be made committing the person to prison unless the court is satisfied there is no practicable alternative.⁹² Where a person is initially confined in a prison there is provision for transfer of the person from prison to an appropriate residential service as a ‘forensic resident’.⁹³

2.49 Alternatively, a non-custodial supervision order can be made releasing the person on conditions required by the court.⁹⁴ A non-custodial supervision order can require a person to live in a particular place or to undergo treatment.

2.50 Both custodial or non-custodial supervision orders are for an indefinite term.⁹⁵ However, the Act contains some safeguards against unjustified detention. The supervision order must include a nominal term. Three months before the end of this nominal term the court must review the order to determine whether the person subject to the order should be released from it. The nominal term set by the court will vary depending on the offence with which the person had been charged.⁹⁶ Either the person against whom the supervision order is made, the Director of Public Prosecutions, the Attorney-General or the Secretary to DHS can appeal against a supervision order.⁹⁷ The provisions requiring review of the

91 *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* ss 11, 12. The sections provide for review of fitness to stand trial at the end of specified periods.

92 *Ibid* s 26. For a full explanation of the provisions for both custodial and non-custodial supervision orders, see Victorian Law Reform Commission, *People with Intellectual Disabilities at Risk: A Legal Framework for Compulsory Care*, Discussion Paper (2002) 26–9.

93 *Intellectually Disabled Persons’ Services Act 1986* s 21A.

94 *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* s 26(2).

95 *Ibid* s 27(1). Under s 27(2) the courts may direct that the matter be brought back to the court for review at the end of the period specified by the court.

96 For the offence of murder, the nominal term will be 25 years; for a serious offence (defined in s 3 of the *Sentencing Act 1991* to include offences such as manslaughter, rape, kidnapping and armed robbery) it will usually be the same as the maximum prison sentence for that offence; for other offences where there is a statutory maximum term of imprisonment the nominal term will be half the maximum prison sentence; and where there is no maximum prison sentence applicable to the offence, the nominal term will be set by the court (*Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* s 28(1)).

97 *Ibid* s 28A.

supervision order provide important protection for people with a mental impairment.

2.51 There are currently three residents detained in a secure facility on custodial supervision orders under the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997*. They live in a secure facility located at the Plenty Residential Service, which is a residential service under the IDPSA.⁹⁸

PAROLE CONDITIONS

2.52 When a prisoner is released on parole, the Adult Parole Board can set terms and conditions of the release.⁹⁹ A parole plan includes services that are available, appropriate and specifically address a person's offending behaviour. In the case of a person with an intellectual disability or a cognitive impairment, release on parole could include conditions requiring the person to live in a particular place or comply with a treatment program or service regime.¹⁰⁰ For example, parole conditions could require a person to live in a community residential unit or at SFS. These conditions come to an end when the parole period is completed.

ROLE OF STATEWIDE FORENSIC SERVICES

2.53 In Chapter 1 we referred to the intensive treatment residential program (ITRP) offered by Statewide Forensic Services for a small number of people with an intellectual disability. SFS provides intensive therapeutic treatment and care to people with an intellectual disability who have typically been involved in the criminal justice system and demonstrate dangerous, antisocial behaviour. Through these services the SFS aims to reduce the risk that clients will harm themselves, other residents in the place where they are living, or members of the general community.¹⁰¹

98 For the definition of a 'forensic resident' see Ibid s 3. People who are mentally ill are held as 'forensic patients' at the Thomas Embling Hospital, which is an approved mental health service under the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997*. Occasionally a person with a dual disability (intellectual disability and mental illness) is held as a forensic patient at Thomas Embling.

99 *Corrections Act 1986* s 74

100 *Report of the Review Panel Appointed to Consider the Operation of the Disability Services Statewide Forensic Service*. Justice Frank Vincent was Chair of the Review Panel, 8.

101 Ibid 5.

2.54 Our discussion above indicates that people may be admitted to the SFS program in a number of different ways. They may have been found guilty of an offence and have agreed to a community based order or justice plan which requires that they participate in the program. They may reside at SFS under parole conditions. They may have agreed to remain at SFS after their community based order or justice plan has expired. Their guardian may have consented to them participating in the program.

2.55 The Vincent Report, which was released in September 2001, examined the operation of the SFS and reported on the legal status of residents over a two year period.¹⁰²

Legal Status of Residents at Statewide Forensic Services

Status	As at July 2001	July 1999 and July 2001	September 2003
Community based orders	5	9	4
Parole	2	2	1
Forensic residents	Nil	3	Nil
Voluntary	6	9	3
Guardianship order	2	4	6
Security residents	Nil	Nil	Nil
Undertaking with conditions	1	2	1
Total	16	29	15

GAPS IN HOW THE CRIMINAL JUSTICE SYSTEM DEALS WITH PEOPLE WITH AN INTELLECTUAL DISABILITY OR COGNITIVE IMPAIRMENT

2.56 By contrast to the human services legislation, the mechanisms discussed above allow independent and external scrutiny of decisions that result in people

102 Ibid 10. The Commission also had access to unpublished data from Statewide Forensic Services for September 2003.

being detained or required to receive treatment and care. There is provision for court review of decisions and there are safeguards against indefinite detention. However, these provisions have a number of limitations.

- The justice plan provisions provide a legal framework for detaining or treating a person with an intellectual disability. However justice plans are limited to situations where the court considers a community based order would be appropriate. This may not be the case where the person has been convicted of a serious offence. By contrast, where a person with a mental illness is found guilty of an offence, a hospital order can be made by the court authorising detention and treatment¹⁰³ where this is necessary in order to prevent deterioration in the person's mental or physical condition or otherwise, or for the protection of members of the public.
- The term of a justice plan cannot exceed two years. This may not provide sufficient time to assist the person to change their behaviour.
- Justice plans only apply to people who are eligible for services under the IDPSA. People with other cognitive impairments may have similar behaviour management needs to people with intellectual disabilities, but the justice plan provisions do not apply to them.
- The CMIA applies only where the person is unfit to plead or not guilty because of the impairment. It does not provide a mechanism for managing the behaviour of a person with an intellectual disability or cognitive impairment who is found guilty of an offence.
- There is no provision in the criminal justice system for the continuation of detention or restrictive practices after the expiry of sentences of people with intellectual disabilities or cognitive impairments, who are not mentally ill. This is the case even if they present a serious danger to others and may benefit from a management program that may help them to change their behaviour.

103 *Sentencing Act 1991* s 93.

GAPS IN THE INTERACTION BETWEEN THE HUMAN SERVICES AND CRIMINAL JUSTICE SYSTEMS

2.57 Both the Discussion Paper and our consultations suggested that the criminal justice and human service systems do not interact effectively. In some cases, it is apparent that the person is likely to continue to behave in a way that places others at risk of harm. Prosecuting the person will not prevent recurrence of the behaviour, but it may be difficult to ensure the person receives services that could help him or her to change.

2.58 Consultations also suggested that justice plans do not always operate as intended. Because services are provided by DHS on a voluntary basis, it was suggested that there is confusion by service providers about whether a person is required to comply with the plan.¹⁰⁴ The court can cancel the justice plan if the person fails, without reasonable excuse, to comply with the plan. However, a court may be reluctant to cancel the plan if it is argued that the person's failure to comply with the justice plan was the result of lack of appropriate supervision or lack of provision of appropriate services.

2.59 Consultations also highlighted the problems that may arise when people have completed their sentence but, because of their impairment, have been unable to take advantage of opportunities for rehabilitation.¹⁰⁵ In these cases it is necessary to persuade them to 'consent' to detention or to other restrictive practices, or a guardian may be appointed to consent on their behalf. As we have discussed above, there may be a conflict between the guardian's obligation to act in the best interests of the client and the goal of ensuring that the person does not harm others.

SUMMARY

2.60 This Chapter has identified gaps, limitations and inconsistencies in the systems that currently affect people with an intellectual disability or cognitive impairment, whose behaviour places themselves or others at risk of harm. Within the human services system these include:

104 Submission 28, Jelena Popovic, Deputy Chief Magistrate and Anne Condon, Disabilities Officer, Magistrates' Court of Victoria, 3.

105 Many of the residents of the service receive treatment at the facility for five years: Submission 11, Statewide Forensic Services, 18.

- inadequate legislative criteria to control use of detention or restrictive practices;
- no independent review process for challenging decisions that substantially limit the freedom of people with intellectual disabilities or cognitive impairments; and
- no effective process for regular monitoring of these practices.

2.61 We have also identified limitations in the way that the criminal justice process can deal with people whose behaviour may harm others. Justice plans are inadequate to deal with people who need long term rehabilitation and treatment to assist them to change their behaviour so that they do not harm others. Unlike the position with respect to people with a mental illness, the criminal justice system does not provide a mechanism for detention or treatment of people with intellectual disabilities or cognitive impairments after the expiry of their sentence. This is the case even if they are likely to seriously harm others.

2.62 Under the current system, this dilemma is sometimes resolved by treating people as if they have ‘consented’ to detention or to restrictive practices, even though they may lack any real capacity to consent. In some cases, a guardian is appointed to make treatment and care decisions on the person’s behalf. This Chapter has argued that it is inappropriate for a guardian to consent to a person being detained in order to prevent that person harming others. Because detention of a person who has not been convicted of a criminal offence very severely restricts that person’s liberty, detention decisions should be made in accordance with transparent criteria and should be subjected to independent scrutiny.

Chapter 3

Principles

INTRODUCTION

3.1 The previous chapter discussed the criticisms that have been made of the current system for care of people with intellectual disabilities or other cognitive impairments, where this occurs without their consent. The reforms recommended in this Report are intended to deal with these concerns. Chapter 4 proposes a legislative framework to regulate decisions to involuntarily detain a person with an intellectual disability. Chapter 5 proposes a framework to regulate use of restrictive practices for these people. Chapter 6 discusses the application of a similar framework to people with cognitive impairments.

3.2 This Chapter proposes principles to underpin our recommendations and explains the broad approach which we take in the Report. The principles are intended to educate the community about the purposes of the legislation and to guide the way it is interpreted by those responsible for making decisions under it, including those who will review such decisions.

3.3 Our proposed principles build on those that are already set out in other State legislation, including the *Intellectually Disabled Persons' Services Act 1986* (IDPSA),¹⁰⁶ the *Disability Services Act 1991* (DSA),¹⁰⁷ and the *Guardianship and Administration Act 1986* (GAA).¹⁰⁸ We note that the *Review of Disability Legislation in Victoria Discussion Paper* asks whether principles should be set out in any new legislation and whether the current principles are adequate.¹⁰⁹

106 *Intellectually Disabled Persons' Services Act 1986* s 5.

107 *Disability Services Act 1991* schs 1, 2.

108 *Guardianship and Administration Act 1986* s 4(2).

109 Disability Services Division, Department of Human Services, *Review of Disability Legislation in Victoria*, Discussion Paper (2003) 10.

3.4 We have also taken account of relevant international instruments such as the *Declaration on the Rights of Mentally Retarded Persons*,¹¹⁰ the *Declaration on the Rights of Disabled Persons*¹¹¹ and the *International Covenant on Civil and Political Rights*.¹¹² These instruments underpin the federal *Disability Discrimination Act 1992* (Cth), which provides protection against discrimination to people with disabilities in Australia.¹¹³

3.5 In addition to the principles set out in legislation and international instruments, the DHS has published the *Victorian State Disability Plan 2002–2012* since the release of our Discussion Paper. The plan includes a number of principles that are intended to underpin the provision of disability services.¹¹⁴ These are:

- equality;
- dignity and self-determination;
- diversity; and
- non-discrimination.¹¹⁵

110 Proclaimed by the United Nations General Assembly, Resolution 2856 (XXVI), 20 December 1971, incorporated into Australian law by the *Human Rights and Equal Opportunity Commission Act 1986* (Cth) sch 4.

111 Proclaimed by the United Nations General Assembly, Resolution 3447 (XXX), 9 December 1975, incorporated into Australian law by the *Human Rights and Equal Opportunity Commission Act 1986* (Cth) sch 5.

112 Adopted and opened for signature, ratification and accession by United Nations General Assembly, Resolution 2200A (XXI), 16 December 1966. Australia ratified the Covenant 13 August 1980. See also the Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment, adopted by the United Nations General Assembly, Resolution 43/173, 6 December 1988.

113 It has been argued that the *Disability Discrimination Act 1992* is ‘in fact a human rights instrument with a sophisticated mechanism for operationalising the human rights of people with disabilities’; Lee Ann Bassar and Melinda Jones, *The Disability Discrimination Act 1992 (Cth): A Three-Dimensional Approach to Operationalising Human Rights* (2002) 26 *Melbourne University Law Review* 254, 258.

114 The framework we recommend focuses on the regulation of the use of restrictive practices and the safety of the community, therefore principles regarding service provision are not central to our proposals. The provision of services is, however, important in our recommendations as we do not consider any restraint, seclusion or detention can be authorised unless there is a care plan in place that is appropriate for the person. See para 5.39.

115 Disability Services Division, Victorian Government Department of Human Services, *Victorian State Disability Plan 2002–2012*, (2002) 9.

PROPOSED PRINCIPLES

3.6 Our proposed principles emphasise the need to protect the rights and liberties of people with an intellectual disability or cognitive impairment, but also take account of the need to protect other members of the community from harm.

3.7 The suggested principles in our Discussion Paper were:¹¹⁶

- maximising social participation and ensuring the quality of life of people with intellectual disabilities or cognitive impairments;
- safeguarding the rights and liberties of people with intellectual disabilities or cognitive impairments;
- preventing exploitation and abuse of people with intellectual disabilities or cognitive impairments; and
- preventing harm to other members of the community.¹¹⁷

3.8 Submissions generally agreed with the above.¹¹⁸ Other suggested principles included:¹¹⁹

- ‘the means which is the least restrictive of a person’s freedom and action as is possible in the circumstances [should be] adopted’;¹²⁰
- the use of compulsory care should be a ‘matter of last resort’;¹²¹
- ‘the interests of a person with a disability [should be] promoted’;¹²²
- ‘the wishes of a person with a disability are wherever possible given effect to’;¹²³ and

116 These principles were, in part, drawn from international agreements such as the Declaration on the Rights of Mentally Retarded Persons, the Declaration on the Rights of Disabled Persons and the International Covenant on Civil and Political Rights.

117 Victorian Law Reform Commission, *People with Intellectual Disabilities at Risk: A Legal Framework for Compulsory Care*, Discussion Paper (2002) 44.

118 Submissions included the endorsement of the principles contained in the Discussion Paper, for example, Submission 3, Southwest Advocacy Association 3.

119 Some of these suggestions were explicitly taken from the factors to be considered by VCAT in guardianship decisions under the *Guardianship and Administration Act 1986*.

120 *Ibid* s 4(2)(a) recommended in Submission 25, Law Institute of Victoria 2.

121 Submission 27, Victoria Legal Aid 2.

122 Submission 16, Mental Health Legal Centre 4.

123 *Guardianship and Administration Act 1986* s 4(2)(b) recommended in Submission 16, Mental Health Legal Centre 4.

- ‘educational and developmental opportunities [should be provided]’.¹²⁴

3.9 These suggestions reflect the view that the rights and interests of anybody who is to be the subject of detention or other restrictive practices must be protected to the fullest extent possible. This is particularly the case where it is proposed that the person should be detained because of the risk that he or she may harm others. As noted by the High Court, detention in custody in circumstances not involving some breach of the criminal law and not coming within well-accepted categories (eg detention of people with mental illness or infectious disease) offends ordinary notions of what is required in a just society.¹²⁵

3.10 We agree with the concerns expressed in these submissions and have added a principle that makes it explicit that detention and other restrictive practices should be imposed in a manner that is the least restrictive¹²⁶ of the person’s freedom as is possible in the circumstances.

3.11 The legislative framework recommended by this Report will only be effective in protecting the rights and liberties of people with intellectual disabilities or cognitive impairments if these people/or their families or guardians are aware of their rights. This has led us to recommend the inclusion of a principle that recognises the importance of ensuring that people are informed about and aware of the monitoring processes, and the right to have decisions reviewed.

!

RECOMMENDATION(S)

1. The legislation that regulates detention and restrictive practices should contain principles to guide its interpretation.

124 Ibid s 4(2)(c), recommended in Submission 14, Intellectual Disability Review Panel 14.

125 *Kable v DPP* (1996) 189 CLR 51 per Gummow J at 131 and quoting Gaudron J in *Chu Kheng Lim v Minister for Immigration* (1991) 176 CLR 1 at 55.

126 The notion of ‘least restrictive alternative’ is not simple, and needs to take account of the needs and abilities of the individual: ‘the use of medication as opposed to seclusion or restraint cannot be seen in the context of which option is less restrictive. The decision as to whether one uses medication, seclusion or restraint to control dangerous behaviour must be made in terms of the individual patient.’ TG Gutheil and K Tardiff, quoted in R Slovenko, ‘The Hospitalisation of the Mentally Ill’ (Paper presented at the Community Issues in Psychiatry, Psychology and Law: Proceedings of 8th Annual Congress of Australian and New Zealand Association of Psychiatry, Psychology and Law, 1987) 11.

! RECOMMENDATION(S)

2. These principles should refer to:
- safeguarding rights and liberties of people who have intellectual disability or cognitive impairment;
 - ensuring that information about rights is provided to these people, their families and guardians;
 - preventing exploitation and abuse;
 - maximising social participation and ensuring that people who have an intellectual disability or cognitive impairment can develop to their fullest capacity;
 - recognising that the liberties of a person may have to be restricted, in order to assist them to modify their behaviour so that they are less likely to harm others and can be encouraged to develop to their full capacity;
 - ensuring that detention and restrictive practices benefit the person who is required to participate in care and treatment;
 - ensuring that such measures are imposed in a manner that is the least restrictive of the person's freedom and action as is possible in the circumstances; and
 - ensuring that decisions that restrict the liberty of a person are reviewable and made in a transparent manner and that decision-makers are accountable for decisions.

DISCRIMINATION

3.12 Some submissions expressed concern that the proposed statutory framework for detention and use of restrictive practices would discriminate against people with an intellectual disability or cognitive impairment.¹²⁷ It was argued that detention was discriminatory because in general our legal system does not allow people to be detained because there is a serious risk that they may harm others in the future.¹²⁸

127 See, for example, Submission 23, Headway Victoria 1 and Submission 20, Disability Advisory Council of Victoria 1.

128 Justice Vincent issued a warning over 10 years ago that: 'once a community starts to decide for itself that it will incarcerate an individual, not for something that he has done but because of something it is feared he might do, the community is moving into dangerous waters': quoted in Paul Ames Fairall, 'Violent

For example, the Equal Opportunity Commission Victoria submission commented that:

compulsory care for people with an intellectual disability assessed at being at risk of engaging in criminal conduct that will harm others is of its very nature discriminatory.¹²⁹

3.13 Submissions also expressed concerns about restraint and seclusion and the practice of locking doors to prevent people from leaving the place where they are living. At the same time submissions and comments made during our consultations recognised that in some cases the duty of care imposed on service providers may make it necessary to use these measures from time to time, in order to prevent people hurting themselves or others.¹³⁰

3.14 The Commission recognises that provisions that allow people to be detained, or subjected to restrictive practices without their consent, are potentially discriminatory. In our view, however, it is sometimes justifiable to control the behaviour of people with an intellectual disability or cognitive impairment to prevent them harming themselves or others. In practice, some people are already being subjected to restraint or seclusion to prevent them harming themselves, staff, or other residents in the same service. Others have their freedom of movement curtailed to prevent harm to themselves or other members of the community. As noted in Chapter 1, the existing controls on these measures are relatively ineffective. A legislative framework is required to control and monitor these practices.

3.15 One of the main aims of our recommendations is to enhance the accountability of service providers by ensuring that:

- there are clear criteria that indicate when that people can be detained, confined or subjected to other restrictive practices without their consent;
- a person who is directly affected by the decision, and any other interested party, can seek a review of the decision; and
- restrictive practices which restrict the freedom of people with an intellectual disability are systematically monitored and regulated in a manner appropriate to the type of service which is provided.

Offenders and Community Protection in Victoria—The Gary David Experience' (1993) 17 *Criminal Law Journal* 40, 50.

129 Submission 8, Equal Opportunity Commission 7.

130 See for example, Submission 14, Intellectual Disability Review Panel 10.

3.16 Victorian legislation already prescribes a process for treating people with a mental illness without their consent, in cases where (amongst other criteria) this is necessary for their own health or safety, or in order to prevent harm to others.¹³¹ Similarly, the *Health Act 1958* allows the restriction of a person's behaviour or movement to prevent the person transmitting an infectious disease.¹³²

3.17 The Commission believes that similar powers and controls are required in relation to people with intellectual disability or other cognitive impairment whose behaviour places others at risk of serious harm. Care and treatment without consent may be necessary because people lack the capacity to control behaviour or to understand the nature or consequences of risk, and they may, because of their disability, require specialised services or treatment that will reduce the future likelihood of harm.

3.18 The recommendations in this Report will not permit people to be detained or be subjected to restrictive practices without their consent, unless it can be shown that they derive some benefit from that process. Detention, or the use of restrictive practices must prevent them harming themselves or help them to modify their behaviour so that they do not harm others, in ways that benefit them. The application of this principle is discussed in more detail in the next section.¹³³ It is the need to demonstrate benefit that makes the proposed framework non-discriminatory. The requirement of benefit differentiates the proposed framework from civil detention laws that allow people to be detained solely for the purposes of preventing them from committing crimes that will harm others.¹³⁴

NEED FOR 'TREATMENT' OR 'BENEFIT'

3.19 As mentioned above, the importance of ensuring effective care and treatment relevant to the needs of the person with the disability was emphasised in many submissions.

131 *Mental Health Act 1986* s 8(1).

132 *Health Act 1958* s 121.

133 See paras 3.19–24.

134 The Discussion Paper noted that, under the common law doctrine of *parens patriae*, there is a history of the law being used to assist those less capable of assisting themselves (Victorian Law Reform Commission, *People with Intellectual Disabilities at Risk: A Legal Framework for Compulsory Care*, Discussion Paper (2002) 46, n 161). For a discussion of the history of the doctrine, see Anne McGillivray, 'Better Living Through Legislation? *Parens Patriae* Reconsidered' in Law Commission of Canada, *Perspectives on Legislation: Essays from the 1999 Legal Dimensions Initiative* (1999) 75.

To avoid discriminating against people who have an intellectual disability, reforms eventually recommended by the Commission should not disadvantage these members of our society, but work to improve the services and systems that respond to their common and individual needs.¹³⁵

[S]ome benefit must be able to be demonstrated to the person with a disability whose rights are being restricted, otherwise the system is essentially punitive. The [Equal Opportunity] Commission lacks sufficient knowledge of forensic programs to suggest what might be regarded as ‘benefit’, but recognises that this term might be suited to a wide rather than narrow definition.¹³⁶

The overall aim of...a compulsory care and treatment application should be to provide a treatment approach that will result in the client being able to access an environment of least restriction relative to their presenting issue at the end of their placement. Clients must therefore not be placed in residential environments where there is not provision for ongoing assessment and treatment support, as has often been the case for problematic clients.¹³⁷

3.20 Submissions provided us with an array of possibilities as to the meaning of ‘treatment’. ‘Treatment’ is broadly defined as ‘things done in the course of the exercise of professional skills to assist or support a person to reduce or stop posing a risk of harm to others’.¹³⁸

3.21 In the Commission’s view, beneficial treatment should be understood as including professional service interventions that:

- deal in a way that is therapeutic and rehabilitative with aspects of that person’s impairment that are associated with their behaviour; or
- enable the person to live a less restricted lifestyle than would be possible if the treatment was not provided.

135 Submission 14, Intellectual Disability Review Panel 4.

136 Submission 8, Equal Opportunity Commission 8.

137 Submission 11, Frank Lambrick, Statewide Forensic Service 11.

138 Submission 14, Intellectual Disability Review Panel 8.

3.22 Neither detention nor use of restrictive practices should produce outcomes for the affected individual that are antitherapeutic, or undermine the person's potential to change his or her behaviour.¹³⁹

3.23 By understanding treatment and benefit in this way we exclude those service interventions that do nothing other than control behaviour for the purpose of ensuring that the service providing them runs smoothly. Such an intervention would be unlikely to satisfy the requirement that it attend to aspects of the person's impairment, or that it be therapeutic and rehabilitative.

3.24 It is clear, however, that the benefit that a person may gain as a result of detention or the use of restrictive practices will, to a large extent, depend on the nature of the disability. For that reason, we have not attempted to define specific forms of 'treatment' in our recommendations. Rather it is, in our view, more useful to state that there must be some benefit to be gained for the person with a disability. In addition, the legislation could include some examples of what could be regarded as a 'benefit' for the purpose of the framework (such as a program that will result in the client being able to enjoy a less restrictive environment). This list would not be exhaustive and it would be for the appropriately qualified decision-maker(s)¹⁴⁰ to consider whether the person who may be subject to a detention order or restrictive practices is likely to receive any benefit as a result of the compulsory care.

! RECOMMENDATION(S)

3. People should only be subjected to detention or restrictive practices where this form of treatment will benefit them.¹⁴¹

139 Bruce Winick and John LaFond (eds) *Protecting Society from Sexually Dangerous Offenders: Law, Justice and Therapy* (2003)

140 In the case of detention, VCAT is the decision-maker. Care plans which authorise use of restraint and seclusion must be approved by the Office of Senior Clinician.

141 Recommendation 5, dealing with the criteria for detention, requires a detention plan to be prepared indicating the services that will be provided to the person and how he or she will benefit from them. Recommendation 57, dealing with restrictive practices, contains a similar requirement.

!

RECOMMENDATION(S)

4. 'Benefit' should be defined in terms of maximising people's quality of life and increasing their opportunity for social participation. Beneficial treatment includes, but it is not limited to, assisting people to reduce their risk of self harm and harm to others.

THE INFLUENCE OF THERAPEUTIC JURISPRUDENCE

3.25 The recommendations in this Report, and in particular the recommendation that a person should only be subjected to compulsory care or restrictive service practices where he or she will gain some benefit from it, reflects the influence of a new body of learning known as therapeutic jurisprudence. Therapeutic jurisprudence may be briefly described as the 'study of the use of the law to achieve therapeutic objectives'. It grew from concerns around the operation of civil commitment laws in the mental health systems of the United States of America.¹⁴² Therapeutic jurisprudence¹⁴³ has been characterised as proposing the 'exploration of ways in which, consistent with principles of justice and other constitutional values, the knowledge, theories, and insights of the mental health and related disciplines can help shape the development of the law'.¹⁴⁴

3.26 Therapeutic jurisprudence offers a way of thinking about how legal rules and clinical care should interact in solving dilemmas for people affected by both systems. Therapeutic jurisprudence argues that law should seize opportunities 'to minimise antitherapeutic consequences and to facilitate achievement of therapeutic

142 David B Wexler, *Therapeutic Jurisprudence: The Law as a Therapeutic Agent* (1990) 4. The concept has been discussed more locally in Michael S King, 'Geraldton Alternative Sentencing Regime: Applying Therapeutic and Holistic Jurisprudence in the Bush' (2002) 26 *Criminal Law Journal* 260.

143 Bruce J Winick, 'The Jurisprudence of Therapeutic Jurisprudence' (1997) 3 *Psychology, Public Policy and Law* 184, 185.

144 Therapeutic jurisprudence is not, however, universally lauded. It has been suggested that the theory is aimed at 'normalising' society. That is, members of the legal profession that practice therapeutic jurisprudence intend to use the law to change the behaviour of the person subject to the law to a form of behaviour with which the members of the legal profession agree. For example, proponents of the Drug Court see that body as changing the behaviour of the people who appear before it with respect to their drug use. That is, the Drug Court is not seen to be there to punish the crime committed but to stop the person using drugs, without there necessarily being a connection between the drug use and the crime and without drug use itself being illegal in NSW. See for example, Stephen Wye, 'Confounding the Axis of Evil Deficits' (2002) 39 *User's News* 22.

ones'.¹⁴⁵ It focuses on the capacity of law to benefit those who are subjected to it and to produce beneficial outcomes.¹⁴⁶ Although not all the tenets of therapeutic jurisprudence are relevant to this Report,¹⁴⁷ it is useful to consider our recommendations in light of this academic work.

3.27 According to the principles of therapeutic jurisprudence, 'legislatures and courts should consider therapeutic values in the balancing of competing interests and concerns'.¹⁴⁸ This focus on balancing interests is important for this Report.¹⁴⁹ One of the aims of the framework is to balance protecting the interests and rights of people with intellectual disabilities and cognitive impairments and safeguarding the community from harm.

3.28 More broadly, therapeutic jurisprudence considers the way the law can be used to assist individual members of the community. Law can be seen as 'a social force that, like it or not, may produce therapeutic or antitherapeutic consequences. Such consequences may flow from substantive rules, legal procedures, or from the behaviour of legal actors (lawyers and judges)'.¹⁵⁰

3.29 This Report aims to develop a legislative framework which protects and cares for people with cognitive disabilities who are a risk to themselves and others, rather than punish them. Our aim is to recommend legislation that will benefit people with cognitive disabilities and protect members of the community from the few people with cognitive disabilities who are likely to seriously harm others.

145 Dennis Stolle et al, *Integrating Preventive Law and Therapeutic Jurisprudence: A Law and Psychology Based Approach to Lawyering* (1997) 34 *California Western Law Review* 15, 17–8.

146 Two submissions highlighted the notion of therapeutic jurisprudence: Submission 9, Astrid Birgden 8; Submission 11, Frank Lambrick 13.

147 For example, a significant amount of the work done in the area relates specifically to mental health law: see n 148 and Bruce J Winick and David B Wexler (eds) *Law in a Therapeutic Key: Developments in Therapeutic Jurisprudence* (1996).

148 Bruce J Winick, *Therapeutic Jurisprudence Applied: Essays on Mental Health Law* (1997)7.

149 Some may argue that there is such an inherent bias towards the 'abled' (the non-disabled) in law that there is no possibility of any legal framework adequately respecting people with disabilities in our community: see for example, Fiona A Kumari Campbell, 'Eugenics in Disguise? Law, Technologies and Negotiating the "Problem" of "Disability"' (2000) 14 *Australian Feminist Law Journal* 55.

150 David B Wexler, 'Putting Mental Health Into Mental Health Law: Therapeutic Jurisprudence' in David B Wexler and Bruce J Winick (eds), *Essays in Therapeutic Jurisprudence* (1991) 3, 8.

Chapter 4

Detaining a Person with an Intellectual Disability to Prevent Serious Harm to Others

INTRODUCTION

4.1 In Chapter 1 we explained that a small number of people with an intellectual disability or cognitive impairment are involved in behaviours that place other members of the community at significant risk of serious harm. This Chapter recommends a legislative framework for independent authorisation and review of decisions allowing people with an intellectual disability who exhibit such behaviours to be detained in a prescribed facility. The applicability of this framework to people with other types of cognitive impairment is discussed in Chapter 6.

DEFINITION OF DETENTION

4.2 ‘Detention’ means detention of a person with an intellectual disability in a prescribed facility, for the purpose of providing the person with therapeutic or rehabilitative services that will reduce a significant risk that he or she will seriously harm others.

THE PURPOSE OF OUR RECOMMENDATIONS

4.3 The recommendations in this Chapter are intended to address problems identified in Chapter 2. Currently, there are no provisions allowing people who have been sentenced for a serious criminal offence, but whose sentence has expired, to be held in a facility where they are required to participate in treatment or rehabilitation that is designed to reduce the risk that they will harm others. Nor are there provisions allowing detention of people with an intellectual disability who have not been charged with criminal offences, although their behaviour seriously endangers others.

4.4 As explained in Chapter 2, some people in this category are currently living in facilities where they are involved in programs to reduce the risk they will harm others. They may have ‘consented’ to living in a secure environment, even though

they lack capacity to give real consent. Alternatively, a guardian may have been appointed to consent on their behalf. In September 2003, nine of the 15 people living at Statewide Forensic Services (SFS) were there because they or their guardian had consented.

4.5 This Chapter deals with

- the criteria that must be satisfied before a person can be detained;
- who can request that a person be detained;
- who should make detention decisions,
- how detention should be initiated; and
- procedures for assessing people who may be subjected to detention.

4.6 The Chapter also makes recommendations on

- interim and emergency detention orders;
- leaves of absence;
- interstate transfers; and
- the detention of absconding detainees.

WHEN SHOULD DETENTION BE PERMITTED?

4.7 The Commission recognises that provisions allowing detention of people with an intellectual disability restrict their freedom on the basis of an assessment of what they *might* do, rather than because they are being punished for committing an offence.¹⁵¹ Such provisions are difficult to apply because of problems in making accurate predictions about whether or not a person with a disability will behave dangerously in the future.¹⁵² They are potentially discriminatory, because people without an intellectual disability cannot normally be detained because of the risk of future harm.

151 This position was accepted in a number of submissions including Submission 19, Office of the Public Advocate 4 and Submission 8, Equal Opportunity Commission of Victoria 6. Submission 25, Law Institute of Victoria 4, accepted the need for the high level of risk of serious harm but did not include a firm position on the necessity of the imminence of any harm.

152 Submission 19, Office of the Public Advocate 3; Submission 8, Equal Opportunity Commission Victoria 6.

4.8 In the Commission's view, detention is only justified if

- the person has previously exhibited violent or dangerous behaviour, which has harmed others seriously, or exposed another person to a significant risk of serious harm to others;
- the risk that they may harm others cannot be substantially reduced by using other less restrictive measures;
- the person will derive some long term benefit because of the services and treatment provided during the period of detention; and
- the services that will be provided to the person during the period of detention will benefit the person by reducing the risk that he or she will harm others.

BENEFIT

4.9 In paras 3.12–18 we discussed concerns about discrimination against people with an intellectual disability. The requirement that persons detained will derive a benefit from detention provides the primary justification for restricting their liberty and is intended to meet these concerns.¹⁵³ In other words, we do not propose the introduction of a preventive detention regime that allows people to be detained simply on the grounds that they present a risk to others. In our view, detention should only be authorised where there is evidence that this will improve the person's quality of life in the long term. The proposed approach is similar to that taken under the *Mental Health Act 1986* (MHA),¹⁵⁴ where involuntary admission and detention is permitted where the person requires treatment and that treatment can be obtained by admitting them to an approved service.

4.10 Obviously intellectual disability is not 'treatable' in the same way as many mental illnesses, but the requirement of 'benefit' expresses a similar philosophy. Before a person can be detained we recommend that a detention plan should be prepared. The plan must indicate how the person will benefit from the detention. This is intended to ensure that detention serves a rehabilitative rather than a punitive purpose.

153 Submission 8, Equal Opportunity Commission 8.

154 *Mental Health Act 1986* s 8(1)(b). In addition it is necessary to show that involuntary treatment is necessary for the person's health or safety or for the protection of members of the public; s 8(1)(c).

4.11 The proposed scheme does not contemplate indefinite detention. We recommend that detention should not be permitted for a period of more than five years. We believe that five years provides sufficient time for a person with an intellectual disability to learn to change dangerous behaviour. The time limit will ensure that people who are no longer receiving any benefit from detention must be released.¹⁵⁵ In addition, we recommend below that detention orders be reviewed every six months.¹⁵⁶

WHAT IS A DETENTION PLAN?

4.12 A detention plan is a plan that proposes that a person will reside in a prescribed facility. Facilities that are prescribed will be required to provide appropriate services to assist residents to modify their behaviour. We anticipate that Statewide Forensic Services would be prescribed as an appropriate facility.

4.13 The plan would also be required to indicate

- the programs that will be provided to the person and how they will benefit the person;
- the extent to which restraint and seclusion may be used during that period;¹⁵⁷
- a process for the person's transition between detention and living in the community, including provision for leaves of absence;¹⁵⁸

4.14 Provisions requiring consultation with the person, his or her primary carer and other appropriate persons, which currently apply to general service plans,¹⁵⁹ should also apply to detention plans. A copy of the detention plan should be provided to the person, the primary carer, and the facility in which the person will be detained.¹⁶⁰

4.15 In para 4.16 we recommend the creation of an Office of Senior Clinician. We recommend that the Senior Clinician should be responsible for ensuring the establishment of guidelines setting out the minimum requirements to be satisfied by

155 Recommendation 37 and 119.

156 Recommendation 28.

157 Provisions with respect to restraint and seclusion are discussed in more detail in the next chapter.

158 Unescorted leaves of absence are discussed below para 4.88.

159 *Intellectually Disabled Persons' Services Act 1986* s 9(5).

160 *Ibid* s 9(6).

prescribed facilities. These requirements will indicate the level of security that is to apply within facilities, the nature of programs to be offered to residents and any other matters considered appropriate by the Senior Clinician.

! RECOMMENDATION(S)

5. A person may be detained if:
 - the person has an intellectual disability;
 - the person has previously exhibited a pattern of violent or dangerous behaviour that has harmed others seriously or exposed another person to significant risk of serious harm;
 - it is necessary to detain the person because there is a significant risk that otherwise he or she will seriously harm others;
 - the risk that the person may harm others cannot be substantially reduced by using other less restrictive measures;
 - a detention plan has been prepared, indicating the services and programs that will be provided during the period that the person is detained and providing for transition between detention and the person being cared for in a less restrictive environment;
 - the services that will be provided under the plan will benefit the person by reducing the risk that he or she will harm others; and
 - the person is unable or unwilling to consent to living in a prescribed facility and to participating in a program to reduce the risk of harming others.
6. A detention plan should include:
 - the programs that will be provided to the person during the period of detention and how they will benefit him or her;
 - any restrictive practices that it is proposed to apply to the person while in voluntary detention;
 - a proposed process for the person's transition between detention and living in the community, including provision for leaves of absence; and
 - the proposed duration of the order.
7. Before a detention plan is prepared, the Office of Senior Clinician must consult with the person and the person's primary carer or guardian.

**RECOMMENDATION(S)**

8. A copy of the detention plan should be provided to the person, the primary carer and the facility in which the person will be detained.

OFFICE OF SENIOR CLINICIAN TO BE ESTABLISHED

4.16 The Commission proposes that an Office of Senior Clinician should be established.¹⁶¹ The Office of Senior Clinician should be an independent statutory body resourced by DHS and reporting to the Minister for Community Services. To ensure public accountability and greater community confidence the Minister should table the Annual Report of the Office of Senior Clinician in Parliament. The reasons for recommending that the Office of Senior Clinician should be an independent statutory authority are explained in Chapter 8.

4.17 The Office of Senior Clinician should have responsibility for:

- receiving requests for the assessment and the development of detention plans;
- preparing guidelines on the content of detention plans;
- arranging for assessments and the development of detention plans to benefit persons whom it is proposed to detain;
- arranging for an appropriate facility to receive a person on a detention order; and
- making an application to an appropriate body for the approval of a detention plan and the making of a detention order.

**RECOMMENDATION(S)**

9. An Office of Senior Clinician should be established as an independent statutory authority resourced by the Department of Human Services and reporting annually to the Minister for Community Services.

¹⁶¹ See Chapter 8 for other functions of the Office of Senior Clinician.

! RECOMMENDATION(S)

10. The Annual Report of the Office of Senior Clinician should be tabled in Parliament.
11. The Office of Senior Clinician should be responsible for overseeing detention of people with an intellectual disability who are at significant risk of causing serious harm to others. The Office of Senior Clinician shall:
 - receive requests for the assessment and the development of detention plans;
 - prepare guidelines as to the other matters which should be included in detention plans;
 - arrange for assessments and the development of a detention plan to benefit persons whom it is proposed to detain;
 - arrange appropriate facilities to receive persons on detention orders;
 - make applications to the relevant body¹⁶² for the approval of detention plans and the making of detention orders.

HOW SHOULD A DETENTION APPLICATION BE INITIATED?

4.18 The Commission recommends that the Office of Senior Clinician should make applications for detention. We contemplate that the process will often be initiated by a request made by some other person. A detention order is most likely to be sought when a person with an intellectual disability is about to be released from prison or from a facility in which they have living under the terms of a community based order or justice plan. In this situation, the Public Advocate, a clinician or other health care professional who has been involved in caring for the person, or a senior DHS officer who is familiar with the person's situation, should be able to request the Senior Clinician to seek a detention order to ensure that the person receives appropriate services to reduce the risk that they may seriously harm others.

4.19 There will be some situations where a person is not charged with an offence, but it is clear that the person's behaviour places others at significant risk of serious

162 It is proposed below that VCAT should be the body which approves detention plans.

harm. In small communities a police officer may become aware that a person with an intellectual disability is behaving dangerously. We consider it appropriate for authorised senior members of Victoria Police to have the power to request the Senior Clinician to seek a detention order. This power should be exercised sparingly.¹⁶³ In most cases it will be preferable for the police officer to inform DHS of the person's need for care, so that DHS can request the Senior Clinician to consider whether a detention application should be made.

4.20 Submissions suggested that family members or guardians, service providers and other people caring for the person with the intellectual disability¹⁶⁴ should be among those able to seek a detention order.¹⁶⁵ We recommend that these people should be able to request the Senior Clinician to apply for an order.

4.21 When a request is made, the Senior Clinician will have responsibility for ensuring that the person's behaviour is assessed and for determining whether an application should be made to authorise the person's detention. The assessment process is discussed in more detail below. We also recommend that the Office of Senior Clinician should have power to apply for a detention order without a prior request being made.

!

RECOMMENDATION(S)

12. Applications for detention orders should be made by the Office of Senior Clinician, acting on its own initiative or on the request of an appropriate person.

163 Most people, including police officers and even professionals working in the field, are not expert at recognising whether or not a person has an intellectual disability and the level at which a person is functioning: Susan Hayes, 'Needle in a Haystack: Identifying the Offender with Intellectual Disability' in Anthony Shaddock et al (eds), *Intellectual Disability & the Law: Contemporary Australian Issues* (2000) 63.

164 This may give rise to a potential conflict of interest. However, as long as there is an independent assessment of the person with a cognitive disability and there is an independent decision-maker then the risks posed by the conflict of interest are minimised.

165 For example, Submission 16, Mental Health Legal Centre 8 stated that the person who is responsible for the ongoing management of the person should be able to seek a detention order. Submission 13, Australian Community Support Organisation 1, identified the courts, the Office of Public Prosecution, victims, police, service providers, legal guardians, DHS, and professionals such as psychiatrists or psychologists as bodies or individuals who should be able to seek a detention order.

! RECOMMENDATION(S)

13. The following persons should be able to request the Senior Clinician to apply for a detention order for a person with an intellectual disability:
- the Public Advocate;
 - an authorised officer of the Department of Human Services;
 - a clinician or other health care professional who has been involved in caring for the person;
 - a guardian or family member of the person with a cognitive disability; and
 - a senior police officer, who is authorised to do so.
14. The Senior Clinician should be able to initiate an application for a detention order without a request from a third party.

WHICH BODY SHOULD AUTHORISE DETENTION?

4.22 The Discussion Paper examined three ways in which compulsory care decisions could be authorised and reviewed. This could be done by a professionally qualified individual, a tribunal or a court.¹⁶⁶

4.23 A number of submissions commented on the appropriate characteristics of the decision-making body. For example, the Law Institute submission commented that the body must be ‘accessible, affordable and responsive’.¹⁶⁷

4.24 The Commission’s view is that the body which makes compulsory care decisions should

- include decision-makers with skills, knowledge and experience relevant to the care of people with an intellectual disability;
- be able to act informally, so that people whose rights are affected can participate in the process to the fullest extent practicable;
- have the capacity to make decisions quickly and at a relatively low cost; and
- act transparently.

166 Victorian Law Reform Commission, *People with Intellectual Disabilities at Risk: A Legal Framework for Compulsory Care* Discussion Paper (2002) 87–91.

167 Submission 25, Law Institute of Victoria 2.

4.25 The decision-making body should be independent from DHS, which usually funds the provision of care. While resource constraints are not irrelevant in deciding on the form of care that should be provided for people with an intellectual disability, a decision restricting a person's liberty must be based on that person's interests and the interests of others who may be affected by his or her actions, rather than on considerations of cost alone.

4.26 Courts are independent bodies. Their decisions are transparent and they are accountable for their decisions. The Discussion Paper¹⁶⁸ noted that the severe restrictions on liberty imposed by detention could arguably justify requiring a court to authorise these decisions.

4.27 On balance, however, we think that an independent tribunal, rather than a court, should make these decisions. A tribunal can be constituted to include members with relevant knowledge and experience and can proceed more informally than a court.

4.28 Informal and flexible procedures make it easier for the person with the intellectual disability to understand and participate in the process.¹⁶⁹ In many of the hearings that will be conducted under this framework, an 'important consideration is that [a person appearing] should feel confident and comfortable in putting his or her side and not feel frustrated... In short, the [Tribunal] should...do what fairness requires in each case'.¹⁷⁰ An independent Tribunal, with expert members, is also likely to be able to make detention decisions quickly and at lower cost than a court.

4.29 The majority of submissions that discussed this issue favoured an independent tribunal.¹⁷¹ The Commission agrees with this view.

168 Victorian Law Reform Commission, *People with Intellectual Disabilities at Risk: A Legal Framework for Compulsory Care* Discussion Paper (2002) 89, 91.

169 Courts in the common law system have traditionally followed an adversarial format. That is, a neutral arbiter has had control of the proceedings with the two parties presenting their arguments to attempt to ascertain the truth of the circumstances that gave rise to the dispute. Tribunals, on the other hand, operate in a more 'inquisitorial' manner. That is, the decision-maker is much more active and may intervene on behalf of either party to maximise equality and fairness in the proceedings.

170 Western Australian Government, *Western Australian Civil and Administrative Review Tribunal Taskforce Report on the Establishment of the State Administrative Tribunal*, (2002) 130.

171 For example, Submission 27, Victoria Legal Aid 5 and Submission 17, Disability Justice Advocacy Inc 1. Other submissions argued for a panel or board rather than a tribunal, for example, Submission 12, Patricia Crowley 1.

TWO OPTIONS FOR THE TRIBUNAL

4.30 Power to authorise compulsory care could be conferred on VCAT or on a new independent tribunal. Either of these bodies could satisfy the requirements outlined in para 4.24. We consider these alternatives below.

VICTORIAN CIVIL AND ADMINISTRATIVE TRIBUNAL

4.31 VCAT was created to function as an accountable and independent decision maker with the capacity to make and/or review decisions in a broad range of areas.¹⁷² Within VCAT there are a number of divisions and ‘lists’ that deal with particular types of decisions.¹⁷³ The Human Rights Division of VCAT has responsibility for making decisions with respect to people with intellectual disabilities (and other cognitive disabilities) under the *Guardianship and Administration Act* and with respect to discrimination under the *Equal Opportunity Act 1995*. VCAT’s jurisdiction could be extended to cover detention decisions.¹⁷⁴

4.32 VCAT has practices and procedures that reflect the principles that we consider appropriate in the context of detention decisions.¹⁷⁵ It:

- is bound by the rules of natural justice;¹⁷⁶
- need not apply technical rules of evidence;¹⁷⁷

172 Victorian Civil and Administrative Tribunal was established under the *Victorian Civil and Administrative Tribunal Act 1998*.

173 Victorian Civil and Administrative Tribunal Regulations 1998 Rule 2.03: ‘(1) Each division of the Tribunal shall exercise its functions in lists. Rule 1 2.03 says that ‘The following lists of the human rights division are established—(a) anti-discrimination list; (b) guardianship list.’

174 One of the reasons for the establishment of VCAT was to reduce the number of separate tribunals and to improve the efficiency of the administration of justice (Victoria, Parliamentary Debates, Legislative Assembly, 9 April 1998, 972 (Jan Wade)). Therefore, it would be in keeping with this rationale for VCAT to be the decision-maker. For a recent discussion of the benefits of the centralisation of administrative review, see *Western Australian Civil and Administrative Review Tribunal Taskforce Report on the Establishment of the State Administrative Tribunal* (2002). Of particular interest to this Report is that the Western Australian Taskforce considered that there are ‘considerable advantages to be gained... from an appropriate alignment of the Guardianship and Administration Board and the Mental Health Review Board’ with its proposed State Administrative Tribunal (SAT). This ‘alignment’ would mean that the ‘Chairperson of each Board should be a Presidential Member of the SAT and that the other members of each Board should also be members of the SAT. Additionally, the two Boards should physically be co-located with the SAT and SAT should provide the registry and staffing requirements of each Board’: 80.

175 One submission suggested that the experience of VCAT may not be appropriate, in the sense that the Tribunal is ‘more legalistic’ than other options could be: Submission 24, Mental Health Review Board 2.

176 *Victorian Civil and Administrative Tribunal Act 1998* s 98(1)(a).

- may inform itself on any matter as it sees fit;¹⁷⁸
- must conduct hearings with as little formality and technicality and determine proceedings with as much speed as a proper consideration of the matters before it permits;¹⁷⁹
- can conduct proceedings using telephones, video links or any other system of telecommunication;¹⁸⁰ and
- must give reasons for any order and must give written reasons if this is requested by a party.¹⁸¹

4.33 VCAT members include a President (a Supreme Court judge), Vice Presidents (County Court judges), Deputy Presidents (people admitted to legal practice in Victoria for not less than five years), senior members and ordinary members. Senior and ordinary members must either be legal practitioners¹⁸² or have knowledge and experience in relation to a class of matter in respect of which functions may be exercised by VCAT.¹⁸³ The provision for appointment of ordinary members would allow appointment of people with expertise on the care of people with an intellectual or cognitive disability.

4.34 VCAT can be constituted differently to make different types of decisions.¹⁸⁴ Between one and five members can preside in a particular proceeding. At least one member must be a legal practitioner.¹⁸⁵ This capacity gives VCAT the flexibility to ensure that sufficient, but not excessive, resources are available for any decision it needs to make. In its Human Rights Division, VCAT already has members with expertise relevant to people with an intellectual disability.

177 Ibid s 98(1)(b).

178 Ibid s 98(1)(c).

179 Ibid s 98(1)(d).

180 Ibid s 100.

181 Ibid s 117.

182 If senior members are members due to their legal experience, they must have been admitted to practice in Victoria for not less than five years.

183 *Victorian Civil and Administrative Tribunal Act 1998* ss 9–14.

184 This discussion of the constitution of the Tribunal and the following section on the practices and procedures of the Tribunal focuses on the Tribunal's original jurisdiction, rather than its jurisdiction to review the decisions of other bodies.

185 *Victorian Civil and Administrative Tribunal Act 1998* s 624(2)

A NEW INDEPENDENT TRIBUNAL

4.35 As an alternative to VCAT, a new independent Tribunal could be established to make compulsory care decisions. This independent tribunal could be a modified form of a decision maker already in existence, such as the Mental Health Review Board (MHRB) or the Intellectual Disability Review Panel (IDRP), or it could be a totally new body. Members of any new body could be drawn from the member pools of the MHRB¹⁸⁶ and the IDRP.¹⁸⁷ To ensure that the new body was independent of the Department of Human Services it would be necessary to exclude departmental officers. The new tribunal could have similar procedures to the MHRB or the IDRP.¹⁸⁸

THE COMMISSION'S VIEW

4.36 The existing legislative constraints on the IDRP have resulted in concerns about a perceived lack of independence of that body. For example, the Auditor-General's report concluded that

the independent review role envisaged in the [*Intellectually Disabled Persons' Services Act 1986*] for the Panel has not been effectively implemented.¹⁸⁹

4.37 Similar concerns about the Mental Health Review Board were expressed during our consultations. Such criticisms may not be justified. However it is important to ensure that any new Tribunal both is, and is perceived to be, entirely

186 Ordinary members of the MHRB are appointed by the Governor in Council on the nomination of the Minister: *Mental Health Act 1986* sch 1 cl 2(1). When nominating, the 'Minister must have regard to (a) the matters which the Board has jurisdiction to hear and determine; and (b) the need for the Board to be comprised of both males and females so qualified by knowledge and experience that the Board is capable of exercising the jurisdiction and performing the functions conferred on it': *Mental Health Act 1986* Schedule 1 cl 2(2). There are no qualification requirements for the President of the Board. Currently, the MHRB is made up of legal members, psychiatrist members and community members: Mental Health Review Board, *Annual Report* (2002) para 4.1.

187 Membership of the IDRP is defined in a similar manner to that of the MHRB in legislation: *Intellectually Disabled Persons' Services Act 1986* Schedule 1 cl 2. The current members of the IDRP include psychologist members, community members and DHS officer members: Intellectual Disability Review Panel, *Annual Report 2001–2002*, (2002) 30.

188 Many of the practices of these bodies are similar to the practices of VCAT discussed above. Any new tribunal could be constituted to operate in the most appropriate manner by incorporating the best practices of any of the existing tribunals.

189 Auditor-General Victoria, *Services for People with an Intellectual Disability* (2000) 48.

independent from service providers and DHS. VCAT's independence is well-established.

4.38 Because detention significantly restricts rights of the person detained, detention decisions must be, and must be seen to be, fair and transparent. The seriousness of the decision should be reflected in the composition of the decision-making body. The composition of VCAT would allow a judge to be involved in the decision-making process. On balance, the Commission believes that VCAT should authorise and review detention decisions.

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RECOMMENDATION(S)

15. The Victorian Civil and Administrative Tribunal (VCAT) should have power to:
 - authorise and review decisions for the detention of a person with an intellectual disability whose behaviour creates a significant risk of serious harm to others;¹⁹⁰ and
 - approve a detention plan for a person who is subject to a detention order
16. Before making a detention order, VCAT must be satisfied that the criteria set out in Recommendation 5 are satisfied.
17. VCAT should determine whether it is necessary to detain a person because there is a significant risk that if not detained the person will harm others, on the balance of probabilities.¹⁹¹

4.39 Later in this Chapter we make recommendations on the composition of the VCAT panel which hears detention applications.

WHAT ASSESSMENT PROCESS SHOULD APPLY?

4.40 A recent review of studies that focused on offending by people with intellectual disabilities noted that:

190 In Chapter 6 we recommend that VCAT should also be able to authorise detention of people with a cognitive impairment.

191 See para 4.44 below for discussion.

- there is ‘no convincing evidence that the prevalence of offending’ among people with intellectual disabilities is higher than for the rest of society;
- there are few offences committed by people with IQs less than 50;
- there is ‘some evidence to suggest that the relative prevalence of sexual offending, criminal damage and burglary, although not theft, are higher’ among people with a borderline intellectual disability than for the wider population; and
- the evidence suggests that the prevalence of ‘very serious offences such as murder or armed robbery’ are lower among people with intellectual disabilities than for the general community.¹⁹²

4.41 The general lack of correlation between intellectual disability and offending behaviour¹⁹³ makes it vital that the assessment process which precedes an application for detention order should be conducted as thoroughly and accurately as possible.¹⁹⁴

4.42 Before an order can be made, VCAT will require:

- an assessment of the risk posed by the person in relation to whom an order is sought; and

4.43 A detention plan covering the matters set out in Recommendation 5.

4.44 The question of whether it is necessary to detain a person because there is a significant risk that if not detained the person will seriously harm others should be determined on the balance of probabilities. We recognise that the serious effect of detention on a person’s liberty could be seen as requiring proof beyond reasonable

192 M K Simpson and J Hogg, 'Patterns of Offending Among People with Intellectual Disability: A Systematic Review. Part 1: Methodology and Prevalence Data' (2001) 45 *Journal of Intellectual Disability Research* 384, 394.

193 An English review of literature suggested that the incidence of offending is lower amongst people with intellectual disabilities who receive services than for people with intellectual disabilities who do not receive services: Simon Halstead, 'Risk Assessment and Management in Psychiatric Practice: Inferring Predictors of Risk. A View from Learning Disability' (1997) 9 *International Review of Psychiatry* 217, 221. This review also highlights an earlier study that found that the evidence was inconclusive with respect to the higher level of arson and sexual offences committed by people with intellectual disabilities, *ibid*.

194 It should be noted that courts regularly indulge in informal risk assessment. For example, a court may refuse bail if it is satisfied that there is an ‘unacceptable risk that the accused person if released on bail would fail to surrender himself into custody in answer to his bail; commit an offence whilst on bail; endanger the safety or welfare of members of the public; or interfere with witnesses or otherwise obstruct the course of justice whether in relation to himself or any other person’: *Bail Act 1977* s 4(2)(d)(i).

doubt.¹⁹⁵ However, given the requirement that a detention order will benefit the individual who is to be detained, and the difficulty of providing a risk assessment which would satisfy this criminal burden of proof, we regard the civil standard of proof (proof on the balance of probabilities) as appropriate.¹⁹⁶

4.45 While specific risk assessment practices were mentioned in some submissions,¹⁹⁷ the Commission does not consider it appropriate to specify a particular assessment approach in our Recommendations.¹⁹⁸

4.46 We note that there is a substantial body of literature on methods of predicting whether people are likely to harm others. Most methods use an understanding of the person's past and present circumstances to gauge the risk of future violence.¹⁹⁹ While past acts of violence are one of the factors that will need to be taken into account in assessing future risk, the literature emphasises the

195 Submission 21, Villamanta Legal Service, argued that this should apply.

196 The *Mental Health Act 1986*, which authorises involuntary detention and treatment of a person who has a mental illness, does not specify the standard of proof. The *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* specifies the court standard of proof in relation to the decision of whether a person is unfit to stand trial (s 7) and in relation to whether a person is not guilty because of mental impairment (s 21). See *Re Percy, Farrell and RJO* [1998] VSC 70. It was decided in that case that when a court was considering a major review of a supervision order, the standard of care required was the balance of probabilities as modified by the 'Briginshaw gloss': para 64, Eames J. The 'Briginshaw gloss' (from *Briginshaw v Briginshaw* (1938) 60 CLR 336) is that a decision maker must be satisfied bearing in mind the 'seriousness of the allegation made, the inherent unlikelihood of an occurrence of a given description, [and] the gravity of the consequences flowing from a particular finding': at 361–2, Dixon J. The decision of *Re Percy, Farrell and RJO* held that in review decisions under the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* 'proof beyond reasonable doubt would be almost impossible to achieve—since the issue is one involving future predictions based on psychiatric and similar evidence concerning the mental state of the reviewe': para 33, Eames J.

197 For example, Submission 9, Astrid Birgden 2–4; Submission 11, Frank Lambrick, Statewide Forensic Services 7–10. See also Vernon Quinsey et al, *Violent Offenders—Appraising and Managing Risk* (1998).

198 One broad division in risk assessment can be characterised as the distinction between clinical and actuarial assessments. The former relies on the training and experience of the assessing clinician and focuses on the specifics of the person being assessed. Actuarial assessment prefers the use of statistics and perceived similarities between the person assessed and others with similar disabilities or conditions. For a discussion of the distinction see Tony Ward and Lynne Eccleston, 'The Assessment of Dangerous Behaviour: Research and Clinical Issues' (2000) 17 *Behaviour Change* 53. See also Marc Miller and Norval Morris, 'Predictions of Dangerousness: Ethical Concerns and Proposed Limits' (1986) 2 *Journal of Law, Ethics and Public Policy* 393, 404–5.

199 See Kevin S Douglas and Christopher D Webster, 'Predicting Violence in Mentally and Personality Disordered Individuals' in Ronald Roesch et al (eds) *Psychology and Law: The State of the Discipline* (1999) 197–219.

complexity of the assessment process, the multiplicity of factors which should be considered, and the need for an extensive knowledge of the person being assessed.²⁰⁰

4.47 The Discussion Paper considered various ways in which the assessment process should be conducted. It could be undertaken by:

- a clinician with expertise in the area of intellectual disability;
- a team comprising clinicians and people with practical expertise in caring for people with intellectual disability; or
- a panel of experts associated with the decision-making body.²⁰¹

4.48 In many cases, the complexity of the necessary assessment will make it impossible for a single practitioner to undertake the assessment. Determining whether detention is the only way to assist the person to modify their behaviour may require contributions from people from a range of disciplinary backgrounds. Where a person has both an intellectual disability and a mental illness, a single clinician may not be qualified to assess accurately the risk posed by the person and oversee the preparation of the detention plan. Those undertaking the assessment will need to be aware of the circumstances surrounding past acts that harmed others. For example, the fact that a person has a record of violence is unlikely to permit an accurate prediction to be made about whether that person is likely to be violent in the future, without an understanding of the environment in which the violence occurred. The assessors would need to be satisfied that the event was not caused by abuse, provocation or a lack of appropriate support for the person concerned.

4.49 The Commission notes that the DHS Report on *Responding to People with Multiple and Complex Needs* proposes the establishment of a multiple and complex needs panel to assess individuals in this category and to prepare a care plan for them.²⁰² Similarly, we take the view that the assessment process will usually require input from people with a range of expertise and practical experience.

4.50 Because we contemplate that only a very small number of applications will be made for detention orders, the Commission does not believe it is necessary to

200 For a discussion of a risk management approach see Submission 9, Astrid Birgden 3–4.

201 Victorian Law Reform Commission *People with Intellectual Disabilities at Risk: A Legal Framework for Compulsory Care* (2002) 84–6.

202 Operation Division, Victorian Government Department of Human Services, *Responding to People with Multiple and Complex Needs: Phase One Report*, (2003) 37–46. These changes have recently been implemented by the *Human Services (Complex Needs) Act 2003*.

constitute a standing panel to undertake assessments. Nor do we think that it is necessary to create an expert assessment body linked with VCAT.

4.51 Earlier in this Chapter we recommended the establishment of an independent statutory authority, the Office of Senior Clinician, connected with DHS.²⁰³ It is contemplated that the Senior Clinician would identify a pool of experts who could be asked to conduct assessments. The pool of assessors would include people with appropriate professional qualifications, for example qualifications in psychiatry,²⁰⁴ psychology,²⁰⁵ neurophysiology,²⁰⁶ pharmacology²⁰⁷ and nursing.²⁰⁸ It should also include people with practical experience in putting behaviour modification programs into practice or caring for people with an intellectual disability.

4.52 We also contemplate that the Office of Senior Clinician would encourage research into the assessment of risks posed by people with intellectual disabilities. In the medium to long term this could result in improvements in risk assessment processes.

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RECOMMENDATION(S)

18. The Office of Senior Clinician should be responsible for arranging for a panel of experts to assess a person who is subject to an application for a detention order, and for providing a report to VCAT.
19. The assessment panel should include a person with appropriate professional qualifications, and a person with experience in behaviour modification programs and direct care of people with an intellectual disability.

203 For more details on the role of the Office of Senior Clinician, see Chapter 8.

204 In Chapter 6 we recommend that detention orders should be able to be made in relation to people with a cognitive impairment. Some of the proposed qualifications are relevant to people with cognitive impairments. Psychiatrists are relevant for the assessment of mental illness (where there is a dual disability) and for assistance in the diagnoses of people who are not easily diagnosed with any particular disability.

205 Relevant for the assessment of intellectual disability and the extent of cognitive disabilities connected with other disorders.

206 Relevant for acquired brain injuries.

207 Relevant for the prescription of drugs, chemical restraint and to assess potential problems with the interaction of different drug programs.

208 Relevant for the direct care of people with an intellectual disability.

! RECOMMENDATION(S)

20. The panel should be required to prepare a report for VCAT on:

- whether there is significant risk that the person not detained will seriously harm others;
- the matters that should be included in the detention plan; and
- the benefits to the person that will result if the detention plan is implemented.

PROCEDURAL ISSUES

4.53 The remainder of this Chapter deals with procedural issues relating to detention orders.

MEMBERSHIP OF THE VCAT LIST

4.54 We recommend that the VCAT panel which hears detention applications should be chaired by the President or a Vice-President (a judicial member). Generally speaking the constitution of VCAT in particular proceedings is left to the President.²⁰⁹ However in our view a detention decision is sufficiently significant to require a judge to preside.²¹⁰ The Tribunal should also include a member with expertise relevant to intellectual disability.²¹¹

209 *Victorian Civil and Administrative Tribunal Act 1998* s 64(3).

210 *Ibid* sch 1 specifies some situations in which a judge may be required to preside. Under *VCAT Act 1998* sch 1 cl 13, a party may require that the President (who must be a judge) preside over a complaint under Division 5 of Part 7 of the *Equal Opportunity Act 1995*. Similarly, under *VCAT Act 1998* sch 1 cl 29C, an applicant may request a judge to preside over a review of a decision under s 29A of the *Freedom of Information Act 1982*.

211 Where the person has a cognitive impairment (see Chapter 6) the member should have expertise relevant to that impairment.

! RECOMMENDATION(S)

21. Applications for detention orders should be heard by a panel that includes a Supreme or County Court judge and at least one other member with knowledge and experience in one of the following areas:

- psychology (with specialisation in intellectual disability);
- psychiatry;²¹²
- neurophysiology;²¹³
- direct care of people with an intellectual disability;
- pharmacology;²¹⁴ or
- disability advocacy.

USE OF EXPERTS

4.55 Under s 94 of the *Victorian Civil and Administrative Tribunal Act 1998*, VCAT can ‘call in the services of an expert to advise it in any matter arising in a proceeding’. The parties are responsible for the costs of calling in an expert.

4.56 The assessment process recommended in this Report will normally ensure that VCAT has the opportunity of hearing expert views about the person for whom the detention application is made. However it may occasionally be desirable for VCAT to commission an independent report from an expert. The MHRB has power to appoint an expert²¹⁵ to assist in a proceeding before the Board, for example when it is making decisions about the need for detention or treatment of people with a mental illness.

4.57 It will often be impractical to require the person with the intellectual disability or cognitive disorder to pay the costs of an expert witness. In our view it is justifiable for government to bear the costs of obtaining such evidence because of

212 Psychiatric qualifications may be important where the person subject to the application has more than one disability.

213 A neuro-physiological qualification would be important where the person subject to the application has an acquired brain injury. We recommend below that VCAT should have jurisdiction to approve detention of a person with a cognitive impairment.

214 Pharmacological knowledge may be important with respect to the purpose and effects of particular drugs and medications.

215 *Mental Health Act 1986* s 25.

the potentially serious impact of detention on the affected person. The preservation of liberty should not be compromised because the person cannot afford to pay for an expert opinion. The Commission recommends that DHS should provide a moderate level of funding to VCAT to enable it to obtain independent expert advice in the few cases where this is required.



RECOMMENDATION(S)

22. Section 94 of the *Victorian Civil and Administrative Tribunal Act 1998*, which allows VCAT to seek the assistance of an expert, should apply to detention proceedings.
23. VCAT should be funded sufficiently to allow it to commission independent expert advice about the need for detention.

ADVOCATES

4.58 When a person's liberty is at stake, it is important that the person should have access to advice and representation.²¹⁶ This is especially so when the person involved has an intellectual disability and is likely to have poor communication skills and limited capacity to understand what is happening.²¹⁷

4.59 Section 62 of the *Victorian Civil and Administrative Tribunal Act 1998* limits the use of professional advocates.²¹⁸ A number of submissions argued that people who are the subject of detention proceedings should have access to a suitably qualified advocate.²¹⁹ The Commission agrees with this view. A lawyer, a disability advocate or any other person chosen by the person, who is approved by the Tribunal, should be able to represent the person with the intellectual disability.

216 In the area of criminal law, the High Court of Australia has held that a trial may be stayed in circumstances where an accused person charged with a serious offence is not represented at trial by a lawyer: *Dietrich v R* (1992) 177 CLR 292.

217 This has been recognised with respect to patients appearing before the Mental Health Review Board—'patients can feel confused, powerless and intimidated by Board processes': Auditor General Victoria, *Mental Health Services for People in Crisis*, (2002) 118.

218 Specified people (for example children and municipal councils) may have professional advocates. A person can be represented by a professional advocate if the parties agree or by any person (including a professional advocate) permitted or specified by the Tribunal. For the definition of professional advocate see s 62(8).

219 For example, Submission 16, Mental Health Legal Centre 4; Submission 17, Disability Justice Advocacy 2.

4.60 In some cases the person will not have an advocate. The Commission believes that VCAT should have power to order that a suitably qualified advocate should represent the person where this is appropriate. The advocate could be a lawyer with expertise in the area of disability law or a person who works in the area of disability and has knowledge and expertise relevant to detention. A number of advocacy services are funded to provide assistance to people with disabilities. The Commission suggests that DHS should consider how to ensure that people have access to representation in detention proceedings. This could be done by funding specified services to provide advocates in these proceedings.

ROLE OF ADVOCATE

4.61 An advocate may face a number of difficulties in representing a person with an intellectual disability. The person may not be able to adequately communicate his or her instructions to the advocate. Even if they can do so, there may be a conflict between what the person wants and the person's best interests. Although the proposed criteria require detention to benefit the individual,²²⁰ the person may not accept that he or she will be benefited.

4.62 Where such a conflict arises, the Commission believes that the advocate should have a duty to act in the best interests of the person who is the subject of the application. The Commonwealth *Family Law Act* provides for the appointment of a separate representative for a child.²²¹ The separate representative is responsible for conveying any wishes of the child to the court, but has a duty to act in the best interests of the child.²²²

4.63 In our view, the advocate of an intellectually disabled person should have a similar duty. The role of the advocate will involve a 'constant need to assess and advocate a client's rights within the broader context of the objectives of care and welfare.'²²³ The advocate's role will include explaining the nature of the proceedings

220 For a theoretical discussion of the role of counsel in civil commitment proceedings, see David B Wexler, *Therapeutic Jurisprudence: The Law as a Therapeutic Agent* (1990), ch 17. For discussion of other problems that arise in representing people with an intellectual disability see M. Ierace, *Intellectual Disability: A Manual for Criminal Lawyers*, (1989) cited in Maria Bisogni, 'What is the Role of a Legal Representative before the Mental Health Tribunal?' (2002) 40 *Law Society Journal* 72, 73–4.

221 *Family Law Act 1975* (Cth) s 68L.

222 *Pagliarella, In the Marriage of* (1993) 16 Fam LR 688, 695.

223 Maria Bisogni, 'What is the Role of a Legal Representative before the Mental Health Tribunal?' (2002) 40 *Law Society Journal* 72, 74.

and the functions of the Tribunal to the client. In the context of mental illness, commentators have suggested people who appear before tribunals need to have more education about how the tribunal operates.

Patients feel that they have not been heard and that their concerns have not been recognised. Communication needs to improve between staff, tribunal members and patients so that the cycle of distress described by patients can be addressed.²²⁴

A suitably qualified advocate could play an important role in reducing this ‘cycle of distress.’²²⁵



RECOMMENDATION(S)

24. Section 62 of the *Victorian Civil and Administrative Tribunal Act 1998* should be amended to allow a person with an intellectual disability to be represented in detention proceedings by a lawyer, a disability advocate, or any other person approved by the Tribunal.
25. VCAT should have power to order that a person with an intellectual disability is represented by an advocate.
26. An advocate in detention proceedings should be obliged to act in the best interests of the client.

APPEAL FROM AND REVIEW OF VCAT DECISIONS

APPEALS

4.64 Provision for appeal from a decision helps to ensure accountability and transparency of decision-making.²²⁶ Submissions which considered the issue agreed

224 Nicola Ferencz and James McGuire, 'Mental Health Review Tribunals in the UK: Applying a Therapeutic Jurisprudence Perspective' (2000) 37 *Court Review* 48, 51.

225 The Victorian Auditor-General recommended, with respect to people with mental illnesses appearing before the Mental Health Review Board, that '[i]nvoluntary patients are given the support and assistance necessary to enable them to participate effectively during Board hearings [and] [i]nvoluntary patients are made aware of their rights': Auditor-General Victoria, *Mental Health Services for People in Crisis* (2002) 118.

that an appeals process is a necessary part of any recommended statutory framework.²²⁷

4.65 Under the *Victorian Civil and Administrative Tribunal Act* an appeal on a point of law can be made to the Supreme Court, if that court gives leave for the appeal.²²⁸ The appeal to the Supreme Court does not amount to a re-hearing, but ensures that the decision made was made legally and was based on the evidence available to the decision-maker. Limiting the grounds of appeal ensures that decisions about facts will be made within VCAT, which is constituted to ensure the involvement of people with expert knowledge about intellectual disability. The right of appeal provides a ‘safety net’ to ensure that the decision is made in accordance with law.



RECOMMENDATION(S)

27. Section 148 of the *Victorian Civil and Administrative Tribunal Act 1998*, which allows an appeal from VCAT to the Supreme Court on points of law, should apply to detention decisions made by VCAT.

REVIEW OF VCAT DECISIONS

4.66 VCAT has power to review decisions²²⁹ if the Act giving VCAT jurisdiction to make the decision confers a power of review.²³⁰ We recommend:

- mandatory periodic review of a detention decision after expiry of a specified period; and

226 Submissions referred to the need for transparency and accountability. For example, Submission 25, Law Institute of Victoria 2 (representation, statements of reasons, conduct of hearings and review and appeal mechanisms); and Submission 16, Mental Health Legal Centre 4 (representation, statements of reasons, conduct of hearings and review and appeal mechanisms).

227 For example, Submission 25, Law Institute of Victoria 10; Submission 22, Victorian Bar, para 14.2 and Submission 14, Intellectual Disability Review Panel 16.

228 *Victorian Civil and Administrative Tribunal Act 1998* s 148. Note that if the original VCAT hearing was decided by the President or Vice President (with or without others), parties may appeal directly to the Court of Appeal.

229 *Ibid* s 48

230 Because we recommend that the original decision should be made by a panel presided over by a judge, we do not recommend the same re-hearing process that applies under the *Guardianship and Administration Act 1986* s 60A.

- a review on application by a person affected by the decision, or someone acting on the person's behalf.

PERIODIC REVIEW

4.67 The majority of submissions agreed that the body with power to authorise and review detention decisions should periodically review its decisions.²³¹ Such decisions substantially limit the freedom of the affected individual. The circumstances that prompted the initial authorisation of detention often change.

4.68 Periodic review ensures that such restrictions are reviewed automatically so that people affected by them are not 'forgotten' by the system. Periodic reviews are likely to provide better safeguards than review on application, as people with an intellectual disability may not have the capacity to apply, or may not have the necessary support for an application to be made on their behalf.²³²

4.69 The regularity of periodic reviews would need to depend, to an extent, on the circumstances of each person subject to detention. We recommend that detention should be reviewed at least every six months. VCAT should have power to order review in a shorter period when it makes a detention order.

Review on Application

4.70 Many submissions also agreed that people who are subject to care without consent should be able to apply for review if circumstances change.²³³ A change sufficient to warrant a reassessment of the detention order may occur between periodic reviews.

4.71 Such change may be recognised by the person concerned, or by a guardian, family member or staff member of the facility where the person lives. Because not all of the people who may be subject to detention orders will be able to communicate effectively, a family member or guardian should be able to apply for a review.

231 For example, Submission 25, Law Institute of Victoria 10; Submission 23, Headway Victoria 6 and Submission 14, Intellectual Disability Review Panel 16.

232 A recent study in Scotland suggests that appeal provisions under the *Mental Health (Scotland) Act 1984* are under utilised. Section 18 of the Act allows for the compulsory detention of people with a mental disorder, which includes learning disability. In one year of the study 2005 orders were renewed, however, only 30 of these were appealed: Scottish Executive Council Central Research Unit, *An Evaluation of Section 18 of the Mental Health (Scotland) Act 1984* (2000) para 6.56.

233 For example, Submission 16, Mental Health Legal Centre 8; Submission 3, Southwest Advocacy Association 14.

Because of their knowledge and experience of the person subject to the care plan or order, a senior staff member of a prescribed facility should also be able to apply.

4.72 There is a need, however, to limit the possibility of people repeatedly applying for the review of decisions. The relatives of a person who is subject to an order may wish to challenge the decision that authorised the order even after it has already been reviewed. Too many unfounded applications will cause a major drain on resources and will reduce the efficiency and effectiveness of the review process. The reviewing body should, therefore, be given the power to reject an application for review.

!

RECOMMENDATION(S)

28. Detention orders should be reviewed by VCAT at least every six months.
29. A VCAT order, authorising detention, may contain provisions requiring review of the original decision within a shorter period.
30. An application may be made to VCAT for a reassessment of a decision authorising detention within the six month period, or the shorter period required by VCAT. The application may be made by the person with an intellectual disability, a family member or guardian, or a person providing services or care to the person.
31. VCAT should have the power to reject an application for review.

PROCEDURAL ISSUES

PROCEDURE

4.73 Prior to approving the detention order, VCAT must be satisfied that all the legal requirements for making an order are met.²³⁴ It is important to ensure an open, transparent and accountable decision-making process. We propose that the person affected by the order should normally be present at the hearing, but that VCAT should have the power to dispense with this requirement. Under the *Intellectually*

²³⁴ See Recommendation 5.

Disabled Persons' Services Act 1986 (IDPSA) the person affected must be present at hearings of the IDR. ²³⁵ By contrast, under section 26 of the *Mental Health Act 1986* (MHA), a person has the right to appear, but is not required to do so. In some cases, the requirement for a person with an intellectual disability to appear before the IDR has created hardship for the individual concerned. We recommend that the person should be required to be present, except where VCAT orders they should not appear because this would be detrimental to the person's health or wellbeing. ²³⁶

4.74 VCAT hearings are normally held in public. Because detention significantly affects the rights of people who are detained we recommend that hearings should normally be held in public, as is currently the case for IDR proceedings. ²³⁷ However the person or their representative should be able to apply for the hearing to be closed and the Tribunal should also have power to direct that the hearing be closed in order to protect the privacy of the person affected. There is already provision under the *Victorian Civil and Administrative Tribunal Act 1998* for the Tribunal to direct a hearing be held in private. ²³⁸ Where the hearing is held in private, any person with a direct interest in the proceedings should have the right to be present and to be heard.

4.75 The Tribunal will be bound by rules of natural justice but should not be required to conduct any proceedings in a formal manner. The rules of natural justice require that the person affected by the decision has the right to be heard and to be informed of documents put before the Tribunal. The Commission recommends that the person should have the right to inspect documents except where the inspection of documents would: cause serious harm to the person's health, safety or wellbeing; expose another person to a risk of serious harm; involve the unreasonable disclosure of information relating to the personal affairs of any person; or breach a confidentiality provision imposed by a person who supplied information that is contained in the documents or document. ²³⁹

235 *Intellectually Disabled Persons' Services Act 1986* s 32

236 This is similar to a provision in the *Mental Health Act 1986* see s 26(6).

237 *Intellectually Disabled Persons' Services Act 1986* s 33. Compare proceedings before the Mental Health Review Board which are closed to the public, except where the Board considers that it is in the interest of the public to open the hearing: *Mental Health Act 1986* s 33.

238 Section 101(2). The tribunal may make such a direction on its own initiative or on the application of a party.

239 Provisions similar to this can be found in the *Mental Health Act 1986* s 26(8) and the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* s 70(5).

**RECOMMENDATION(S)**

32. The person affected by the proceedings must be present at the hearing, except where VCAT orders that the person should not appear because appearance would be detrimental to the person's health or wellbeing.
33. VCAT hearings should be open to the public, unless VCAT otherwise directs. An application may be made by a party to the proceedings or the party's representative, to have the hearing closed.
34. If the hearing is closed, VCAT may permit a family member of the person, or any other person with a direct interest in proceedings to be present during the whole or any part of the hearing.
35. The person who will be affected by a detention decision has the right to be heard and to inspect any relevant documents, except where:
 - inspection of documents would cause serious harm to the person's health, safety or wellbeing;
 - this would expose another person to a risk of serious harm;
 - involve the unreasonable disclosure of information relating to the personal affairs of any person; or
 - breach a confidentiality provision imposed by a person who supplied information that is contained in the documents or document.
36. Any other person with a direct interest in a detention decision has the right to be heard.
37. The term of a detention order cannot exceed five years. An order cannot be received beyond the five year period.

4.76 The remaining sections of this Chapter deal briefly with some practical issues which arise in the context of detention. These include:

- provision for interim and emergency detention orders;
- the authorisation of leaves of absence;
- interstate transfers; and
- procedures with respect to absconding detainees.

ASSESSMENT AND EMERGENCY PROCEDURES

4.77 Most people with intellectual disabilities whose behaviour poses a significant risk of serious harm to others will already be in the human services system or the prison system. Pending a detention order being made, the recommendations in Chapter 5 will allow a service provider to restrain or seclude persons in an emergency, or where their care plan provides for this to be done, in order to minimise the chance that they may harm others.²⁴⁰ However, where a person's dangerous behaviour has only recently come to the attention of police or DHS, and the person is not receiving services under the IDPSA, it may be necessary to detain the person for a brief period, to assess whether the criteria for detention are met. There may also be some emergency situations in which a person should be detained quickly because a change of circumstances and/or a change in their behaviour has created a risk of serious harm to others.²⁴¹

4.78 Most legislation which permits detention provides for a short period of detention for the purposes of assessment and in emergencies. The ACT legislation for example, includes provision for an assessment period of up to 14 days.²⁴² In the United Kingdom, a 28-day assessment period has been recommended.²⁴³ Currently VCAT has the power to make a temporary order appointing a guardian or administrator for a person with a disability. Such order lasts up to 21 days and can be renewed for a further 21 days.²⁴⁴

4.79 Because detention severely restricts individual freedom we believe that an 'assessment order,' requiring a person to be detained for the purpose of assessing

240 Recommendations 56–8.

241 The need for procedures governing interim and emergency detention was accepted in a number of submissions including Submission 16, Mental Health Legal Centre 10; Submission 14, Intellectual Disability Review Panel 16–7; Submission 3, Southwest Advocacy Association 15.

242 *Mental Health (Treatment and Care) Act 1994* (ACT) s 17. Under this section, an assessment is to be conducted within seven days, however, if the Mental Health Tribunal is satisfied, based on clinical evidence, that seven days will be insufficient, then the tribunal can order that the period be extended by another seven days.

243 No submissions dealt specifically with the time period necessary for assessments. The recent United Kingdom White Paper on the reform of powers of compulsory care for people with mental disorders included the recommendation that the period of formal assessment and initial treatment under compulsory powers would be up to 28 days: United Kingdom Home Office and Department of Health, White Paper, *Reforming the Mental Health Act* (2000) para 3.38.

244 *Guardianship and Administration Act 1986* s 60. There are VCAT members on call 24 hours a day in the guardianship list. The same members may be able to authorise emergency detention orders.

whether he or she should be subject to long term detention, should be approved by a judge and should last no longer than 14 days. If an assessment order is approved by VCAT, the person subject to the order must be moved to a suitable secure facility for the conducting of the assessment. In some circumstances, this may require authorisation for the power to apprehend, detain and transport the person to the facility. After 14 days, the Senior Clinician must apply for a detention order, or determine an alternate behaviour management strategy.

4.80 Detention orders, for the purposes of assessment, or in an emergency, will only be required when there has not been an opportunity to seek prior authorisation for detention from VCAT. In an extreme emergency an ordinary member of VCAT should be able to authorise emergency detention for up to 72 hours.

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RECOMMENDATION(S)

38. The Office of Senior Clinician may apply to VCAT for an assessment order or an emergency detention order, either on the initiative of the Office or on the request of an authorised police officer or a clinician.
39. An assessment order should only be able to be made in circumstances where it is necessary to detain the person for the purposes of assessment, because there is a significant risk of serious harm being caused to other members of the community. A judicial member of VCAT can authorise the detention of a person for the purposes of assessment, for a period of up to 14 days.
40. In the case of an emergency, where the person's behaviour has created an extreme risk of harm to others, an ordinary member of VCAT can authorise a detention order for up to 72 hours. The person must be released at the end of that period, unless a judicial member authorises detention for the purposes of assessment, for a period of up to 14 days.

LEAVES OF ABSENCE

4.81 A major aim of detention is to assist the detained person to change his or her behaviour, so that he or she can live in the community. This makes it important to give people who are subject to a detention order the opportunity to be allowed out of the facility, to participate in everyday activities and to show that their behaviour has changed, so that they should no longer be detained. In addition, it may be appropriate for a person subject to an order to be allowed out of the facility

on compassionate grounds. It is clear, however, that any such leave needs to be regulated.

4.82 There are two types of leaves of absence that may be appropriate. These are escorted and unescorted leave. Escorted leave describes those circumstances where a person subject to a detention order leaves the secure facility under the supervision of an authorised person. Unescorted leave is where a person subject to a detention order leaves the secure facility without being accompanied by an authorised person.

4.83 The submissions that included reference to leaves of absence did not differentiate between escorted and unescorted leaves.²⁴⁵ A number of the submissions considered that the provision for leaves of absence under the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* provide an appropriate model.²⁴⁶

4.84 During 2001 there were reviews of leave arrangements for Statewide Forensic Service²⁴⁷ as well as the Victorian Institute of Forensic Mental Health (Forensicare).²⁴⁸ Some of the review recommendations apply only to people with mental illnesses who are under sentence and transferred from prison. The recommendations that are applicable include the need to develop detailed leave plans, which would include the purpose and nature of the leave, the destination and duration, transport and escort, if any, arrangements.²⁴⁹ We have drawn on these reviews in making our recommendations.

4.85 The Commission is of the view that leave plans, both escorted and unescorted should be included in the detention plan. The plan should outline the type of leave proposed up until the next review period; the purpose of leave, and how it is to be managed.

245 Submission 16, Mental Health Legal Centre 10.

246 For example, Submission 14, Intellectual Disability Review Panel 17; Submission 11, Statewide Forensic Services 24.

247 Victorian Government, *Report of the Review Panel Appointed to Consider the Operation of the Disability Services Statewide Forensic Service*, Justice Frank Vincent, Chair (2001) 25–8.

248 Victorian Government, *Report of the Review Panel Appointed to Consider Leave Arrangements for Patients at the Victorian Institute of Forensic Mental Health*, Justice Frank Vincent, Chair (2001) 6–20.

249 Ibid 15.

ESCORTED LEAVE

4.86 The detention plan should indicate whether and when regular escorted leave is permitted. However it will not be possible for the detention plan to include provision for escorted leave to deal with unexpected situations, such as the funeral of a family member. Both regular escorted leave, or leave to deal with a situation not covered in the detention plan should be approved by the person in charge of the facility and reported to the Office of Senior Clinician.²⁵⁰ The reporting of leaves of absence will enable the monitoring of the use of escorted leaves to assess whether regular leave is over or under-used and may be taken into account when the detention order is reviewed. Instituting safeguards to ensure that leave is not *under-used* is an important mechanism to protect the rights of people with an intellectual disability, that currently does not exist.

4.87 The Forensicare Report recommended minimum requirements and desirable qualifications for escorts.²⁵¹ The Office of Senior Clinician should publish criteria indicating when escorted leave should be permitted and the qualifications and skills required for escorts.



RECOMMENDATION(S)

41. Escorted leaves of absence may be authorised by the person in charge of the prescribed detention facility. All escorted leaves of absence must be reported to the Office of Senior Clinician on a quarterly basis.
42. The Office of Senior Clinician shall prepare and publish guidelines indicating when escorted leave should be permitted and the qualifications and skills required for escorts.

250 When a service provider is applying for recognition as a prescribed facility for the purposes of this framework (see Chapter 8) then a particular employee or position in the organisation should be designated as the office holder who approves escorted leaves of absence.

251 *Report of the Review Panel Appointed to Consider Leave Arrangements for Patients at the Victorian Institute of Forensic Mental Health* (2001) 35–6.

UNESCORTED LEAVE

4.88 As the purpose of detention is to enable the detained person to change his or her behaviour so that he or she may live in the community without posing a risk of harm to others, detention plans should usually make provision for unescorted leaves of absence.²⁵² However if the Office of Senior Clinician considers that there should be no unescorted leave for the duration of a particular detention order, the detention plan should make this clear. If, during the period of the detention order, those with responsibility for the person consider that the leave provisions need to be amended, then application can be made to the Office of Senior Clinician for an amendment to the detention plan. The unescorted leave in the detention plan which is approved by VCAT, should be endorsed by the person in charge of the facility after there has been an assessment by of the person's current behaviour. If leave is not endorsed by the nominated officer this must be reported to the Office of Senior Clinician.



RECOMMENDATION(S)

43. The detention plan may provide for unescorted leaves of absence from a facility. The criteria for authorising an unescorted leave of absence should be contained within the detention plan.
44. Unescorted leave must be endorsed by the person in charge of the facility after there has been an assessment of the person's current behaviour. If leave allowed for in the plan is not permitted this must be reported to the Office of Senior Clinician.

INTERSTATE TRANSFERS

4.89 A person may want to change his or her State of residence, for family or financial reasons. The ability for a person without a disability to move from state to state is, in most cases, unfettered. Where possible, a person with an intellectual disability should have similar freedom.

²⁵² The inclusion of provision for leaves of absence in the care plan was supported in the submissions. For example, Submission 25, Law Institute of Victoria 11.

4.90 We, therefore, consider it appropriate for the legislation to provide for interstate transfers be made to and from states that have similar laws to the legislation that establishes this framework. The Minister responsible for the carriage of the framework will have the power to declare the laws of another State to be similar laws.²⁵³ However, we note that at this point lack of similar legislation in other states may make such a provision inoperative. This issue could be placed on the agenda of the Community and Disability Services Minister's Conference.

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RECOMMENDATION(S)

45. Interstate transfers may be approved to and from other states that have provisions allowing detention on similar grounds to those recommended above.

ABSCONDING DETAINEES

4.91 The legislative framework we recommend must take account of the possibility that a person subject to a detention order may abscond. If a person is detained, the police or a prescribed person should have the authority to apprehend and return the person to the facility if she or he absconds.

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RECOMMENDATION(S)

46. The police or a prescribed person should be authorised to detain people who abscond while subject to a detention order and to return them to the facility specified in the detention plan.

CHILDREN

4.92 The terms of reference do not make it clear whether our recommendations should deal with children, as well as adults with a cognitive disability, whose behaviour places others at risk. Where a child, because of age or disability, is unable

²⁵³ Provisions of this nature have been recently introduced into the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* Pt 7A.

to consent to care or treatment, the child's parent or guardian can usually do so on their behalf. The Discussion Paper noted that the *Children and Young Persons Act 1989* (CYPA) provides for:

- placement in a secure welfare service of a child who is at immediate substantial risk of harm;²⁵⁴ and
- trial and sentencing—including custodial sentencing—of a child charged with a criminal offence, in the criminal division of the Children's Court.²⁵⁵

4.93 Some submissions argued that the current provisions of the CYPA and the current powers of the Children's Court are adequate to deal with the issues that arise for children with cognitive impairments:

The Children's Court of Victoria is a specialist court dealing with matters relating to children and young persons. The provisions of the legislation concerning both criminal matters and protective issues are comprehensive. The Court is extremely experienced in dealing with issues relating to special needs children.²⁵⁶

[An] advantage of dealing with children with an intellectual disability within the current child protection legislation is that children will be dealt with by specialist judicial officers who are experienced in making decisions about children. If children with an intellectual disability are fitted into a predominantly adult system they will not enjoy the advantages of being dealt with in a forum designed especially to meet the needs of younger people.²⁵⁷

4.94 It was acknowledged, however, that some changes to the *Children and Young Persons Act 1989* may be needed. In particular, it was pointed out that the care and protection provisions focus on situations in which the child is at risk of being harmed by others, rather than situations where the child needs care to ensure they do not harm others. For example, the National Children's and Youth Law Centre suggested that there was a need to expand the grounds on which the Court could make orders for a child's protection:

254 *Children and Young Persons Act 1989* ss 69, 73, 74 and see Victorian Law Reform Commission *People with Intellectual Disabilities at Risk: A Legal Framework* Discussion Paper (2002) 54–6.

255 *Children and Young Persons Act 1989* Division 7—Sentencing Orders.

256 Submission 22, Victorian Bar para 4.2.

257 Submission 18, National Children's and Youth Law Centre 2.

An additional ground could be added to s 63 of the *Children and Young Persons Act 1989* to cover the situation of a child or young person with an intellectual disability whose behaviour causes or is likely to cause serious harm to themselves or others.²⁵⁸

The same submission expressed the view that it would be preferable to modify the current child protection system than to expect a framework geared primarily towards adults to cater for young people.

4.95 In principle, the Commission supports the amendment of s 63 to allow a protection order to be made to allow the provision of care or treatment to a child to prevent the child from seriously harming others.²⁵⁹ However, we do not make a formal recommendation to this effect. Our consultations and research have not presented sufficient justification for applying the proposed legislative framework to children and young people, except in the situation discussed in 4.96 below. We believe that more extensive research on the appropriate framework for responding to children with intellectual impairments who pose a risk to themselves or others is needed.

4.96 There is, however, one situation in which it is appropriate for our recommendations to apply to young people. Under the CYP A, protection orders²⁶⁰ can only be made for a person under the age of 17.²⁶¹ A person under the age of 18 cannot have a guardian appointed under the *Guardianship and Administration Act 1986*.²⁶² This means that there is no mechanism available for detention or application of restraint or seclusion to a child of 17 with an intellectual disability, whose behaviour is placing others at significant risk of serious harm. We therefore recommend that the detention provisions proposed in this Report should cover

258 Ibid 1.

259 In some cases it may be possible to argue that this is covered by s 63(f).

260 These include supervision and custody orders and the other types of order discussed in s 85(1).

261 If a protection order is in force it continues until the child turns 18, see s 85(2). 'Child' is defined in s 3 of the Act as:

(a) in the case of a person who is alleged to have committed an offence, a person who at the time of the alleged commission of the offence was under the age of 17 years but of or above the age of 10 years but does not include any person who is of or above the age of 18 years before being brought before the Court; and

(b) in any other case, a person who is under the age of 17 years or, if a protection order, a child protection order...or an interim order...continues in force in respect of him or her, a person who is under the age of 18 years.

262 See ss 19(1) and 43(1).

young people aged 17 with an intellectual disability, whose behaviour places others at significant risk of serious harm.

!**RECOMMENDATION(S)**

47. The provisions for authorisation and review of detention should apply to people of 17 years of age or older, who satisfy the relevant statutory criteria.

Chapter 5

Regulating Use of Restrictive Practices

INTRODUCTION

5.1 Chapter 4 proposed a legislative framework for authorisation and review of decisions to detain people with an intellectual disability, whose behaviour places others at significant risk of serious harm. The criteria which we have recommended will ensure that only a very small number of people with an intellectual disability are likely to be detained.

5.2 By contrast, a much larger number of people with an intellectual disability have restrictions imposed on them, in the course of their care.²⁶³ These restrictions may be imposed to prevent people harming themselves, injuring other residents in the place where they are living or injuring someone who is caring for them. For example people with an intellectual disability may be medicated to make them less anxious or to control their sexual behaviour. They may be restrained by mechanical means, such as by using a belt to prevent them from injuring themselves. They may be locked in a room on their own to give them ‘time out’. They may be prevented from entering or leaving the place where they are living.

5.3 As explained in Chapter 2, these restrictions can significantly restrict the freedom of people with an intellectual disability. The current law does not regulate them adequately. This Chapter proposes a legislative framework to regulate the use of such restrictive practices.

263 In June 2001, 1250 people eligible for services under the Act were reported as having been the subject of restraint or seclusion that month. This amounts to 17% of the 7166 people attending service outlets from which reports were sent: Intellectual Disability Review Panel, *Annual Report 2001–2002*, (2002) 41. In April 2002, restraint or seclusion measures were applied to 1285 people using DHS services: *ibid.* The total number of persons using services in that month was 7417. For qualifications on the data see 18–9. However, the Intellectual Disability Review Panel believes these figures are under-representative, and consider that up to 50% of recipients of services may be subject to restraint and seclusion; Submission 14, Intellectual Disability Review Panel 4–5.

INTERACTION WITH DEPARTMENT OF HUMAN SERVICES (DHS) REVIEW OF THE DISABILITY LEGISLATION

5.4 As we explained in Chapter 1,²⁶⁴ DHS is currently reviewing the *Intellectually Disabled Persons' Services Act 1986* (IDPSA) and the *Disability Services Act 1986* (DSA). The recommendations in this Chapter could be made by amending the current legislation or could be taken into account in any new legislation which replaces it. References to the IDPSA in recommendations in this Chapter are intended to include any legislation which replaces it.

PROBLEMS WITH CURRENT PROVISIONS

5.5 As we have seen²⁶⁵ the IDPSA already imposes controls on use of mechanical and chemical restraint and seclusion.²⁶⁶

5.6 However, it is clear that there are deficiencies in current controls on use of restraint and seclusion. Provision for review of use of restraint and seclusion does not provide effective safeguards against unlawful use of these practices or inappropriate decision-making. It is rare for people with intellectual disabilities or their families to seek review of decisions. Even if they do so successfully this may not change use of these practices in relation to other people in the same or other services.

5.7 Nor does the legislation allow for effective monitoring of these practices. In its *Annual Report 2001–2002* the Intellectual Disability Review Panel (IDRP) commented on 'its limited ability to meaningfully monitor practices that have the potential to infringe the human rights of people who have an intellectual disability'.²⁶⁷ Similarly, the Auditor-General's Report indicated there was a need to strengthen and clarify the statutory controls on the restraint and seclusion of people with an intellectual disability.²⁶⁸ The Report noted that

264 See paras 1.45–7.

265 *Intellectually Disabled Persons' Services Act 1986* s 44. For a more detailed description of these controls see Victorian Law Reform Commission *People with Intellectual Disabilities at Risk: A Legal Framework for Compulsory Care* Discussion Paper (2002) 13–4.

266 A proposed definition of these terms is discussed below.

267 Intellectual Disability Review Panel, *Annual Report 2001–2002*, (2002) 41.

268 Auditor General Victoria *Services for People With an Intellectual Disability* (2000) 44–5.

Although the use of restraint and seclusion must be reported to the IDRPs on a monthly basis, there is not a clear legislative mandate for the Panel to monitor or act on reports received.²⁶⁹

5.8 As the Discussion Paper noted, the IDRPs do not have determinative powers.²⁷⁰ In view of the significant restrictions to liberties and rights that these practices can entail, the Commission believes that more effective safeguards and controls need to be put into place.

5.9 Particular concerns have been expressed about the use of medication to control people's behaviour (chemical restraint). Medication is frequently used to manage the behaviour of people with an intellectual disability.²⁷¹ A person may consent to taking drugs without fully understanding their purpose or side effects, or a guardian or relative may agree that medication should be prescribed for the person. Although the IDPSA places restrictions on the use of 'chemical restraint'²⁷² it does not define this expression. The IDRPs currently excludes the prescription and administration of 'any drug prescribed and administered to treat a medical condition or as an adjunct to a surgical or diagnostic procedure' from its working definition of chemical restraint.²⁷³ The purpose of this exclusion is to make it unnecessary for service providers to report use of drugs which are prescribed for the purposes of treatment of a person's condition, rather than for the purposes of behaviour control.

5.10 The IDRPs have pointed to some significant anomalies in the reporting of chemical restraint, noting that medications might be reported as chemical restraint in one setting but not in another, depending on whether or not a client has been diagnosed as having a mental illness. If the medication is used for treatment of a

269 Ibid 45.

270 Victorian Law Reform Commission *People with Intellectual Disabilities at Risk: A Legal Framework for Compulsory Care* Discussion Paper (2002) 13–7.

271 See for example, Intellectual Disability Review Panel, *Annual Report 2001–2002*, (2002) 20–4.

272 *Intellectually Disabled Persons' Services Act 1986* s 44.

273 Intellectual Disability Review Panel *Restraint and Seclusion: Notes for Authorised Program Officers under the Intellectually Disabled Persons' Services Act 1986* (2001) 6. Note that the Disability Services, Department of Human Services, *Restraint and Seclusion—Policy: January 2001—Amended September 2002*, (2002) states that 'the key issue regarding chemical substances is the intent or primary purpose of the use of the substance'. If it is prescribed by a general practitioner, primarily for treating a physical illness or condition, or by a psychiatrist, primarily for treating a mental illness, it is not treated as chemical restraint. For a discussion on the differences between these two policies, see n 11.

mental illness, it does not have to be reported as chemical restraint. The Panel notes some peculiar outcomes of this position:

...some years ago the management of Kew Residential Services engaged the services of a consultant psychiatrist who sees a number of residents on a regular basis. The residents have all been diagnosed as having a mental illness. Accordingly Kew reported only 4 of its 454 residents or 0.9% as having been subject to chemical restraint for the month of April 2002. This compares with 47% of residents at Colanda, 75% of residents at Sandhurst and 73% of residents at Plenty Residential Services.²⁷⁴

5.11 Chemical restraint and the use of medications that would, without a diagnosis of mental illness, constitute chemical restraint, pose potentially serious threats to the liberties and rights of the individual concerned. The Commission therefore believes that a more rigorous and effective system is needed to monitor and regulate the use of medications to control a person's behaviour.

5.12 The Commission also notes that some people who are receiving services under the IDPSA have their freedom of movement restricted because the doors of the residential service where they live are kept locked, so that they cannot enter and leave without permission. Alternatively, they may be locked into an area inside the place where they are living. Because this practice does not come within the current definition of 'seclusion'²⁷⁵ the use of locked door policies cannot be reviewed and is not required to be reported to the IDRP. The Commission's view is that this practice should also be regulated.

WHICH PRACTICES ARE TO BE COVERED BY THE PROPOSED LEGISLATIVE FRAMEWORK?

5.13 The legislative framework proposed by the Commission covers

- mechanical restraint of a person for behavioural control purposes, for example using straps to restrain a person who is behaving aggressively;
- physical restraint of a person for behavioural control purposes, for example holding a person down;
- seclusion of the person, for example locking a person in an area apart from others;

274 Intellectual Disability Review Panel, *Annual Report 2001–2002*, (2002) 25.

275 The definition is discussed below. It only covers a person who is confined in a room alone.

- locking doors to prevent a person leaving a facility or an area within the facility; and
- prescribing medication to control a person's behaviour.

We call these 'restrictive practices'. Each of these forms of restrictive practice is defined in more detail below.

ELEMENTS OF A REGULATORY SYSTEM

5.14 An effective system for regulating restrictive practices must protect the rights of people with an intellectual disability. However, it must also be flexible enough to allow service providers to fulfil their duty of care to their staff and ensure that the people with an intellectual disability are not harmed by other residents. There would be little point in the Commission recommending a framework to regulate use of restrictive practices which was so inflexible or expensive to apply that it was unworkable in practice.

5.15 Our recommendations are intended to create a transparent process for regulating restrictive practices, so that they can be subjected to external scrutiny and so that service improvements can be made if necessary. The framework is also intended:

- to provide clear criteria indicating which practices can be used and when it is permissible to use them;
- to ensure accountability of service providers; and
- to ensure regular review of the care of individuals who are affected by these practices.

5.16 As we have seen, the main accountability measures contained in the IDPSA relate to the use of mechanical restraint and seclusion. These practices are controlled by the requirement that (except in an emergency) the person's individual program plan must provide for these measures and their use must be approved by an authorised program officer and reported to the IDR. ²⁷⁶ Decisions to use restraint or seclusion are reviewable by the IDR ²⁷⁷ and service providers must make monthly reports on use of restraint and seclusion measures to the IDR. ²⁷⁸ The

276 *Intellectually Disabled Persons' Services Act 1986* s 44.

277 *Ibid* s 51(f).

278 *Ibid* s 44(9).

IDRP can also review a person's general service plan, which 'specifies the areas of major life activity in which support is required and the strategies to be implemented to provide that support'.²⁷⁹ However, it has no power to review the inclusion of restraint and seclusion provisions in the person's individual program plan.²⁸⁰

5.17 The recommendations in this Report are intended to increase the accountability of service providers and regulate use of restrictive practices by applying a broader range of accountability measures. These include:

- enacting legislative criteria to control use of restrictive practices;
- requiring that provision for mechanical and chemical restraint and seclusion is made in a care plan
- , which is approved by the Office of Senior Clinician and reviewed annually;
- providing for monitoring of mechanical and chemical restraint and seclusion and adoption of locked door policies;
- providing a right of review of care plans allowing for mechanical and chemical restraint and seclusion;
- providing for random audits of service providers (discussed in Chapter 8); and
- establishing an independent system for resolving complaints against service providers (also discussed in Chapter 8).

5.18 In the remainder of this Chapter we discuss the particular accountability measures which should apply to different types of restrictive practices.

APPLICABILITY OF LEGISLATIVE FRAMEWORK

5.19 The legislative framework recommended in this Report is intended to apply to people with an intellectual disability who are receiving services provided by government or by other providers under the IDPSA.²⁸¹ As is the case with the current provisions relating to use of mechanical restraint and seclusion, our recommendations do not apply to family members or friends who are caring for

279 Ibid s 3 (definition of general service plan).

280 Ibid s 3 (definition of individual program plan).

281 Note that the *Intellectually Disabled Persons' Services Act 1986* s 12A applies the Act to certain former clients of the Office of Disability Services. If they are receiving services under the IDPSA they will also be covered by our recommendations.

people with an intellectual disability. There would be little point in requiring compliance with these provisions in a situation where enforcing compliance was impossible. We note, however, that our recommendations set standards of practice which may have the indirect effect of improving care of people with an intellectual disability who do not receive services under the IDPSA, because they are living with their families.

! RECOMMENDATION(S)

48. The legislative framework controlling restrictive practices should apply to people who receive services or participate in programs under the *Intellectually Disabled Persons' Services Act 1986*.

LEGISLATIVE CRITERIA FOR USE OF RESTRICTIVE PRACTICES

5.20 Currently, provisions regulating use of restrictive practices are found in both legislation and departmental policies. The IDPSA regulates use of 'mechanical and chemical means of bodily restraint' and seclusion. It does not define these terms but relevant definitions are contained in the DHS Restraint and Seclusion Policy.²⁸² This policy also explains the meaning of 'physical restraint' (which is not defined in the IDPSA) and explains the circumstances in which it can be used. DHS also has a policy clarifying the situations in which it is appropriate to lock doors and windows in community based accommodation services and training centres.²⁸³

5.21 Because the restrictive practices discussed in this Chapter have the potential to discriminate against people with an intellectual disability, the Commission recommends that criteria for their use should be specified in either the IDPSA or regulations made under it. Workers involved in caring for people with an intellectual disability should receive training to inform them about when particular practices can be used.

282 Disability Services, Department of Human Services, *Restraint and Seclusion—Policy: January 2001—Amended September 2002*, (2002) 4. See also definitions under Intellectual Disability Review Panel, *Restraint and Seclusion: Notes for Authorised Program Officers Under the Intellectually Disabled Persons' Services Act 1986* (2001) and *Guide to Completing Monthly form for Restraint and Seclusion Monitoring (RASM) System* (2000). For an explanation of the differences of the definitions in these policies, see n 11.

283 DisAbility Services, Department of Human Services, *Locked Doors and Windows Policy*, (1999) 2. See paras 5.61–4 for further discussion of this policy.

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RECOMMENDATION(S)

49. Clear criteria regulating use of the following restrictive practices should be set out in the IDPSA or in regulations under that Act.
50. The restrictive practices that should be regulated are:
- mechanical restraint of a person for behavioural control purposes, for example using straps on a person who is behaving aggressively;
 - prescribing medication for behavioural control purposes (chemical restraint);
 - seclusion of the person, for example locking a person in an area apart from others;
 - physical restraint of a person for behavioural control purposes, for example holding a person down; and
 - locking doors to prevent a person leaving a facility or an area within the facility.

5.22 The practices referred to in Recommendation 50 above are described in more detail in the next section.

REGULATING MECHANICAL AND CHEMICAL RESTRAINT AND SECLUSION**DEFINITIONS*****MECHANICAL RESTRAINT***

5.23 The DHS Restraint and Seclusion Policy defines ‘mechanical restraint’ as ‘[m]echanical devices used to prevent, restrict or subdue movement of the person’s body’ for the primary purpose of behavioural control.²⁸⁴ This definition includes the use of devices such as harnesses, sheets or straps to restrict a person’s movement, to prevent them endangering themselves or others.²⁸⁵ The DHS Restraint and

284 Disability Services, Department of Human Services, *Restraint and Seclusion—Policy: January 2001—Amended September 2002*, (2002) 4–5.

285 A further example of restraint as a restriction of a person’s movement to a particular area is applicable to people who use motorised wheelchairs as their means of movement. If the drive of the wheelchair is

Seclusion Policy excludes the situation where the mechanical restraint is used for therapeutic purposes, for example where leg braces are used on a person with cerebral palsy to limit muscular contractions. It also excludes use of mechanical restraints such as seat belts, to enable a person to be transported safely. The Commission proposes a similar definition of mechanical restraint.

! RECOMMENDATION(S)

51. Mechanical restraint should be defined as use of a mechanical device to prevent, restrict or subdue movement of a person's body for the primary purpose of behavioural control.
52. The definition should exclude mechanical restraint used for therapeutic purposes (such as where leg braces are used on a person with cerebral palsy to limit muscular contractions), and mechanical restraint used to enable a person to be transported safely.

CHEMICAL RESTRAINT

5.24 The DHS Restraint and Seclusion Policy defines chemical restraint as '[a]ny chemical substance used to control or subdue a person's behaviour'. If a drug is prescribed by a general practitioner for the **primary purpose** of treating a physical illness or condition or by a psychiatrist for the **primary purpose** of treating a mental illness, it does not come within the definition.²⁸⁶ As discussed above,²⁸⁷ the IDRPs has raised concerns about failure to report use of drugs in situations where the drug has the dual purpose of treating the person and controlling the person's behaviour to prevent him or her from harming others. The Commission believes that the definition of chemical restraint should only exclude drugs which are prescribed **solely** to treat a physical condition or illness or to treat a mental illness.

disconnected (often through the use of levers at the rear of the base of the chair) then the person in the wheelchair cannot move and, in most circumstances, does not have the capacity to re-engage the drive of the wheelchair.

286 Disability Services, Department of Human Services, *Restraint and Seclusion—Policy: January 2001—Amended September 2002*, (2002) 4. See also definitions under Intellectual Disability Review Panel, *Restraint and Seclusion: Notes for Authorised Program Officers Under the Intellectually Disabled Persons' Services Act 1986* (2001) and *Guide to Completing Monthly form for Restraint and Seclusion Monitoring (RASM) System* (2000). For an explanation of the differences of the definitions in these policies, see n 11.

287 See paras 5.9–11.

5.25 The recommendations discussed below will require provision for use of chemical restraint to be included in the person's care plan, which will have to be approved by the Senior Clinician.

5.26 We do not propose that the plan should include provision for drugs prescribed solely for treatment purposes. Although this change may go some way towards meeting the concerns about lack of controls on prescribing psychotropic medications, the Commission believes that there is a need to ensure more detailed monitoring of prescriptions for people with an intellectual disability who are receiving services under the IDPSA. Later in this Chapter we recommend that an annual medical report should be prepared for all people with an intellectual disability covered by the legislative framework. This requirement will allow prescribing practices affecting people with an intellectual disability to be monitored more effectively.



RECOMMENDATION(S)

53. Chemical restraint should be defined as the use of a chemical substance to control or subdue a person's behaviour.

54. It should exclude a drug prescribed:

- by a general practitioner for the sole purpose of treating a physical illness or condition;
- by a psychiatrist for the sole purpose of treating a mental illness; and
- a drug prescribed to control a person's behaviour so that person can receive treatment for a physical illness or condition (for example an anaesthetic drug).

SECLUSION

5.27 Section 44 of the IDPSA defines seclusion as 'the sole confinement of a [...] person at any hour of the day or night in a room in which the doors or windows are locked from the outside'. The DHS Restraint and Seclusion Policy also covers the case where the person's physical state prevents them from opening a closed door. The Commission recommends that both these situations should be included within the legislative definition of seclusion.

! RECOMMENDATION(S)

55. Seclusion should be defined as:

- the confinement of a person alone at any hour of the day or night in a room, the door and window of which cannot be opened by the person from the inside; or
- the confinement of a person alone at any hour of the day or night in a room in which the doors or windows are locked from the outside.

5.28 It will be noted that the definition does not cover situations where a person is confined with other people, in a place which is kept locked, so that they are not free to enter and leave when they choose. Later in this Chapter we make recommendations about the circumstances in which services should be able to adopt locked door policies and the controls which should be imposed on this practice.

WHEN SHOULD USE OF MECHANICAL AND CHEMICAL RESTRAINT AND SECLUSION BE PERMITTED?

HARM TO SELF OR OTHERS?

5.29 The Discussion Paper sought the views of individuals and organisations about when use of mechanical and chemical restraint and seclusion should be permitted. These practices severely affect the rights of people with an intellectual disability. Some submissions suggested that they should only be used where it is necessary to restrict a person's freedom to prevent serious harm to others. This approach would mean that the criteria for use of restrictive practices would be similar to those which apply to detention decisions.

5.30 However, during our consultations service providers highlighted the difficulties of discharging their duty of care, if the criteria for use of restrictive practices were limited to preventing a person from harming others. A number of submissions also emphasised this issue. For example, the Intellectual Disability Review Panel drew attention to

the large numbers of people who have an intellectual disability who, under a mantle of ‘duty of care’ or for their own welfare and safety, currently live with some level of restrictions.²⁸⁸

5.31 Restrictions may take several forms, ranging from the use of restraint and seclusion, to enforcing a diet. However, preventing people with an intellectual disability from making lifestyle choices that may be harmful will sometimes discriminate against them. Generally our society permits individuals to engage in (almost) any activity that does not harm others. The Equal Opportunity Commission Victoria (EOCV) focuses on the example of smoking:

[L]imiting a person’s cigarette intake is clearly beneficial, but people without an intellectual disability are free to literally smoke themselves to death should they choose to do so.²⁸⁹

5.32 ‘Dignity of risk’ encapsulates the concept that most adults decide to take risks because they perceive some benefit: ‘[m]any individuals engage in risk taking behaviour without challenge or restriction – in some instances our community may even be regarded as celebrating such choices by some people.’²⁹⁰ Permitting people with an intellectual disability to take some risks recognises their dignity and autonomy to make choices that affect their lives. The EOCV emphasises that ‘[w]e therefore need to be extremely cautious about applying a different standard to people with an intellectual disability as it often involves...an arbitrary restriction on a person’s right to choose.’²⁹¹

5.33 Denying a person with an intellectual disability the ‘dignity of risk’ or the autonomy to make ‘bad’ decisions can be discriminatory and disabling. However, this must be balanced against the duty of care owed by the service provider to the person with an intellectual disability. This obligation requires the carer to consistently protect the person from harm.

5.34 In circumstances where people, because of their intellectual disability, are not even *aware* that they are harming themselves, (for example, where a person repeatedly bangs his or her head against the wall) dignity of risk becomes meaningless. Even if people are fully aware of their actions, their disability may limit

288 Submission 14, Intellectual Disability Review Panel 10.

289 Submission 8, Equal Opportunity Commission Victoria 10.

290 Ibid.

291 Ibid.

their capacity to reason, accurately assess the risk, or fully understand the short or long term consequences and risks of their actions.²⁹² In these situations, the duty of care owed by the service provider requires him or her to intervene to protect the person with an intellectual disability from self harm. Limiting the use of restrictive measures to those contexts where only others are at risk may prevent a service provider from discharging this duty. Such benevolent decisions could include: locking the facility's external doors to prevent a person who doesn't understand the danger of cars from wandering into traffic;²⁹³ putting boxing gloves on a person to prevent the person engaging in self-harming activities; locking a person in his or her room to prevent the person fighting someone and being injured; or prescribing a psychoactive drug to reduce a person's anxiety and aggression.

5.35 We note that the current legislation allows the use of restraint:

- in order to prevent the person from causing injury to himself or herself or any other person; or
- to prevent the person from persistently destroying property;²⁹⁴ or
- in the case of an emergency.

5.36 Seclusion is permitted where it is authorised in the person's individual program plan or in an emergency where

it is necessary for the protection, safety or well-being of the person or other persons with whom the person would otherwise be in contact.²⁹⁵

5.37 The Commission's view is that use of mechanical and chemical restraint and seclusion may be justified where it is necessary to prevent people from harming themselves, as well as to prevent them harming others. However it is important to ensure that these measures are not used routinely to control the behaviour of people with an intellectual disability, simply because a particular service does not have adequate staff resources to provide appropriate care. Nor should it be used to prevent a person behaving offensively, for example by verbally abusing staff, where there is no risk of harm to themselves or others.

292 The EOCV suggests that compulsory care decisions should include a criterion that 'the person's disability prevents them from understanding the harmful consequences of their conduct and choices: *ibid.*

293 See DisAbility Services, Department of Human Services, *Locked Doors and Windows Policy*, (1999) 2 which is discussed in further detail in paras 5.61–4.

294 *Intellectually Disabled Persons' Services Act 1986* s 44(3)(a).

295 *Ibid* s 44(4)(a)(i).

5.38 The legislative criteria recommended by the Commission will allow mechanical restraint or seclusion to be used where:

- it is necessary to prevent the person from physically harming himself or herself or any other person;
- it is necessary to prevent a person persistently destroying property, or destroying property in a way that will pose a risk of serious harm to others; and
- the particular form of restraint or seclusion which is used is the least restrictive means of preventing self harm or harm to others.

CARE PLAN REQUIREMENT

5.39 Under the IDPSA,²⁹⁶ provision for use of restraint or seclusion must be contained in the person's individual program plan, except in an emergency. Similarly, we propose that, except in an emergency, restraint or seclusion should only be permitted if provision is made for the person to be restrained or secluded in their care plan. We propose that a care plan should be prepared indicating how the person is to be looked after. In many situations a care plan will provide for mechanical restraint and seclusion to be used as a short term strategy, while the person is being assisted to change his or her behaviour. As we explain below, the care plan must be approved by the Office of Senior Clinician.

EMERGENCY USE OF RESTRAINT AND SECLUSION

5.40 The legislation should also permit emergency use of restraint or seclusion, where this is necessary to prevent immediate harm to the person being cared for or others. We recommend that emergency use of restraint or seclusion should be authorised by the person in charge of a service or facility and notified to the Office of Senior Clinician within 48 hours. This will give the Office the opportunity to collect data on emergency use of restraint and seclusion. This will allow identification of patterns which indicate whether these practices are being used appropriately by service providers.

296 Ibid ss 44 (3)(b), (4)(a).

! RECOMMENDATION(S)

56. The IDPSA should provide that mechanical or chemical restraint or seclusion (as defined in Recommendations 51–5) may only be used where:
- this is necessary to prevent the person from physically harming himself or herself or any other person; or
 - this is necessary to prevent a person persistently destroying property, or destroying property in a way that will pose a risk of serious harm to others; and
 - the particular form of restraint or seclusion used is the least restrictive means of preventing the person from physically harming himself or herself or any other person or destroying property; and
 - use of restraint and seclusion on the particular occasion has been authorised by the person in charge of the service.
57. Where it is proposed that provision of services to a person with an intellectual disability may require the use of mechanical or chemical restraint and seclusion:
- a care plan must be prepared that indicates how the proposed form of restraint or seclusion will be used in managing the person’s behaviour;
 - the care plan must indicate how the use of restraint or seclusion will benefit the person; and
 - the care plan proposing use of these measures must be approved by the Office of Senior Clinician, who must be satisfied that the statutory criteria apply.
58. Where restraint or seclusion have not been authorised in a care plan that has been approved by the Senior Clinician, they can be used in an emergency where:
- the measure is necessary to prevent the person from seriously injuring himself or herself or any other person;
 - the particular form of restraint or seclusion used is the least restrictive means of preventing the person from doing such serious harm; and
 - use of restraint or seclusion has been authorised by the person in charge of the service.
59. Where restraint or seclusion is used in an emergency the Office of Senior Clinician must be notified within 48 hours.

ROLE OF THE OFFICE OF SENIOR CLINICIAN

5.41 Consultations repeatedly highlighted the shortcomings of the existing system for authorising and reviewing restraint and seclusion of people with an intellectual disability. Some service providers felt that the most appropriate way of regulating use of restraint or seclusion was through existing general service plans and individual program plans.²⁹⁷ However, advocates for people with an intellectual disability also said that the rights of such persons are often infringed in service environments and that there was a need for more stringent monitoring of such practices.²⁹⁸ The Commission agrees, and believes that a more rigorous process is required to ensure that these practices are used appropriately and only where absolutely necessary.

5.42 We considered three possible means of authorising use of restraint and seclusion.

- VCAT could be responsible for authorising care plans which provide for restraint and seclusion, as well as for authorising detention. This approach would ensure that such practices were monitored by a body independent of service providers.
- An expert body, independent from DHS, could be made responsible for authorising care plans which provide for restraint and seclusion, reviewing these plans regularly, and monitoring the practices of service providers.
- The approval process could differentiate between situations where restraint or seclusion is proposed to prevent a person with an intellectual disability from harming him or herself, and where it is proposed to prevent the person harming others. Where restraint and seclusion is necessary to prevent the person harming him or herself it would be necessary for an application to be made to VCAT for the appointment of a guardian to consent to the use of these practices. Where it is proposed to prevent the person harming others, approval could be required by either VCAT or the expert body mentioned above.

297 See for example, Submission 21, Villamanta Legal Service 1–2 which commented that all people eligible for services should have general service plans and individual program plans to provide justification for use of restraint and seclusion, ‘but the state must take a greater monitoring and supervisory (and where necessary interventionist) role to ensure that restraint and seclusion is justified.’

298 Submission 21, Villamanta Legal Service 2; Submission 19, Office of the Public Advocate 2, 10; Submission 14, Intellectual Disability Review Panel, 12.

5.43 The Commission initially considered empowering VCAT to authorise and review care plans for people with an intellectual disability, but concluded that this would be impractical,²⁹⁹ as it would require VCAT to authorise a very large number of care plans (restraint or seclusion are applied to more than 1000 people with an intellectual disability each month).³⁰⁰ It would also be difficult to ensure that VCAT members had sufficient expertise to review plans that made provision for the use of restraint and seclusion for a particular individual with intellectual disabilities. The Commission therefore believes it would be preferable to confer formal power to approve care plans on a body with expertise in the area of intellectual disability.

5.44 Consultations raised concerns about inappropriate use of restraint and seclusion because of inadequate staff training or because service organisations did not have enough staff to allow management of the behaviour of people with an intellectual disability without use of these practices. A number of submissions argued that that use of restraint and seclusion should be authorised by a body that is independent from DHS.³⁰¹ The Intellectual Disability Review Panel, which currently has responsibility for receiving reports on use of restraint and seclusion, is not independent of the Department of Human Services, and its determinations are not enforceable.

5.45 In Chapter 4 we recommended the creation of an independent statutory body (the Office of Senior Clinician). We propose that this Office should also be responsible for arranging assessment of people to whom it is proposed to apply restraint and seclusion measures. The assessment would be undertaken by DHS or a person authorised by DHS. On the basis of that assessment, the Office of Senior Clinician would have power to approve a care plan that allows use of restraint and seclusion, or to decide that other less restrictive means should be used in caring for them, so that they do not physically harm themselves or others.

5.46 Provisions requiring consultation with the person, his or her primary carer and other appropriate persons, which currently apply to general service plans and individual program plans,³⁰² should also apply to care plans. A copy of the plan

299 See for example, Submission 19, Office of the Public Advocate 5. To some extent these concerns related to the inclusion of people with a cognitive impairment within the framework.

300 See para 2.14.

301 Submission 3, Southwest Advocacy Association; Submission 8, Equal Opportunity Commission; Submission 16, Mental Health Legal Centre.

302 *Intellectual Disabled Persons' Services Act 1986* s 9(4).

should be provided to the person subject to the plan, the person's primary carer and any association or organisation that will provide services to the person.³⁰³

5.47 The independence of the Office of Senior Clinician from DHS will safeguard the rights of people with an intellectual disability and help to maintain community confidence that restraint and seclusion are not used unnecessarily.

5.48 The Auditor-General's Report drew attention to

[r]egular renewal of Individual Program Plans specifying the use of restraint and seclusion, and the accompanying formal approvals, with little evidence of formal review of the effectiveness or continued appropriateness of the strategy, an absence of consultation with family members and in some cases, little evidence of a review of the Individual Program Plan itself.³⁰⁴

5.49 To overcome this problem, it is recommended that care plans containing provision for restraint and seclusion should be reviewed by the Office annually. The review should include re-assessment of the person to ensure that their behaviour continues to require use of these measures. In situations where the Office of Senior Clinician declines to authorise continuing the use of restraint and seclusion, it must liaise with the service provider to make arrangements as to how the person should be managed. The Office of Senior Clinician might, for example, require a gradual reduction over time in the use of restraint and seclusion.

5.50 In Chapter 7 we propose that the Office of Senior Clinician should prepare guidelines for the preparation of care plans which permit restraint or seclusion. Such guidelines should provide for appropriate consultation with family members.

303 Cf *Intellectual Disabled Persons' Services Act 1986* s 9(6).

304 Auditor-General Victoria *Services For People With An Intellectual Disability* (2000) 44.

! RECOMMENDATION(S)

60. In addition to the functions that are recommended to be conferred on the Office of Senior Clinician in Chapter 4, the Office should be responsible for:
- approving care plans, including provision for restraint or seclusion;
 - conducting an annual review of care plans that provide for use of restraint and seclusion to determine whether the plans should be changed;
 - receiving reports on emergency use of restraint or seclusion; and
 - monitoring use of restraint and seclusion.
61. Before a care plan is approved, DHS must consult with the person and the person's primary carer or guardian.
62. A copy of the care plan must be provided to the person, the primary carer and any association or organisation that provides the person with services.
63. Where DHS has prepared a care plan that provides for restraint and seclusion, the Office of Senior Clinician should have power to request additional information from DHS or to direct a more detailed assessment of the person's needs, before approving the care plan.
64. The Office of Senior Clinician must annually review plans that contain provisions for restraint and seclusion. In situations where the Office declines to authorise a care plan providing for use of restraint and seclusion, the Office shall liaise with the service provider to make arrangements as to how the person should be managed.
65. The Office of Senior Clinician must establish a system for monitoring the use of restraint and seclusion.

RIGHTS OF REVIEW

5.51 Currently the Intellectual Disability Review Panel has power to review 'a decision to use restraint and seclusion under s 44'.³⁰⁵ Such reviews are rarely sought.

305 *Intellectually Disabled Persons' Services Act 1986* ss 28, 52.

To some extent, this reflects a lack of awareness among people with an intellectual disability and their families of their right to seek a review of the decision.³⁰⁶ However, even if people with an intellectual disability are told they have a right to a review, this may be infrequently exercised, because of the difficulties that many of these people will have in pursuing these rights.³⁰⁷ The approval requirement, discussed in this Chapter, and the Senior Clinician's role in monitoring use of restraint and seclusion are likely to be a more effective means of ensuring the accountability of service providers.

5.52 Nevertheless the Commission believes it is appropriate for the legislation to give people the right to have restraint and seclusion decisions reviewed. We propose that a person with an intellectual disability, their guardian or a member of their family, or the Office of the Public Advocate should be able to apply to VCAT for a review of a care plan providing for use of restraint and seclusion. Chapter 4 discussed VCAT membership and procedures for authorising detention decisions. The same principles should apply to reviews of a decision of the Office of Senior Clinician to approve a care plan providing for restraint and seclusion.



RECOMMENDATION(S)

66. VCAT should have jurisdiction to review care plans providing for restraint and seclusion for persons with an intellectual disability.
67. The following persons may apply for a review:
 - the person to whom the plan applies;
 - a family member or guardian of that person; or
 - the Office of the Public Advocate.
68. The membership of the VCAT panel and the procedures applied by VCAT in reviewing care plans providing for restraint and seclusion should be the same as those recommended for VCAT reviews of detention plans.

306 Auditor-General Victoria *Services For People With An Intellectual Disability* (2000) 44.

307 Ibid.

REGULATING USE OF PHYSICAL RESTRAINT

5.53 In certain situations people with an intellectual disability may be physically restrained by those caring for them. For example, people might be restrained by their carer to prevent them from running on to the road, might be carried out of a room to prevent them breaking windows or damaging property, or might be held to prevent them from harming another resident or a staff member. If this form of physical intervention is not authorised by law it may expose carers to the risk of civil action for assault or false imprisonment.³⁰⁸ However, in the course of caring for people, it is sometimes necessary to physically restrain them to ensure that they do not harm themselves or others.

5.54 At present ‘physical restraint’ does not come within the definition of ‘mechanical or chemical restraint,’ both of which are regulated by the IDPSA. Currently, use of physical restraint is regulated by common law principles which protect individuals’ bodily integrity³⁰⁹ and by DHS policy.³¹⁰ Because use of physical restraint affects the rights of people with an intellectual disability, the Commission believes that the IDPSA should clarify when physical restraint is permitted.

DEFINITION OF PHYSICAL RESTRAINT

5.55 The DHS Restraint and Seclusion Policy defines ‘physical restraint’ as ‘[t]he use of any part of one’s body to prevent, restrict, or subdue movement of any part of another person’s body.’³¹¹ We recommend that a similar definition be included in the IDPSA or in regulations under the Act.

WHEN IS USE OF PHYSICAL RESTRAINT JUSTIFIED?

5.56 The exclusion of physical restraint from the controls which the IDPSA imposes on restraint and seclusion presumably reflects the fact that it is often used in an emergency situation.

5.57 In paras 5.5–12 we argued that criteria for use of restrictive practices that have a significant effect on the rights of people with an intellectual disability should

308 *Halsbury’s Laws of Australia*, JLR Davies, TORT [415–345] – [415–395].

309 It is a civil wrong to assault or falsely imprison a person, *ibid*.

310 Disability Services, Department of Human Services, *Restraint and Seclusion—Policy: January 2001—Amended September 2002*, (2002) 5.

311 *Ibid* 5.

be included in the IDPSA or in regulations. The Commission recommends that physical restraint (as defined above) should normally be permitted only in an emergency, where its use by a service provider is required to discharge the duty of care which is owed to the individual, to other residents, or to staff members, or to prevent serious harm to another person. In occasional situations, physical restraint may regularly be used in managing the behaviour of an individual to prevent him or her harming others. We propose that the legislation should make recommendations to deal with this situation below.

5.58 The person applying physical restraint should only be permitted to use the minimum force required for that purpose. They should be required to end the physical restraint as soon as the emergency has been resolved. The proposed criteria for the use of physical restraint are consistent with the current DHS Guidelines for its use. Where physical restraint is used inappropriately, the person affected, or a member of their family should be able to complain to an independent complaints body. We discuss the establishment of such a body in Chapter 8.

SHOULD IT BE NECESSARY FOR THE OFFICE OF SENIOR CLINICIAN TO APPROVE A PLAN AUTHORISING EMERGENCY USE OF PHYSICAL RESTRAINT?

5.59 The Commission does not recommend that it should be mandatory to include provisions allowing emergency use of physical restraint in care plans. Because physical restraint is normally used in emergencies, a requirement of approval might simply result in the inclusion of a standard clause in care plans permitting use of physical restraint. This would not necessarily produce any improvements in care standards.

REGULAR USE OF PHYSICAL RESTRAINT

5.60 We recognise, however, that physical restraint is sometimes used as a reactive behavioural strategy for individuals who frequently behave aggressively to others. The Commission believes that the legislation should require routine use of physical restraint to prevent a person from harming him or herself or others to be included in a care plan. Such a provision should require approval by the Senior Clinician, under the same process which is proposed for mechanical and chemical restraint. Such plans should also be reviewable by VCAT.

! RECOMMENDATION(S)

69. Physical restraint should be defined as the use of any part of a person's body to prevent, restrict, or subdue movement of the body or part of a body of an person with an intellectual disability.
70. The IDPSA should provide that physical restraint may only be used
- in an emergency situation that makes it necessary to restrain a person with an intellectual disability in order to discharge the duty of care that is owed to the individual, to other residents, or to staff members, or to prevent serious harm to another person.
 - where provision is made for the routine use of physical restraint in a care plan, because it is necessary to prevent the person from self-harming or causing serious harm to another person, a care plan providing for routine use must be approved by the Office of Senior Clinician.
71. When physical restraint is permitted under Recommendation 70 the person applying it must use the minimum force necessary for the purpose for which it is used.
72. The person applying physical restraint should cease to do so as soon as it is no longer necessary to prevent the person from harming him or herself or causing serious harm to another person.
73. VCAT should have jurisdiction to review a care plan that provides for routine use of physical restraint.

REGULATING LOCKED DOOR POLICIES

5.61 A person's freedom of movement may be restricted by locking them into the place where they are living or into an area within that place. As long as they are locked in with others this does not amount to 'seclusion,' under the IDPSA. This means that a resident of a facility which is kept locked cannot seek a review of the policy and the locking of doors is not required to be reported to the IDRP. Where a service provider is caring for a number of people with an intellectual disability, some may need to have their freedom of movement restricted to prevent them harming themselves. For example, a person may be unsafe in traffic if they are not accompanied. Sometimes doors may be kept locked to prevent this person leaving

premises, with the consequence that other residents have their freedom of movement restricted as well.

5.62 DHS has adopted a policy to clarify the situations in which it is appropriate to lock doors and windows from the inside in community based accommodation services. The policy covers ‘the deadlocking of external doors and key locking of windows while clients and staff are inside the building, restricting exit from the building at any time without the use of a key or activation of an electronic device (door strike)’ and locking of internal doors ‘preventing movement to any designated exit without the use of a key or activation of a door strike.’³¹² Except in an emergency situation, the implementation of a locked doors and windows strategy must be ‘the least restrictive option to minimise the likelihood of injury or harm to clients’ and must be approved by the Manager of Disability Accommodation Services or the training centre manager.³¹³ Standard household security measures, such as locking doors at night, do not require approval.

5.63 The Commission considers that a person’s freedom of movement should only be restricted where this is necessary to prevent the person from harming him or herself (for example by wandering on to a busy road) or from causing serious harm to another person. This principle should be incorporated in the IDPSA.

5.64 We also recommend that the Office of Senior Clinician should prepare guidelines to assist organisations caring for people with an intellectual disability who have a range of abilities and needs. The Guidelines should indicate when it is appropriate for doors and windows to be kept locked and the fire and other safety measures that should apply to locked premises. Service providers should be required to provide an annual report to the Office of Senior Clinician about their practices in relation to residents’ access to and exit from premises. The Senior Clinician should have power to instruct them to change these practices.

312 DisAbility Services, Department of Human Services, *Locked Doors and Windows Policy*, (1999) 2.

313 *Ibid* 3.

! RECOMMENDATION(S)

74. A locked door policy should be defined as
- the regular locking of external doors and windows while clients and staff are inside the building, which restricts the entrance and exit of clients;
 - the regular locking of doors and windows, which confines a client to a particular part of a building or premises.
75. The Senior Clinician should develop guidelines indicating the circumstances in which a service provider may adopt a locked door policy.
76. Service providers should be required to provide an annual report to the Office of Senior Clinician about practices affecting access to and exit from premises.
77. The Senior Clinician should monitor service providers' practices relating to the locking of doors and windows and should have power to instruct service providers to change practices relating to client's access to and exit from premises.

OVERSIGHT OF PRESCRIBING PRACTICES

5.65 In paras 5.39–40 we recommended that chemical restraint should only be permitted in an emergency or where the Senior Clinician has approved a care plan that provides for use of chemical restraint. However, it is recommended that these controls should not apply to drugs prescribed solely for treatment of a medical condition or a mental illness.

5.66 Drug prescription is, of course, a matter for medical judgment. However the Commission believes that the current system does not permit adequate monitoring of prescribing practices which affect a particularly vulnerable group of people. Many people with an intellectual disability do not have guardians appointed to protect their interests. They may 'consent' to medication without understanding its purpose and side effects. We recommend that the IDPSA should be amended to require annual preparation of a medical report for any person who is receiving services under that Act. The medical report should assess the person's physical and mental

health and the appropriateness of any drug prescriptions. The report should be provided to the Office of Senior Clinician.³¹⁴

5.67 Where a person is also receiving treatment for a mental illness, but does not have the capacity to consent to that treatment and is not being treated under the *Mental Health Act 1986*, we recommend that the Senior Clinician should have power to request the Chief Psychiatrist to assess the person, to determine whether the process for authorising involuntary treatment of a mental illness should apply to that person.

5.68 Where the person is being prescribed drugs for a physical condition, but lacks the capacity to consent, the Senior Clinician should be able to report the matter to the Office of Public Advocate, who may decide that an application should be made to appoint a guardian for that person.



RECOMMENDATION(S)

78. The IDPSA should require preparation of an annual medical report for all people receiving services under the IDPSA.
79. The medical report should be provided to the Office of Senior Clinician.
80. Where the person is being prescribed drugs for the treatment of a mental illness, the Senior Clinician may request the Chief Psychiatrist to assess the person, to determine whether the provisions for involuntary treatment for mental illness should apply to that person.
81. Where the person is being prescribed drugs for the purposes of treatment of a physical condition the Senior Clinician should have power to refer the matter to the Office of the Public Advocate, who may decide that an application should be made to appoint a guardian for the person.

314 A similar requirement is imposed in the *Mental Health Act 1986* s 78, which requires the authorised psychiatrist to submit the report to the Chief Psychiatrist.

Chapter 6

Applying the Legislative Framework to People with Cognitive Impairments

INTRODUCTION

6.1 In Chapter 4 we recommended a legislative framework to control decisions to detain people with an intellectual disability, whose behaviour poses a significant risk of serious harm to others. It is recommended that detention should only be permitted where a detention order is made by the Victorian Civil and Administrative Tribunal (VCAT). Detention orders must be regularly reviewed and a time limit of five years is imposed on detention. People who are detained must derive some therapeutic benefit from the services provided to them while they are detained.

6.2 In Chapter 5 we made recommendations to regulate the use of restrictive practices, in the process of caring for people with an intellectual disability. Such practices include the use of mechanical and chemical restraint, seclusion, and the locking of doors to prevent a person leaving a facility or an area within a facility. The Commission recommended that an Office of Senior Clinician be established to approve care plans providing for use of restraint and seclusion and to monitor the quality of service provision.

6.3 The terms of reference for this project require the Commission to consider the applicability of our recommendations to people with a cognitive impairment, including people with acquired brain injury or autism spectrum disorders.

6.4 This Chapter proposes a definition of cognitive impairment. It recommends that the proposed legislative framework for detention decisions should also apply to people with cognitive impairments. It also recommends that controls on use of restrictive practices affecting people with a cognitive impairment should be phased in over the next three years.

DEFINITION OF COGNITIVE IMPAIRMENT

6.5 There is no current legislative definition of ‘cognitive impairment.’ Cognitive impairment does not refer to any specific disability or condition, but may be a consequence or component of number of disabilities and conditions. For psychiatrists and psychologists the expression refers to a person’s clinical presentation, which may be relevant in diagnosing the nature of the person’s disability or disorder. This makes it difficult to define ‘cognitive impairment’ for legal purposes. The standard text on diagnostic categories of mental disorders warns that there is an ‘imperfect fit between the questions of ultimate concern to the law and the information contained in a clinical diagnosis’.³¹⁵

6.6 The Discussion Paper asked whether the legislation should define cognitive impairment broadly, or should refer to specific instances of cognitive impairment to which the compulsory care regime should apply. Some submissions³¹⁶ favoured a broad definition which focused on the issue of capacity to exercise appropriate judgment.

The current thinking by experts in this area is that disability is not a predictor of offending behaviour. Therefore the capacity to make reasonable judgements is a more appropriate standard for such legislation... Some people with a disability are unable to understand that their actions are unlawful or to understand the nature of harm they cause to others. It may also be assessed that because of their disability they are unable to form criminal intent, control their behaviour or learn non-offending behaviour.³¹⁷

The absence of research linking any particular disability to an increased risk of either offending or at risk behaviour makes it discriminatory for the legislation to apply to a particular disability. If the definition of disability is defined too narrowly there is also the danger that it may exclude people that such legislation should seek to protect.³¹⁸

315 American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* (4th ed, Text Revision, 2000) xxxiii.

316 Some submissions argued for the narrower approach see Submission 11, Frank Lambrick, Statewide Forensic Service 3, which commented that ‘[i]t is the concern of this service that by having a broader frame of reference [than a focus solely on the population addressed in the Vincent review of Statewide Forensic Service] regarding who should be covered by this proposed legislation, sight will be lost in relation to the particular needs of this client group.’

317 Submission 19, Office of the Public Advocate 3–4.

318 Submission 19, Office of the Public Advocate 3. See also Submission 13, Australian Community Support Organisation 4, ‘Legislation authorising compulsory care should apply to any mental disorders, intellectual

6.7 Other submissions noted that the particular nature of the disability was more relevant to the type of treatment or care required by the individual, than to the need to care for the person in a way that reduces the risk they may seriously harm others.

[We] believe that there should be provision for compulsory care for people at risk of harming themselves or others regardless of their diagnostic category... At the same time [we] would argue that there must be adequate flexibility and resources in the system to account for the needs of, and circumstances that apply to, people in different diagnostic categories.³¹⁹

6.8 The Commission agrees that it is preferable to focus on cognitive factors that affect insight or make it difficult for a person to control his or her behaviour, rather than on the nature of the person's particular cognitive impairment. The definition proposed by the Commission does not refer to particular diagnoses of particular conditions that may result in cognitive impairment, but instead focuses on the person's capacity to make reasonable judgments, and to control his or her behaviour. The absence of reference to diagnostic categories is not, of course, intended to limit the input of clinicians in the making of decisions under the legislative framework.³²⁰



RECOMMENDATION(S)

82. Cognitive impairment should be defined as a significant and long-term disability in comprehension, reasoning, learning or memory that is the result of any damage to, or any disorder, imperfect or delayed development, impairment or deterioration of the brain or mind.

6.9 The definition is intended to exclude people whose cognitive impairment is solely due to a mental illness. Mental illness is excluded because the *Mental Health Act 1986* already provides for involuntary care and treatment of people with a mental illness.

disabilities or cognitive impairments where the person cannot make a rational and informed decision, and/or cannot give informed consent.'

319 Submission 3, Southwest Advocacy Association Inc 9.

320 As will be seen below, clinicians are to play a central role in the assessment process.

6.10 There was some discussion in our consultations about whether the definition of impairment should include people with personality disorders. This would permit detention of people with personality disorders, whose behaviour poses a serious risk of significant harm to others.

6.11 Personality disorder can be defined as:

an enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment.³²¹

A person with an antisocial personality disorder is likely to exhibit a 'pattern of disregard for, and violation of, the rights of others'.³²²

6.12 Currently the definition of mental illness in the Victorian *Mental Health Act 1986* excludes people whose sole diagnosis is personality disorder, so that they cannot be subjected to involuntary treatment.³²³ Bodies that have reviewed the law in the past have usually opposed treating personality disorder as a mental illness.³²⁴ In part this reflects the lack of effective treatments available for people with personality disorders.

6.13 In Chapter 3 we recommended that a person should only be able to be detained or subjected to restrictive practices where there is evidence that they will gain some benefit from the proposed form of care. Because there is relatively little evidence suggesting that people with personality disorders can be effectively treated, we recommend that the definition of cognitive impairment should exclude people

321 American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* (4th ed) (2000) 685.

322 Ibid 701.

323 *Mental Health Act 1986* s 8(2).

'A person is not to be considered to be mentally ill by reason only of anyone or more of the following:...
'(l) that the person has an antisocial personality;...'

324 See David Neal, 'Personality Disorder, The Criminal Justice System and the Mental Health System' in William Lucas (ed) *Serious Violent Offenders: Sentencing, Psychiatry and Law Reform: Proceedings of a Conference held 29-31 October 1991, Melbourne* (1993) for a summarised account of this debate and in particular for an account of the different positions of the Victorian Law Reform Commission and the Social Development Committee of the Victorian Parliament. See also Law Reform Commission of Victoria, *The Concept of Mental Illness in the Mental Health Act 1986*, 31 (1990) and Social Development Committee, Parliament of Victoria, *Interim Report upon Inquiry into Mental Disturbance and Community Safety: Strategies to Deal with Persons with Severe Personality Disorder who Pose a Threat to Public Safety* Parliamentary Paper No 131 (1990).

with personality disorders, unless the personality disorder is accompanied by damage to, or any disorder, imperfect or delayed development, impairment or deterioration of the brain or mind. This will preclude use of detention for people whose only diagnosis is a personality disorder.



RECOMMENDATION(S)

83. The proposed framework for regulating detention should not apply to people whose cognitive impairment is solely due to mental illness.
84. The proposed framework for regulating detention should not apply to people with a personality disorder, unless the personality disorder is accompanied by damage to, or any disorder, imperfect or delayed development, impairment or deterioration of the brain or mind.

6.14 The definition of cognitive impairment could include people suffering from Alzheimer's Disease and other cognitive impairments experienced in old age. This means that if the criteria for detention are satisfied such a person could be subjected to a detention order, though this is likely to occur very rarely. Because aged care facilities are already regulated under federal legislation we do not propose that controls on restrictive practices should be extended to cover such facilities.³²⁵

DETENTION

6.15 Chapter 4 proposed a legislative framework to regulate decisions to detain people with an intellectual disability, whose behaviour poses a significant risk of serious harm to others. We recommend that the same legislative criteria and approval process should apply to people with a cognitive impairment who have previously exhibited violent or dangerous behaviour that has harmed others or exposed others to a significant risk of serious harm.

6.16 Under the proposed framework VCAT is required to approve and review detention orders. We recommend that where the Senior Clinician applies to VCAT for an order for detention of a person with a cognitive impairment, the panel should

³²⁵ See para 1.26.

include a person with professional expertise or experience in caring for people with cognitive impairments, for example a person with experience in providing direct care to people with a similar cognitive disability, or a psychiatrist or neuro-physiologist with relevant experience.

! RECOMMENDATION(S)

85. The legislative criteria and approval process for detention orders should apply to people with a cognitive impairment, as well as to people with an intellectual disability.
86. The VCAT panel constituted to hear a detention application for a person with a cognitive impairment shall include a person with professional expertise or experience in caring for people with cognitive impairments.

RESTRICTIVE PRACTICES

6.17 The Commission was unable to obtain reliable information on the numbers of people with cognitive impairments who are currently subjected to practices such as restraint and seclusion, or who live in facilities where they cannot enter and leave without permission because doors are kept locked. In principle the criteria and processes for use of these practices should be the same, regardless of whether they affect people with an intellectual disability or people with a cognitive impairment.

6.18 In practice however, it is likely to take some time to establish a system for developing, approving and regularly reviewing care plans which allow people with a cognitive impairment to be restrained or secluded. To give time for development of appropriate processes the Commission believes that the system should be phased in over a three year period. This will give the Office of Senior Clinician the opportunity to obtain more information on care patterns for people with a cognitive impairment and the circumstances in which and extent to which restraint and seclusion are currently being used. Prior to setting up the system we recommend that the Office of Senior Clinician should establish and publicise a system requiring quarterly reporting of use of restraint and seclusion affecting people with cognitive impairment. The information obtained will assist the Office of Senior Clinician to develop processes for a more transparent and accountable system of care.

6.19 As we have previously mentioned we do not propose that the system should apply to people with a cognitive impairment who are in aged care facilities. If the

Office of Senior Clinician considers there is a need to monitor practices in aged care facilities, such a system of monitoring could be established at a later stage.

!**RECOMMENDATION(S)**

87. The Office of Senior Clinician should develop legislative criteria and a process for developing, approving and regularly reviewing care plans that allow people with a cognitive impairment to be restrained or secluded.
88. The process for developing, approving and regularly reviewing care plans that allow people with a cognitive impairment to be restrained or secluded should be phased in over a three year period.
89. In the meantime the Office of Senior Clinician should establish and publicise a system to require quarterly reporting of use of restraint and seclusion.
90. Recommendation 126 which requires service providers to provide the Senior Clinician with an Annual Report about their practices in relation to access to and exit from premises, should apply to service providers which provide facilities for people with cognitive impairments.
91. Aged care facilities should not be required to report on use of restraint and seclusion and practices in relation to locking of doors.

Chapter 7

Criminal Justice System

INTRODUCTION

7.1 In Chapter 2 we highlighted a number of deficiencies in the way the criminal justice system deals with people with an intellectual disability or cognitive impairment. Chapters 4 and 5 recommended a legislative framework to regulate the way that people with an *intellectual disability* are dealt with in the human service system. In Chapter 6 we recommended extension of certain aspects of the proposed framework to cover people with a *cognitive impairment*.

7.2 Our terms of reference require us to examine the relationship between the human services system and the criminal justice system. This Chapter makes recommendations to overcome gaps and deficiencies in the way that people with *both* intellectual disabilities and cognitive impairments are dealt with under the criminal justice system.

7.3 The Chapter deals first with the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (CMIA), which allows a person with an intellectual disability or cognitive impairment to be held unfit to stand trial, or to be found not guilty because of mental impairment. It goes on to discuss sentencing options for people with an intellectual disability or cognitive impairment who are convicted of offences.

DISPOSITION UNDER THE **CRIMES (MENTAL IMPAIRMENT AND UNFITNESS TO BE TRIED) ACT**

7.4 Under the CMIA a person with an intellectual disability or a cognitive impairment may be found unfit to stand trial³²⁶ or not guilty because of mental impairment.³²⁷

326 *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* s 6. The procedure for determining this question is set out in Part 2.

7.5 If the person is found unfit to stand trial³²⁸ he or she can be remanded to a prison or other appropriate place for a specified period.³²⁹ If the person is found not guilty because of mental impairment, the court can make a supervision order.³³⁰ There are two forms of supervision order, a custodial and non-custodial supervision order.³³¹ Conditions attached to a non-custodial supervision order may require people to live in a particular place or to participate in a program to help them to modify their behaviour.

7.6 Where the court makes a custodial supervision order, the person can be committed to custody in an ‘appropriate place’ or in a prison. The court must not make an order committing a person to custody in prison unless it is satisfied that there is no practicable alternative in the circumstances.³³² An ‘appropriate place’ is defined in the Act as either an approved mental health service or a residential service under the *Intellectually Disabled Persons’ Services Act 1986* (ISPSA).³³³

7.7 In Chapter 8 we recommend a process for prescribing facilities that will receive people subject to detention orders. Facilities prescribed for the detention of people who have an intellectual disability or cognitive impairment should also be treated as appropriate places³³⁴ for the purposes of the CMIA.



RECOMMENDATION(S)

92. The *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* should be amended to allow facilities prescribed for people subject to detention orders to be ‘appropriate places’ to receive persons subject to custodial supervision orders.

327 Ibid s 20.

328 The determination is made by a jury see *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* s 11.

329 Ibid ss 12(2)–(5), 13, 14. The sections provide for review of fitness to stand trial at the end of specified periods.

330 Supervision orders can only be made in the Supreme Court and the County Court.

331 *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* s 26.

332 Ibid s 26(4).

333 Ibid s 3 and *Intellectual Disabled Persons’ Services Act 1986* s 3.

334 The approval of facilities is discussed in paras 8.16–8.

LIMITATIONS ON MAGISTRATES' POWERS

7.8 Although the defence of mental impairment applies to people who are tried for offences in the Magistrates' Court,³³⁵ magistrates do not have power to determine that a person is unfit to stand trial or to make supervision orders for people found not guilty because of mental impairment.³³⁶ This means that if a magistrate finds a person not guilty because of mental impairment, the person must be discharged. For minor offences this may be appropriate. However if the person is in need of care and is acting violently or dangerously, and may do so again in the future if he or she does not receive appropriate care, the Magistrate has no power to deal with the situation.³³⁷

7.9 The Discussion Paper asked whether the CMIA should be extended to the Magistrates' Courts, so that Magistrates can decide that a person is unfit to be tried or can make custodial or non-custodial supervision orders. This would enable a person who has committed an offence, and whose behaviour poses a significant risk of serious harm to others, to be placed in an 'appropriate place' such as a residential facility under the IDPSA where the person could be assisted to change his or her behaviour. It would also enable magistrates to make non-custodial supervision orders.³³⁸

7.10 Submissions were divided on this option.³³⁹ It was suggested that the Magistrates' Court does not have the time or expertise to deal with the complex issues involved in hearings concerning fitness to be tried, and that traditionally fitness to be tried is assessed by a jury and there is no provision for use of a jury within the Magistrates' Court.

7.11 On balance, the Commission considers that the CMIA should not be extended to the Magistrates' Court. This approach could result in supervision orders being made for people with a mental impairment who have been charged with very

335 Ibid s 5.

336 Section 26, which creates the power to make supervision orders, does not apply to the Magistrates Court: see definition of court in s 3.

337 Where a person is charged with an indictable offence that is triable summarily, the trial could be held in the County Court rather than the Magistrates' Court, where a supervision order could be made.

338 Victorian Law Reform Commission, *People with Intellectual Disabilities at Risk: A Legal Framework for Compulsory Care* Discussion Paper (2002) 111.

339 For example, Submission 22, Victorian Bar, paras 71–2 did not agree with the option; Submission 3, Southwest Advocacy Association 16 did.

minor offences. It could result in human service system resources being directed to managing people simply because they have committed such offences, rather than to people with an intellectual disability or cognitive impairment who have a higher level of needs.

7.12 In our view it is preferable for magistrates to be given power to refer people found not guilty because of mental impairment to the Office of Senior Clinician. The Office of Senior Clinician will be responsible for arranging an assessment of the person to determine whether the person is being appropriately cared for. Where the Office of Senior Clinician shows that the provision of services would reduce the likelihood of the person re-offending, the Office may recommend to DHS that such services be provided. It will be for DHS to determine the priority to be given to that person's needs. In cases where the person's behaviour poses a significant risk of serious harm to others, the Office of Senior Clinician may decide to apply to VCAT for a detention order, under the procedure set out in Chapter 4.

!

RECOMMENDATION(S)

93. Where a magistrate finds a person with an intellectual disability or mental impairment is not guilty because of a mental impairment under s 20 of the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997*, the Magistrate may refer the person to the Office of Senior Clinician.
94. The Office of Senior Clinician shall consider whether the person is eligible for services under the *Intellectually Disabled Persons' Services Act 1986* or the *Disability Services Act 1991* and whether the provision of such services could reduce the likelihood of the person re-offending.
95. Where the Office of Senior Clinician believes that the provision of services would reduce the likelihood of the person re-offending, the Office may recommend to DHS that such services be provided to the person.
96. Where the Office of Senior Clinician is of the view that the person's behaviour poses a significant risk of serious harm to others, the Senior Clinician shall arrange for the assessment of the person to determine whether an application for detention should be made.

! RECOMMENDATION(S)

97. If a Magistrate refers a person to the Office of Senior Clinician, the Office must file a report with the Court within 14 days of the referral, indicating any steps which are being taken in relation to the person.

SENTENCING OPTIONS

7.13 If a person with an intellectual disability or a cognitive impairment is convicted of an offence, a court can make various sentencing orders including:

- in the case of a person with an intellectual disability, a community based order combined with a justice plan;³⁴⁰ or
- a term of imprisonment.³⁴¹

7.14 In the section which follows we discuss some limitations in these options and make recommendations to improve the operation of the system.

COMMUNITY BASED ORDERS AND JUSTICE PLANS

7.15 Under section 36 of the *Sentencing Act 1991*, a court may impose a community based order on a person who has been convicted of an offence attracting a term of imprisonment or a fine of not more than five penalty units. The Act contains special provisions for people with an intellectual disability. If a court has found a person with an intellectual disability guilty of an offence and the court is either considering making a community based order in respect of the person, or releasing the person on an adjourned undertaking with or without recording a conviction, then the court may request a:

- declaration of eligibility under the IDPSA;
- a justice plan; and
- a pre-sentence report.

340 Other options which may be relevant to people who have an intellectual disability or a cognitive impairment include a suspended sentence; *Sentencing Act 1991* ss 49–69, or a dismissal, discharge or adjournment of the charges. Conditions may be imposed on some of these orders. See *Sentencing Act 1991* ss 71–89 and Richard Fox and Arie Freiberg, *Sentencing: State and Federal Law in Victoria* (2nd ed, 1999).

341 In certain situations a person who has committed a serious offence can receive an indefinite sentence; see *Sentencing Act 1991* ss 27–31.

If the court has received these, then the court may impose a community based order with a special condition that the person participate in services specified in a justice plan for a period up to two years or the period of the sentence, whichever is the shorter.³⁴²

7.16 Compliance with the justice plan is a condition of the community based order, and is in addition to the core conditions of the community based order.³⁴³ The purpose of the core conditions is to provide for monitoring and supervision of the offender by Community Corrections. Justice plans can provide a useful means of assisting people whose behaviour places others at risk of serious harm. For example, an intellectually disabled man whose sexual behaviour places children at risk of harm could be required under a justice plan to live at a particular place and participate in a program, to assist him to change his behaviour.

7.17 Where a justice plan is ordered, DHS supervises the plan. In practice, DHS may liaise with Corrections Victoria to advise of the progress of the justice plan. If the offender is not complying with the justice plan, DHS may report the breach for action to be taken by Corrections Victoria.

7.18 As we discussed in Chapter 2, justice plans have a number of limitations.

- Justice plans are not available to people with cognitive impairments such as acquired brain injury.
- The period of a justice plan cannot exceed two years. It may be necessary for a person to live in a place where their activities are supervised or to participate in a program for a longer period.

7.19 Our consultations suggested that justice plans were often ineffective because compliance with them was perceived by DHS and service providers as voluntary. One submission commented that

disability services persist with the notion that [justice plans] are voluntary, and in fact instruct their clients accordingly...[and] individuals on justice plans are generally not responsive to any form of voluntary scheme – the justice plans are ‘toothless tigers’.³⁴⁴

342 Ibid s 80.

343 Ibid s 37.

344 Submission 28, Jelena Popovic, Deputy Chief Magistrate and Anne Condon, Disabilities Officer, Magistrates’ Court of Victoria 3.

7.20 In addition, the offender may have difficulty in complying with the Plan because changes are made to service provision. Where a person fails to comply because adequate services have not been provided, the court which has imposed a justice plan may be reluctant to impose sanctions for non-compliance.³⁴⁵

EXTENDING JUSTICE PLANS TO PEOPLE WITH A COGNITIVE IMPAIRMENT

7.21 There is no logical reason for limiting the availability of justice plans to people with an intellectual disability. The Commission believes that people with a cognitive impairment (as defined in Chapter 6) who commit offences for which a community based order would be appropriate, should also be eligible for justice plans.

7.22 We accept, however, that it would be difficult to extend the availability of justice plans immediately, because of the lack of services currently available for people with some cognitive impairments, for example acquired brain injury. Justice plans for people with a cognitive impairment will be unworkable unless it is clear that appropriate services are available to assist the person and the person is eligible to receive them. The court would need to be provided with a certificate of eligibility for services, in the same manner that the court must be provided with a certificate for eligibility for services under the IDPSA, before a justice plan can be imposed.

7.23 We propose a phasing in of this provision, to allow for development of appropriate services and eligibility criteria for services, participation in which would be a condition of plans for people with a cognitive impairment. The current review of the *Disability Services Act*, which is being undertaken by DHS may contribute to the development of services. A justice plan could then require a person with a cognitive impairment to participate in programs or to live in a particular place.



RECOMMENDATION(S)

98. The *Sentencing Act 1991* should be amended to make justice plans available to offenders with a cognitive impairment.

345 The sanctions for breach of a community-based order are set out in *Sentencing Act 1991* s 47.

**RECOMMENDATION(S)**

99. Operation of this provision should be deferred for two years, to allow for development of appropriate services for people with cognitive impairments who commit offences.

EXTENDING THE TERM OF JUSTICE PLANS

7.24 It was suggested that the maximum period for a justice plan should be extended to five years,³⁴⁶ because it may take more than the two years for which they can currently be ordered, to assist a person to change his or her behaviour.

7.25 The Commission does not recommend extending the period of justice plans. Justice plans are linked to community based orders. Community based orders are limited to a maximum of two years³⁴⁷ and are usually made for offenders who have committed minor offences.

7.26 The nexus between justice plans and community based orders could be broken to allow justice plans to be imposed for a longer period than community based orders. However such an approach would discriminate against people with a disability by making them potentially subject to orders for a longer period than people who did not have an intellectual disability or cognitive impairment when they committed an offence. Another problem with this approach is that it might result in offenders not raising their disability or impairment with the court because they might be disadvantaged by being placed on a justice plan. This would make it less likely that they would receive services that would benefit them and assist them to avoid re-offending.

7.27 Rather than extending justice plans, we recommend that the court should have power to make orders to provide care or treatment for an offender with an intellectual disability or cognitive impairment. This is discussed in more detail below.³⁴⁸

346 For example, Submission 11, Statewide Forensic Services 25.

347 *Sentencing Act 1991* s 36(3).

348 Recommendations 104–9.

LACK OF ENFORCEMENT OF JUSTICE PLANS

7.28 This problem can only be resolved by ensuring better coordination between the criminal justice system and the human services system. DHS should require service providers to undertake appropriate training to ensure they understand that compliance with a justice plan is not voluntary.

7.29 Provision should also be made to ensure that changes are made to plan conditions to take account of service provision changes. The *Sentencing Act* already allows the court to change plan conditions where the needs of the offender are not being met by the conditions, or the justice plan is no longer appropriate. Currently the Secretary of DHS must review the justice plan at least yearly, or as directed by the Court. The Secretary must also review the plan if application is made to him or her by the offender or the Secretary of the Department of Justice.³⁴⁹ If it becomes apparent that the needs of the offender are not being met by the justice plan or the justice plan is no longer appropriate, the court may confirm, vary or cancel the justice plan.³⁵⁰ An application to confirm, vary or cancel the plan may be brought any time the plan is in force by the offender, or if the plan is attached to a community based order by the Secretary to the Department of Justice, or if the application relates to the appropriateness of the plan, the Secretary to DHS.³⁵¹

7.30 However, as the Act does not give any person primary responsibility for making the application in this situation, it may be left up to the offender to take that action, which therefore may not occur. The recommendations below are intended to ensure that, when appropriate, applications are made by the authorities and that this is not left to an offender whose disability may create barriers in making an application.

7.31 We recommend that where changes are required to the plan, DHS should have responsibility for referring the matter to the appropriate agency which should be required to return the matter to court. Where the plan is part of a community based order, DHS should refer it to the Secretary of the Department of Justice to make the application, as the plan is a condition of the community based order.³⁵²

349 Ibid s 81.

350 Ibid s 82.

351 Ibid s 82(2).

352 An application can be made under *Sentencing Act 1991* s 82(2). Note that under current arrangements a service provider may notify community Correctional Services who may arrange an alternative service or decide that the matter should be dealt with by the court.

Where the plan is attached to an adjourned undertaking, the Act specifies that the police make the application.³⁵³ The offender should also be able to request DHS to refer the matter to the court.

! RECOMMENDATION(S)

100. DHS should ensure that service providers are aware that offenders must comply with justice plans.

101. Where a change in program provision occurs, which would prevent the offender complying with the conditions of a justice plan, DHS should be required to refer the matter to the Secretary to the Department of Justice, or in the case of a justice plan entered into as a condition of an adjourned undertaking, to Victoria Police.

102. Where a change in program provision has prevented the offender from complying with the justice plan, the offender may request the Secretary to the Department of Human Services to advise the Secretary to the Department of Justice.

103. Where the matter is referred to the Secretary to the Department of Justice, or to the Victoria Police, the Secretary or Victoria Police must consider whether an application should be made to the court under section 82 of the *Sentencing Act 1991* for a change to the provisions of the justice plan.

DEALING WITH PEOPLE WITH AN INTELLECTUAL DISABILITY OR COGNITIVE IMPAIRMENT WHO RECEIVE PRISON SENTENCES

7.32 Justice plans only apply to offenders who commit offences for which a community based order would be appropriate. People with an intellectual disability or cognitive impairment who commit more serious offences may be sentenced to a term of imprisonment. The options that are available for mentally ill offenders who commit offences and who would otherwise receive a custodial sentence do not apply to people with other forms of cognitive impairment.

353 Ibid s 82(2) and Sentencing Regulations 2002 Reg 6.

7.33 The Discussion Paper³⁵⁴ noted that a number of studies show that people with intellectual disabilities are over-represented in the prison population.³⁵⁵ Statistics kept by the Corrections Victoria indicate that 54 of the 3793 people in the prison population on 1 October 2003 had an intellectual disability.³⁵⁶ It is likely that this is an understatement. A recent review of the literature regarding patterns of offending among people with intellectual disabilities said that there was 'only a low level of consistency in what 'intellectual disability' actually meant and how it was assessed'.³⁵⁷ No information is available on the number of people in prison who have a cognitive impairment.

7.34 Irrespective of the numbers of people with an intellectual disability or cognitive impairment who are in prison, it is important that those sentenced to a term of imprisonment have access to the assistance they need to support them and assist them to change their behaviour.

7.35 Currently, the *Sentencing Act 1991* allows offenders with a mental illness to be detained in an approved mental health service so that their illness may be treated. Provision is made for the court to make various orders for the purposes of assessing and treating a person with a mental illness,³⁵⁸ and for admitting them into, and detaining them in, an approved mental health service where they will receive treatment.³⁵⁹ Where the court makes a hospital security order, as an alternative to

354 Victorian Law Reform Commission *People with Intellectual Disabilities at Risk: A Legal Framework for Compulsory Care* Discussion Paper (2002) 23. For example the New South Wales Law Reform Commission, *People with an Intellectual Disability and the Criminal Justice System*, Report No 80 (1996) para 2.5 showed that while the incidence of intellectual disability in the general population is 2–3%, at least 12–3% of the NSW prison population has an intellectual disability.

355 Submission 11, Statewide Forensic Services 4 argued that NSW figures are not mirrored in Victoria, providing data that classifies less than two per cent of prisoners as being formally diagnosed with an intellectual disability.

356 Corrections Victoria, unpublished data 2003.

357 M K Simpson and J Hogg, 'Patterns of Offending Among People with Intellectual Disability: A Systematic Review' (2002) 45(5) *Journal of Intellectual Disability Research* 384, 394–5. Some studies surveyed used a clinical diagnosis of intellectual disability while others simply asked offenders if they had experienced 'reading problems or intellectual difficulties or had been to a special school'.

358 Assessment orders are for a maximum period of 72 hours and are used to ascertain the suitability of the offender for orders under s 93: *Sentencing Act 1991* s 90; diagnosis, assessment and treatment orders are for a maximum of 3 months: *Sentencing Act 1991* s 91.

359 *Sentencing Act 1991* ss 92, 93. The court may make a hospital order (instead of passing sentence) under which the person is admitted to and detained in an approved mental health service as an involuntary patient. Alternatively, the court may, by way of sentence, make a hospital security order under which the person is admitted to and detained in an approved mental health service as a security patient for a period

sentencing a person with a mental illness to a term of imprisonment, the court cannot order detention for a longer period than the period of imprisonment to which the person would have been sentenced had the order not been made.³⁶⁰

7.36 These provisions are aimed at treating the person and reducing the chance that he or she will re-offend as, in many cases, the mental illness has contributed to the offending behaviour.

7.37 The Commission believes that offenders with an intellectual disability or cognitive impairment also have a right to receive care and treatment that may help to reduce the possibility of them re-offending. Sentencing dispositions should include provisions that ensure that they receive services that will assist them to change behaviour which results from their intellectual disability or cognitive impairment. A number of submissions supported this approach.³⁶¹

7.38 While such care can sometimes be provided in prison, it will sometimes be preferable for the person to be placed in a facility with expertise in caring for people with an intellectual disability or cognitive impairment.

7.39 We propose that the *Sentencing Act 1991* should be amended to allow care and treatment to be provided in one of two ways. First, the court should have power to order the preparation of a care plan by DHS, which indicates the programs which will be delivered to such people while they are in prison, to reduce the possibility that they will re-offend. We call this a care plan order. Before making a care plan order the court must find that the person is guilty of an offence and has an intellectual disability or cognitive impairment and that the person would benefit from the preparation of a care plan providing for the provision of services in the prison that would assist the person to modify his or her behaviour.

7.40 Secondly, the court should have power to order that the person should serve their sentence in a facility which provides services to people with an intellectual disability or cognitive impairment. We call this a ‘security order’. Before a court

specified in the order; see Richard Fox and Arie Frieberg, *Sentencing: State and Federal Law in Victoria* (2nd ed) (1999) paras 10.206–7.

360 *Sentencing Act 1991* s 93(3) See also s 18E which allows hospital orders to be made in relation to people who have received an indefinite sentence.

361 This is supported in a number of submissions, for example, Submission 22, Victorian Bar, para 8.4 and Submission 28, Jelena Popovic, Deputy Chief Magistrate and Anne Condon, Disabilities Officer, Magistrates’ Court of Victoria 2. Support in the latter submission, however, was limited to circumstances where the person with a cognitive disability was detained in specially designed and separately maintained facilities away from the mainstream prison.

makes a security order the court must find that the person is guilty of an offence and has an intellectual disability or cognitive impairment. A detention plan must have been prepared for the person by DHS and the court must be satisfied that the services that will be provided for him or her in the prescribed facility will benefit the person by reducing the risk that he or she will re-offend.

7.41 The court should not be able to make a security order under which the person will be detained in a secure facility, unless it would have sentenced the person to a term of imprisonment but for the person's intellectual disability or cognitive impairment. Security orders must specify a period of detention that is no longer than the period of imprisonment to which the person would have been sentenced had the security order not been made.



RECOMMENDATION(S)

104. The *Sentencing Act 1991* should be amended to allow the court to refer a person with an intellectual disability or cognitive impairment, who has been found guilty of an offence, and is to be sentenced to a term of imprisonment, to DHS, for an assessment and the development of a care plan, indicating the services that will be provided to the person during his or her period of imprisonment.
105. Where the court refers a person to DHS, a care plan must be prepared for the person indicating the services that are to be provided to the person during his or her imprisonment, for the purposes of reducing the risk that the person will re-offend.
106. The Court shall not make a care plan order unless the court is satisfied that the proposed care plan will reduce the risk that the person will re-offend.
107. Where a person with an intellectual disability or cognitive impairment has been found guilty of an offence, the court may order that the person serves his or her sentence in a prescribed facility instead of in jail (this is known as a security order).

**RECOMMENDATION(S)**

108. The Court may not make a security order unless:
- a detention plan has been prepared by DHS indicating how the person will be cared for and the services that will be provided to the person in the secure facility;
 - the court is satisfied that the services which will be provided to the person in the prescribed facility will reduce the risk that the person will re-offend; and
 - but for the person's intellectual disability or cognitive impairment, the court would have sentenced the person to a term of imprisonment.
109. The term of the security cannot exceed the period of imprisonment to which the person would have been sentenced had the care and treatment order not been made.
110. A security order can only be made where the services that the person needs to reduce the possibility that he or she will re-offend cannot be effectively provided within a prison environment.

TRANSFERS FROM PRISON

7.42 There is already provision under the *Intellectually Disabled Persons' Services Act 1986* (IDPSA) for prisoners with an intellectual disability who are eligible for services under the Act to be transferred to a more appropriate facility,³⁶² where they will be held as a security resident. Under the IDPSA, one of the factors taken into consideration for such transfers is whether a person is or could be exposed to increased risks of harm in a prison environment, because of his or her intellectual disability. This provision is rarely, if ever, used³⁶³ and the Commission believes that people with an intellectual disability could benefit if this option was used more frequently. Provision for transfer should therefore be retained in the legislation following completion of the review of the IDPSA being conducted by DHS.

362 *Intellectually Disabled Persons' Services Act 1986* s 21.

363 This was confirmed by a number of submissions including Submission 22, Victorian Bar, para 8.2.

7.43 Provision for transfer is, at present, limited to prisoners with intellectual disabilities. This means that prisoners with an acquired brain injury or other cognitive disability, despite having similar capacities and vulnerabilities to prisoners with intellectual disabilities, have to serve their time in prison, rather than a more appropriate facility. We recommend that the legislation be amended to allow transfer of a person with a cognitive impairment to an appropriate place.



RECOMMENDATION(S)

111. Provision should be made to allow prisoners with a cognitive impairment to be transferred to an appropriate residential institution for the whole or a part of their sentence.

LEAVES OF ABSENCE

7.44 The provisions relating to leaves of absence for prisoners apply to people with an intellectual disability or cognitive impairment who are sentenced to a term in prison.³⁶⁴

7.45 The IDPSA provides for leave of absence for people with an intellectual disability who are transferred from prison to a residential facility (security residents).³⁶⁵ The Minister for Community Services, on recommendation of the Secretary or the IDRP, can allow a security resident leave of absence from the residential institution in which the person are detained for the period, and subject to the conditions, that the Minister considers appropriate. The Secretary must not recommend leave of absence unless the safety of members of the public will not be seriously endangered and the Secretary of the Department of Justice has been consulted.³⁶⁶

7.46 A different process applies to the granting of leave for people with a mental illness whom the court has ordered should be admitted into, and detained in, an approved mental health service instead of receiving a term of imprisonment. The Chief Psychiatrist can grant special leave to a security patient for a period not

364 *Corrections Act 1986* Part 8 (and see particularly Division 3).

365 *Intellectually Disabled Persons' Services Act 1986* s 41.

366 *Ibid* s 41(2).

exceeding 24 hours.³⁶⁷ Extended leave can be granted for a period not exceeding six months, by the Secretary to the Department of Justice. Leave cannot be granted unless the Secretary is satisfied, on the evidence available, that the safety of members of the public is not endangered and that the Chief Psychiatrist has been consulted.³⁶⁸

7.47 We have recommended that the court should have power to make care and treatment orders for people with an intellectual disability or cognitive impairment. The legislation will need to make provision for the granting of leaves of absence for people who are living in prescribed facilities under care and treatment orders and for people with cognitive impairment who are transferred from prison to a prescribed facility.

7.48 It is important that leave of absence provisions do not undermine community confidence in care and treatment orders that will allow people with an intellectual disability or cognitive impairment to receive appropriate care outside a prison environment. However, it should be noted that not all offenders on care and treatment orders will pose a risk to others. Some of them will be less likely to harm others than people who have been detained under a VCAT order because they pose a significant risk of harm to others.

7.49 We recommend that the provisions for leave of absence for people with a cognitive impairment or intellectual disability who are sentenced to security orders, or transferred from prison to an appropriate institution, should mirror those applicable to mentally ill offenders. Instead of consulting the Chief Psychiatrist, the Secretary to the Department of Justice should be required to consult with the Office of Senior Clinician before granting extended leave. Approval for special leave, not exceeding 24 hours, should be granted by the Office of Senior Clinician, who will be required to be satisfied on the evidence available that the safety of members of the public is not endangered by the granting of leave.

367 *Mental Health Act 1986* s 52.

368 This reflects the recommendations in the review of leaves of absence from the Victorian Institute of Forensic Mental Health: *Report of the Review Panel Appointed to Consider Leave Arrangements for Patients at the Victorian Institute of Forensic Mental Health* (2001) Recommendation 4.

! RECOMMENDATION(S)

112. Leaves of absence, not exceeding six months, for offenders sentenced to security orders, or for offenders transferred from prison to an appropriate facility, should be approved by the Secretary to the Department of Justice.
113. Before granting leave, the Secretary to the Department of Justice must be satisfied that the safety of members of the public is not endangered by the granting of leave and that the Office of Senior Clinician has been consulted.
114. Special leave, not exceeding 24 hours, for offenders sentenced to security orders should be approved by the Office of Senior Clinician.
115. Before granting leave, the Office of Senior Clinician must be satisfied that there are special circumstances justifying the granting of leave and that the safety of members of the public will not be endangered by the granting of leave.

WHAT HAPPENS AFTER PEOPLE SERVE THEIR SENTENCE

7.50 People with an intellectual disability or cognitive impairment who have completed serving their sentence in a prison or a prescribed facility may have a continuing need for care. The Adult Parole Board or the Corrections Victoria Commissioner will have access to reports on the history of offending behaviour and the manner in which a particular person has behaved while she or he was in custody. Occasionally reports may indicate that risk of harm to others is so significant that an application should be made to detain the person. We recommend below that in these circumstances the Adult Parole Board or the Corrections Victoria Commissioner should refer the matter to the Senior Clinician who can arrange an assessment of the person and determine whether an application to detain the person should be made to VCAT.³⁶⁹

7.51 At para 4.11 we said that there should be a maximum five year limit on detention orders in order to ensure that the system operated beneficially, rather than punitively. The risk that this system will operate unfairly and in a discriminatory manner increases in circumstances where a detention order is being contemplated

369 Recommendations 116–8.

for a person who is about to complete a prison sentence. People who are being released from prison has served their punishment for their actions and should not be punished twice. At the same however, they may not have had access to a full range of programs and interventions that may reduce the risk of them re-offending. The Commission believes that the most appropriate balance in these circumstances is that the duration of a post-custodial detention order should take into account any time that a person who has been in prison has spent on a care and treatment order. Cumulatively these orders should not exceed five years.

!**RECOMMENDATION(S)**

116. If the Corrections Victoria Commissioner or the Adult Parole Board considers that a person's behaviour is likely to pose a significant risk of serious harm to others after the expiry of his or her prison sentence or care and treatment order, they may refer the person to the Office of Senior Clinician.
117. The Office of Senior Clinician shall consider whether the person should be assessed, to determine whether they meet the criteria for the making of a detention order.
118. If an assessment is made, the Office of Senior Clinician must consider whether an application should be made to VCAT for a detention order.
119. The duration of a detention order that is to take effect when a person is released from prison must take into account any period of time that a person has spent on a care and treatment order whilst in prison and the cumulative total of the two orders must not exceed five years.

Chapter 8

Overseeing the Operation of the System

INTRODUCTION

8.1 The purpose of this Chapter is to recommend mechanisms for ensuring that the rights and interests of people subject to detention and restrictive practices are protected and that appropriate service standards are met by those caring for them. The Chapter discusses the role of the Office of Senior Clinician. It also makes recommendations about the role of community visitors and proposes a process for handling complaints about service providers.

CREATION OF THE OFFICE OF SENIOR CLINICIAN

8.2 In Recommendation 9 we proposed the establishment of the Office of Senior Clinician. The Senior Clinician should be a clinical psychologist or a psychiatrist, with professional expertise in the area of intellectual disability.

AN INDEPENDENT STATUTORY AUTHORITY

8.3 There are some similarities between the role that the Senior Clinician will play in relation to people with an intellectual disability, and the responsibilities currently exercised by the Chief Psychiatrist, in relation to people who have a mental illness.³⁷⁰ We have said that the Office of Senior Clinician should be established as an independent statutory authority. This is not the case for the Chief Psychiatrist.

8.4 We consider that it is important that the Office of Senior Clinician should be independent from Department of Human Services (DHS) for a number of reasons. Historically, the rights of people with an intellectual disability have not been protected to the same extent as the rights of people who have a mental

370 *Mental Health Act 1986* ss 106.

illness.³⁷¹ The creation of the Office of Senior Clinician as an independent statutory authority is intended to contribute to a change in culture which will place greater emphasis on the protection of the rights of people who have an intellectual disability.

8.5 The Office of Senior Clinician will have responsibility for applying for detention orders and approving care plans. People who have intellectual disabilities will often be affected by these forms of care for much longer periods than people who are involuntarily detained and treated under the *Mental Health Act*. In these circumstances it is particularly important that decisions made about the care of particular individuals are, and are seen to be, independent from resource decisions made by DHS.

8.6 We recognise, however, that the Office of Senior Clinician will need to work cooperatively with DHS. We have proposed that the Office of Senior Clinician should contribute to the improvement of service standards by developing guidelines in a number of areas. Where these guidelines have resource implications our recommendation below will require the Office of Senior Clinician to develop guidelines jointly with DHS. This will require approval by the Minister.

FUNCTIONS OF THE OFFICE

8.7 Chapters 4, 5 and 8 considered the Office of Senior Clinician's role in applying for detention orders and overseeing use of restrictive practices. Other functions of the Office including:

- development of guidelines on care practices;
- systemic regulation of service providers;
- service monitoring and random audits; and
- education and training

are considered in more detail below.

371 For example, the right to appeal or seek a review of detention of a person as an involuntary patient, *Mental Health Act 1986* s 29.

DEVELOPING GUIDELINES

8.8 The Office of Senior Clinician will play a central role in developing and distributing codes of conduct and guidelines for service providers who are involved in caring for people subject to detention orders or to restraint and seclusion. Elsewhere in this Report we have made recommendations relating to preparation of guidelines on

- use of restraint and seclusion;
- qualifications of escorts;
- the content of detention plans;
- emergencies necessitating use of restrictive practices; and
- use of locked door policies.

8.9 In the section below we propose that the Office of Senior Clinician should also develop service standards for facilities prescribed for the purposes of detention orders and should develop minimum standards for staff competence, after consultation with DHS.

8.10 Guidelines are intended to ensure that people receive the services they need in a manner that is both effective and respectful of their rights. The general principles which should be taken into account in preparing guidelines are discussed below.

GENERAL PRINCIPLES

8.11 All guidelines proposed in this Report should reflect the principles set out in Chapter 3 of this Report. In addition guidelines should take account of

- the desirability of obtaining consent to treatment and care wherever possible;
- the need to ensure that care is culturally appropriate;³⁷² and
- the need to ensure that, so far as possible, people are aware of their rights.

³⁷² The need for guidelines such as these is already recognised within the Department of Human Services. See for example Disability Services, *Meeting the Needs of Koori People with a Disability: Developing and Implementing Strategies for Improving Service Equity and Access* (2000).

Consent

8.12 At present people with intellectual disability or a cognitive impairment are often treated as if they have consented to various forms of treatment and care, when this is not the case. The framework we propose regulates the detention and use of restrictive practices. Both detention and restrictive practices may occur without the person consenting, provided that the statutory guidelines are satisfied.

8.13 However, there will be many care situations in which a person has the capacity to consent to treatment or care.³⁷³ For example the person may be capable of consenting to medical treatment or agreeing to live in a particular place if this is explained to him or her. All Office of Senior Clinician guidelines should ensure that wherever possible a person who is capable of consenting is given the opportunity to do so.

Culturally Appropriate Programs

8.14 Guidelines should recognise the cultural and linguistic needs of people who are subjected to detention and restrictive practices. Treatment and care should take account of culturally related differences in modes of communication and behaviour. Office of Senior Clinician guidelines should ensure that people with an intellectual disability or cognitive impairment receive services in a manner that respects them and their culture.

Rights Information

8.15 The framework which is recommended attempts to ensure transparent and accountable decision-making and the protection of rights and interests of people affected by detention or use of restrictive practices. People who may be affected, their family, carers or guardians need accessible, accurate and clear information about legal processes, rights to have decisions reviewed and rights to complain about care practices that may affect them.³⁷⁴ Guidelines prepared by the Office of Senior Clinician should ensure that people are provided with information in a form that they can understand, wherever possible.

373 Note the test of incapacity to consent in the *Health Records Act 2001* s 85(3) which provides that a person is incapable when unable to understand the general nature and effect of giving the consent or communicating the consent or refusal of consent despite the provision of assistance by another person.

374 Under the *Intellectually Disabled Persons' Services Act 1986* s 63 and the *Mental Health Act 1986* s 18 people must be given a printed statement advising the person of her or his rights and entitlements under the Act.

! RECOMMENDATION(S)

120. All guidelines prepared by the Office of Senior Clinician should take account of the principles in Chapter 3 of this Report. They should also:

- emphasise the importance of obtaining the consent of people with an intellectual disability or cognitive impairment to treatment and care, wherever possible;
- prescribe standards of treatment and care which take account of cultural factors that affect people who are being cared for; and
- ensure that people receiving treatment and care and their families and guardians receive information about their rights, including information about their opportunity to make complaints and to seek a review of care decisions.

DEVELOPING GUIDELINES FOR PRESCRIBED FACILITIES

8.16 Because the Commission does not envisage that many people who have an intellectual disability or cognitive impairment will be detained, relatively few facilities will be needed to accommodate people subject to detention orders. However it will be necessary to ensure that such facilities provide an appropriate standard of care and programs and treatment that assist people to change their behaviour.

8.17 Currently service providers that provide disability services in Victoria do so in accordance with the *Victorian Standards for Disability Services*. Service providers which operate aged care facilities must seek approval under the *Aged Care Act 1997* (Cth). Operators of private prisons enter into agreements with the government under the *Corrections Act 1986*. The requirements that need to be satisfied by the service provider in each of these areas depends on the services to be provided and the vulnerabilities and needs of the ‘clients’ under the care of the providers.

8.18 Because detention substantially restricts the liberty of the person detained, effective regulation of prescribed facilities is essential. The Office of Senior Clinician should be responsible for developing service standards for facilities prescribed for the

purposes of detention orders.³⁷⁵ It would be pointless for the Senior Clinician to set standards that were incapable of being met in the short term, or that government was unable to fund. For this reason we recommend that minimum standards should be developed jointly by the office of Senior Clinician and DHS and approved by the Minister for Community Services.³⁷⁶ Stakeholders, including service providers and disability advocacy groups, should be consulted about proposed minimum standards.

!

RECOMMENDATION(S)

121. Minimum standards for prescribed facilities should be developed jointly by the Office of Senior Clinician and DHS and should be approved by the Minister of Community Services.
122. Stakeholders, including service providers and disability advocacy groups, should be consulted about proposed minimum standards.
123. Facilities prescribed for people subject to detention orders should be proclaimed by the Governor-in-Council.

DEVELOPING MINIMUM STAFFING STANDARDS

8.19 During our consultations we were told that restrictive practices are sometimes used unnecessarily because staff members lack expertise in managing the behaviour of people with an intellectual disability. The Commission was not in the position to assess whether this perception was accurate. However, whether or not this is the case, it is clear that staff must be sufficiently qualified and experienced to provide the level of care which is needed. The Senior Clinician could play an

375 The Office of Senior Clinician could function as a ‘Centre of Excellence’ which could include objectives such as the creation of opportunities for staff development, the promotion and dissemination of ‘best practice’ information and the collaboration with universities and training institutions to provide additional expertise and resources for teaching and research. For a discussion of the notion of ‘Centres of Excellence’ in the context of staff at aged care facilities, see Department of Human Services, *High Care Residential Aged Care Facilities in Victoria—Report of the Ministerial Advisory Committee* (2001) 13–5.

376 The approval of service providers is a form of ‘positive licensing’. That is, a facility has to be licensed to operate before it can commence operation. For a discussion of this form of regulation in the health sector, see Health Department of Western Australia, *Report on National and International Approaches to the Licensing/Regulation of Facilities Providing Healthcare and Supported Accommodation* (2001).

important role in developing, documenting and monitoring minimum qualifications for staff employed in services under the *Intellectually Disabled Persons' Services Act 1986* (IDPSA) and in encouraging staff to develop skills over time. Improvements in staffing and care standards cannot be brought about overnight and will require long term workforce planning and consultation with relevant unions. For the reasons discussed in para 8.18 we recommend that minimum staffing standards should be developed in consultation with DHS and approved by the Minister.

! RECOMMENDATION(S)

124. Minimum standards for staff employed by service providers under the IDPSA should be developed jointly by the Office of Senior Clinician and DHS and be approved by the Minister for Community Services.

125. The Office of Senior Clinician should be responsible for monitoring compliance with minimum staffing standards.

SYSTEMIC REGULATION

8.20 The Office of Senior Clinician will oversee the provision of care to people with an intellectual disability and the operation of the legislative framework for detention and use of restrictive practices, to ensure that services are provided with appropriate respect for the rights of people with intellectual disabilities and in accordance with guidelines. The Office will also

- receive annual medical reports on people with an intellectual disability and where necessary, take action on reports which indicate problems in relation to the person's treatment and care;³⁷⁷
- receive and monitor reports on the emergency use of restrictive practices affecting people with an intellectual disability;³⁷⁸
- conduct audits and inspections of facilities providing services to people with an intellectual disability;

³⁷⁷ See para 5.66.

³⁷⁸ See para 5.40.

- recommend sanctions for service providers who repeatedly fail to comply with guidelines Reports and Audits; and
- encourage the development of educational programs for service providers and their staff.

These responsibilities are discussed in more detail below.

REPORTS ON RESTRAINT AND SECLUSION

8.21 Under the IDPSA all instances of the use of restraint and seclusion must be recorded and forwarded monthly by the service provider to the IDRPs.³⁷⁹ We have been told that the current IDRPs fail to provide the level of monitoring and supervision required to protect the human rights of people reported to it, who are undergoing restraint and seclusion. The current IDRPs have no capacity to intervene if restraint or seclusion are used inappropriately.³⁸⁰ The recommendations in Chapter 5 require care plans providing for use of restraint and seclusion for people with an intellectual disability to be approved in advance by the Office of Senior Clinician and reviewed annually.³⁸¹ We recommend that the Office of Senior Clinician should operate as a central records agency for all care plans (and also detention plans).

8.22 Where use of restraint and seclusion is authorised in a care plan we recommend that service providers be required to record all instances of use of restraint and seclusion and to provide an annual report on the extent to which the care of service recipients has involved the use of restraint and seclusion. These reports can be taken into account by the Office of Senior Clinician when the person's care plan is reviewed. In our view this will result in more effective monitoring and control on use of restrictive practices for people with an intellectual disability.

8.23 We recommended in Chapter 5 that service providers should be required to report emergency use of restraint and seclusion relating to people with an intellectual disability to the Office of Senior Clinician within 48 hours.³⁸² Where

379 See paras 2.14 and 5.16.

380 Submission 21, Villamanta Legal Service 2. See also Submission 14, Intellectual Disability Review Panel 12 for suggestions of how current frameworks could be revamped to improve monitoring and accountability.

381 See paras 5.39, 5.45, 5.49–50.

382 See para 5.40; Recommendation 59.

emergency use is reported to the Office of Senior Clinician we recommend that the Office of Senior Clinician should have power to direct that a person is not to be restrained and secluded, after consultation with the service provider.

8.24 In Chapter 6 we discussed the applicability of the proposed legislative framework to people with a cognitive impairment. We recommended that the proposed controls on use of restraint and seclusion be phased in for these people. In the meantime, we propose that use of restraint and seclusion by persons providing services under the DSA should be reported quarterly to the Office of Senior Clinician. This will give the Office an opportunity to consider the extent of use of these practices and to plan how more rigorous safeguards can be phased in over time.

8.25 We have also recommended that service providers be required to report details of locked door policies.³⁸³ Such reports should include details as to how many people within the facility are affected by the practice. For example, if a facility locks a door to prevent a resident from wandering, then all residents who have their movement restricted should be included in the report. Failure to report the use of restraint, seclusion or other restrictive service practices may attract sanctions, which are discussed below.³⁸⁴

8.26 Currently monthly reports on use of restraint and seclusion are submitted on paper. This can result in delays in reporting and ensures that the monitoring of the reports is highly resource intensive.³⁸⁵ If all information was transmitted electronically, then software could be used or developed to effectively monitor the statistics with minimal input from Office of Senior Clinician staff. We recommend that the Office of Senior Clinician be resourced sufficiently to be able to receive and process all reports electronically and to put programs in place to encourage and facilitate all service providers to submit electronically.

383 See paras 5.61–4; Recommendations 74–7.

384 The enforcement provisions of the framework are discussed below.

385 Intellectual Disability Review Panel, *Annual Report 2001–2002*, (2002) 19.

! RECOMMENDATION(S)

126. Where a person with an intellectual disability is subjected to restraint and seclusion in accordance with their care plan, this must be recorded by the service provider. Service providers must forward an annual report to the Office of Senior Clinician on all persons in their care, indicating all instances of use of restraint and seclusion.
127. Where emergency use of restraint and seclusion is reported to the Office of Senior Clinician, the Office of Senior Clinician may direct that use of restraint and seclusion should cease, either immediately or after an alternative method of care is put in place. Before giving such a direction the Office of Senior Clinician must consult with the service provider about alternative means of managing the person's behaviour.
128. Providers of services under the DSA should be required to record all instances of use of restraint and seclusion affecting people with cognitive impairments.
129. Providers of services under the DSA should report quarterly to the Office of Senior Clinician on all instances of use of restraint and seclusion.
130. The Office of Senior Clinician should function as a central records agency for detention plans and care plans.
131. The Office of Senior Clinician should be resourced with the computer infrastructure to enable all reports and records from service providers to be submitted and monitored electronically and to permit systems to be established for monitoring particular care practices.

Power to visit and inspect facilities

8.27 The Office of Senior Clinician should have power to audit care practices, to visit and inspect facilities which provide services for people with an intellectual disability, to inspect documents and to meet with any person who is receiving care. The primary purpose of this process should not be to detect wrongdoing, but to provide an opportunity for interactions with service providers and staff which will contribute to improvements in care standards. For example, where it becomes apparent that a particular facility is using restraint to manage the people who are being cared for, it may be useful for the Office to arrange a visit to the facility to ascertain whether residents have attributes that make them particularly difficult to

manage, or whether improvements need to be made to care practices. Similar powers are conferred by the *Mental Health Act 1986* on the Chief Psychiatrist.³⁸⁶

! RECOMMENDATION(S)

132. The Office of Senior Clinician should develop mechanisms to monitor the performance of service providers.
133. The Office of Senior Clinician should have power to visit and inspect premises, to obtain access to records of service providers, to inspect documents and to see any person who is receiving care.

REPORT ON CONSISTENT FAILURE TO COMPLY WITH GUIDELINES OR SERVICE STANDARDS

8.28 We have recommended above that the Office of Senior Clinician should have power to direct that emergency use of restraint and seclusion should cease, or that changes should be made to a locked door policy, after consultation with the service provider. The Office of Senior Clinician's power to visit premises will also assist service providers to identify practices that should be changed. Where appropriate care standards are not being met, the Office of Senior Clinician could play an important role in advising the service provider³⁸⁷ and encouraging better performance.³⁸⁸ Where persuasion is unsuccessful³⁸⁹ we recommend that the Office

386 *Mental Health Act 1986* ss 106, 107.

387 See Andrew Hopkins, 'Compliance with What? The Fundamental Regulatory Question' (1994) 34 *British Journal of Criminology* 431, 431–2, for a discussion of the use of 'persuasion' (which involves dialogue between the service provider and the regulator) rather than 'punishment' to bring about compliance.

388 The interaction between the statutory authority and the organisations being regulated can be seen as a form of 'co-operative regulation' [this form of regulation and examples of it are discussed in Organisation for Economic Co-operation and Development, *Co-operative Approaches to Regulation*, Public Management Occasional Paper No. 18 (1997)]. That is, both parties are working together to improve services. In some circumstances, the Office of Senior Clinician may consider that the practices of the service provider are inappropriate, however, in the course of the process of 'persuasion', the provider may show that in the particular situations faced by the provider, the practices followed are the only reasonable practices available. The Office of Senior Clinician, therefore, may learn from this interaction and this may, in turn, affect the manner in which the Office advises and regulates other service providers (this can also be seen as a form of 'responsive regulation').

389 This continued emphasis on an interaction between the regulator and the service providers is a recognition of the need for communication with respect to compliance. It has been argued that there are six sources of

of Senior Clinician should have power to direct the service provider to change the way a particular individual is being cared for.

8.29 Most service providers will have entered into a funding agreement with the Department of Human Services. Service agreements normally provide for amendment of the agreement or imposition of additional conditions on the service provider. DHS has responsibility for contract management. If the service provider is not providing appropriate standards of care, DHS will have access to a range of remedies, including amending or rescinding the agreement. If a facility which is prescribed to receive people on detention orders or care and treatment orders fails to comply with relevant requirements, it may be necessary to rescind approval of a prescribed facility. It is in the interests of the residents as much as it is in the interests of the operator of the facility that this should only be done as a last resort. If a service provider loses its status as a prescribed facility, then it can no longer care for people with intellectual disabilities or cognitive impairments who are a serious risk to others. Residents would have to be moved to other secure facilities.

8.30 We do not contemplate that the Office of Senior Clinician should have a direct role in contract management. However the Office of Senior Clinician should have power to report breaches of guidelines or failure to comply with the terms of service agreements to the Secretary to the Department, so that DHS can decide how to deal with the contract management issues.



RECOMMENDATION(S)

134. Service agreements should permit the Secretary of the Department of Human Services to amend the agreement or impose additional conditions on the service provider to ensure compliance with guidelines and appropriate standards of care.

non-compliance in any given regulatory system. These are: failure of understanding; collapse of belief in the law; procedural injustice; cost of regulation; enforcement failure and failure of civil society (for a discussion of these sources see John Braithwaite, *Improving Regulatory Compliance: Strategies and Practical Applications in OECD Countries* (1993), 7. A later OECD report added one additional source of non-compliance—incapacitation of those regulated and divided ‘enforcement failure’ into either deterrence failure or failure of persuasion: Organisation for Economic Co-operation and Development, *Reducing the Risk of Policy Failure: Challenges for Regulatory Compliance*, (2000) 13. The impact of a majority of these sources can be reduced by maintaining a dialogue between the regulator and the non-compliant body.

! RECOMMENDATION(S)

135. The Office of Senior Clinician should have power to report breaches of service agreements, failure to comply with guidelines or directives of the Office of Senior Clinician or inappropriate service practices, to the Secretary of the Department of Human Services.
136. Where the service provider has consistently failed to comply with guidelines or directives of the Office of Senior Clinician or to provide an acceptable level of care, the Secretary should consider whether the service agreement should be amended or rescinded.
137. In the case of persistent breaches with guidelines or failure to comply with directives of the Office of Senior Clinician the Secretary of the Department of Human Services may recommend to the Minister that approval of a prescribed facility should be rescinded.

COMMUNITY VISITORS

8.31 Currently Victorian human services systems rely on community visitors as one mechanism of quality assurance.³⁹⁰ Community visitors are volunteers who visit facilities to carry out inspection functions.³⁹¹ They are independent of the service provider and can bring concerns raised by residents to the attention of DHS.

8.32 Under the IDPSA some services (ie residential institutions) must be visited at least once a month.³⁹² Residents may also request to see a community visitor. Any request must be passed on to the community visitor, but the legislation does not impose an obligation on the community visitor to actually visit the person who made the request.³⁹³

390 Community visitors may be appointed under the *Intellectually Disabled Persons' Services Act 1986* s 53, the *Health Services Act 1988* s 116 and the *Mental Health Act 1986* s 108.

391 For example, under the *Intellectually Disabled Persons' Services Act 1986*, the functions of a community visitor include inquiring into the 'appropriateness and standards of facilities... whether services are being provided in accordance with the principles specified in [the Act] and the use of restraint and seclusion': s 54.

392 *Intellectually Disabled Persons' Services Act 1986* s 56.

393 Any resident may request the designated officer of the facility to arrange for the resident to be seen by a community visitor. The officer must within seven days of receiving the request, advise one of the community visitors for the region that a request has been made: *ibid* s 58.

8.33 The community visitors' program is managed within the Office of the Public Advocate (OPA).³⁹⁴ The Commission believes that the system could be improved by requiring a community visitor who has received a request to visit a facility and decides not to make the visit, to advise the OPA of the request and the community visitor's reasons for not complying. Copies of this letter should be sent to the person who made the request, to the person's guardian, if she or he has a guardian, and to the Office of Senior Clinician. Included in the copy of the letter sent to the resident and to his or her guardian should be details of how the resident may make a complaint under the complaints handling system which it is proposed should be established.

8.34 A further level of accountability could be added to the system. Currently, only the responsible Minister may direct a community visitor to visit a facility.³⁹⁵ In cases where the OPA does not consider that the community visitor's reasons for failing to visit are sufficient, then the Office of Public Advocate should be able to request that the Minister direct a community visitor to make the requested visit.

! RECOMMENDATION(S)

138. Community visitors must respond to a request to be seen by a resident or her or his representative within 14 days of being advised of the request. The community visitor must respond to the request by visiting the person who made the request or by notifying, in writing, the Office of the Public Advocate of the reasons for not visiting the person who made the request.

139. Where the community visitor notifies the Office of the Public Advocate of the reasons for not visiting the person who made the request, the Office of the Public Advocate should send copies of these reasons to the person, the person's guardian, if any, and to the Office of Senior Clinician.

140. If the Office of the Public Advocate does not consider the community visitor's reasons for not making a requested visit are sufficient then the Office may request the responsible Minister to direct a community visitor to visit the facility.

394 *Intellectually Disabled Persons' Services Act 1986* s 60.

395 *Ibid* ss 56(3), 60.

COMPLAINTS HANDLING SYSTEM

8.35 Provision for regulation and inspection of facilities provides an external means of quality assurance. The capacity of people in facilities to call on community visitors is a form of way of ensuring accountability from within. Accountability can also be enhanced by provision for a formal complaints handling system.³⁹⁶

8.36 Complaints will often provide opportunities to improve quality of care and redress systemic issues. They should be seen primarily as a method of quality assurance, rather than as providing a means of detecting and punishing wrongdoers. A complaints body can operate as a practical mechanism to support and enforce a statement of core values.

8.37 Some submissions dealt specifically with the issue of complaints procedures.³⁹⁷ There are a number of models for complaints handling procedures.³⁹⁸ Further, there are a number of complaints procedures already included in Victorian legislation such as in the *Health Service (Conciliation and Review) Act 1987* (which established the Health Services Commissioner), *Ombudsman Act 1973* (the Ombudsman)³⁹⁹ and *Whistleblowers Protection Act 2001*.⁴⁰⁰ Options available for the complaints body include

- giving an existing body (for example the Health Services Commissioner) the power to investigate, conciliate and resolve complaints; and

396 The need for an appropriate complaints mechanism for people receiving treatment in the mental health system was recognised in Auditor General Victoria, *Mental Health Services for People in Crisis*, (2002) 118.

397 For example, Submission 24, Mental Health Review Board 6–7; Submission 19, Office of the Public Advocate 8, 11–4 and Submission 3, Southwest Advocacy Association 3.

398 For example, Standards Australia have released a standard for complaints handling procedures (AS 4269–1995), Disability Services Queensland recently produced Disability Services Queensland, *Policy and Procedures for Complaints Regarding DSQ Services*, (2000) and the Australian Law Reform Commission included a discussion of a complaints handling system in Australian Law Reform Commission, *The Coming of Age: New Aged Care Legislation for the Commonwealth*, Report No 72 (1995) 197–211. Disability Services Division, Victorian Government Department of Human Services, *Victorian State Disability Plan 2002–2012*, (2002) 30 also includes reference to a complaints handling procedure without a discussion of the necessary detail of the procedure.

399 The Ombudsman is limited to hear and investigate complaints against government departments and public statutory bodies: *Ombudsman Act 1973* s 13.

400 We also recognise that already the requirement of a ‘documented grievance resolution procedure’ is part of Disability Services, Department of Human Services, *Victorian Standards for Disability Services* (2002) Standard 7.

- setting up a new complaints body to deal specifically with complaints about detention and use of restrictive practices.

8.38 The principles that should underpin an effective complaints handling system were articulated in the submission from the OPA.⁴⁰¹ These included:

- independence from any bodies that fund disability services;
- a strong rights focus;
- adequate infrastructure, including staff with relevant skills and understanding, to support the system; and
- a focus on conciliation, advice and supports at the facilities.

The OPA submission argued that the complaints body should be separate from any health complaints system.

8.39 The experience of the New Zealand Health and Disability Commissioner is that, relatively speaking, not many people with disabilities take advantage of complaints procedures.⁴⁰² This suggests that the expense and infrastructure involved in the establishment of a new complaints handling procedure may not be cost-effective.

!

RECOMMENDATION(S)

141. An independent complaints handling system should be established to receive, investigate, mediate and resolve complaints with respect to detention and use of restrictive practices, and other aspects of service provision for people with an intellectual disability or cognitive impairment.

8.40 The DHS review of disability services is likely to recommend a process for handling complaints about service provision. The VLRC believes that an

401 Submission 19, Office of the Public Advocate, 11–4.

402 In the financial year 2001–2, seven disability consumers (there is no breakdown of the types of disability) made complaints to the New Zealand Health and Disability Commissioner. In total there were 1073 complaints in the same period (not including complaints from professional bodies). 286 of the complaints made were made by a relative of a consumer; some of whom may have been complaining on behalf of a relative with a disability: New Zealand Health and Disability Commissioner, *Annual Report for the Year Ended 30th June 2002*, (2002) 29.

independent, accessible complaints handling body should be established to deal with complaints about service providers. However, at this stage we do not recommend that any particular body should exercise this function.

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Appendix 1: List of Submissions

No	Date received	Name	Affiliation
1	23 Aug 2002	Andrew Carroll	Victorian Institute of Forensic Mental Health
2	26 Aug 2002	John O'Donoghue	Law Institute of Victoria
3	13 Sep 2002	Robert Dick	Southwest Advocacy Association Inc.
4	19 Sep 2002	Ron Webster	
5	1 Oct 2002	John Billings	Guardianship and Administration List
6	1 Oct 2002	Pauline Williams	AMIDA
7	26 Aug 2002	Gerry Blackney	Disability Services, DHS
8	1 Oct 2002	Ben Rice	Equal Opportunity Commission Vic.
9	2 Oct 2002	Astrid Birgden	
10	2 Oct 2002	Stephen Grant	Transport Accident Commission
11	2 Oct 2002	Frank Lambrick	Statewide Forensic Services
12	4 Oct 2002	Patricia Crowley	
13	4 Oct 2002	Lachlan DuRinck	Australian Community Support Organisation
14	7 Oct 2002	Sue Tait	Intellectual Disability Review Panel
15	2 Oct 2002	Esther Harris	STAR Victoria Inc.
16	3 Oct 2002	Vivienne Topp	Mental Health Legal Centre Inc.
17	3 Oct 2002	Niki Sheldon	Disability Justice Advocacy Inc.
18	8 Oct 2002	Robert Ludbrook	National Children's Youth Law Centre
19	15 Oct 2002	Julian Gardner	Office of the Public Advocate
20	16 Oct 2002	Patsie Frawley (on behalf of Keran Howe)	Disability Advisory Council of Vic
21	16 Oct 2002	Keir Henshaw	Villamanta Legal Service
22	21 Oct 2002	Ross Nankivell	The Victorian Bar
23	18 Oct 2002	Merrilee Cox	Headway Victoria
24	28 Oct 2002	John Lesser	Mental Health Review Board of Victoria

No	Date received	Name	Affiliation
25	31 Oct 2002	David Faram	Law Institute of Victoria
26	7 Nov 2002	Ron Tully	Supportive Residents and Carers Action Group Inc
27	14 Nov 2002	Tony Parsons	Victoria Legal Aid
28	12 Nov 2002	Jelena Popovic	Melbourne Magistrates' Court
29	29 Jan 2003	Lance Wallace	Department of Human Services
30	29 Aug 2003	Tony Parson	Victoria Legal Aid

Other Publications

Disputes Between Co-owners: Discussion Paper (June 2001)

Privacy Law: Options for Reform—Information Paper (July 2001)

Sexual Offences: Law and Procedure—Discussion Paper (September 2001)
(Outline also available)

Annual Report 2000–01 (October 2001)

Failure to Appear in Court in Response to Bail: Draft Recommendation Paper
(January 2002)

Disputes Between Co-owners: Report (March 2002)

Criminal Liability for Workplace Death and Serious Injury in the Public Sector: Report
(May 2002)

Failure to Appear in Court in Response to Bail: Report (June 2002)

People with Intellectual Disabilities at Risk—A Legal Framework for Compulsory Care: Discussion Paper (June 2002)

What Should the Law Say About People with Intellectual Disabilities Who are at Risk of Hurting Themselves or Other People? Discussion Paper in Easy English (June 2002)

Defences to Homicide: Issues Paper (June 2002)

Who Kills Whom and Why: Looking Beyond Legal Categories by Associate Professor Jenny Morgan (June 2002)

Annual Report 2001–02 (October 2002)

Workplace Privacy: Issues Paper (October 2002)

Defining Privacy: Occasional Paper (October 2002)

Sexual Offences: Interim Report (June 2003)

Defences to Homicide: Options Paper (September 2003)

