



Victorian
Law Reform
Commission

Compulsory Care and Treatment of People with Intellectual Disabilities Discussion Paper

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Call for Submissions

The Victorian Law Reform Commission invites your comments on this Discussion Paper and seeks your responses to the questions that are raised. You can send your written submissions by post, or by email to <law.reform@lawreform.vic.gov.au>. If you need any assistance with preparing a submission, please contact the Commission.

Please note that all submissions made to the Commission are treated as public documents, unless they are identified otherwise. If you do not want your name to be identified or if you want your submission to be confidential, please make this clear on the document. Members of the public can contact the Commission to obtain copies of submissions.

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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
CLR	Commonwealth Law Reports
CMIA	<i>Crimes (Mental Impairment and Unfitness to be Tried) Act 1997</i> (Victoria)
DHA	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
OPP	Office of Public Prosecutions

para	paragraph
s	section (ss pl)
SA	South Australia
SASR	South Australian State Reports
SFS	Statewide Forensic Service
US	Reports of Cases in the Supreme Court (USA)
VCAT	Victorian Civil and Administrative Tribunal
VR	Victorian Reports
WLR	Weekly Law Reports (UK)

Summary

SCOPE OF THE DISCUSSION PAPER

This Discussion Paper considers how Victorian law should regulate care and treatment of people with intellectual disabilities or cognitive impairments without their consent, when their behaviour places them or others at risk of harm. In the Discussion Paper this is referred to as compulsory care and treatment. The present law is inadequate because it does not provide clear guidelines on when compulsory treatment or detention of people with intellectual disabilities or cognitive impairments is allowed and does not provide for review of most compulsory care decisions. In this respect, people with intellectual disabilities have fewer rights than people with mental illnesses.

THE CURRENT LAW

The law in Victoria currently regulating compulsory care falls into two main categories—that which applies to people with intellectual disabilities who have been charged with or convicted of offences, and that which applies to people who have not been charged with offences, but who are nevertheless seen to be at risk of harming themselves or others.

The Criminal Justice System

Where a person with an intellectual disability has been charged with or convicted of a criminal offence, a court can order that she or he is detained or cared for without consent. This includes the following situations.

- As a condition of a community-based order, a court can order that a person with an intellectual disability complies with requirements set out in a justice plan. The maximum term of a justice plan is two years.
- If a person has been sentenced to a term of imprisonment he or she can be transferred from the prison to a residential institution to serve the term in the residential institution as a 'security resident'. She or he must be released at the end of the sentence.

- The *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* deals with people who are unfit to stand trial because they are 'mentally impaired' or not guilty of offences because they have mental impairments. A court can make a supervision order requiring those people to be placed in 'an appropriate place' or can release them on conditions specified by a court.
- When a person has served some of his or her sentence, they may be released on parole. The Adult Parole Board can set terms and conditions of parole which require people to live in a particular place or to have treatment or comply with a particular regime.

The Human Services System

There are fewer safeguards when people with intellectual disabilities or cognitive impairments are being cared for within the human services system. If a person's behaviour is believed to place her or him or others at risk, they may be placed in a residential service and not allowed to leave it or they may be given behaviour-controlling drugs, because it is feared they will harm others. There is no time limit on these restrictions.

There are some safeguards covering the restraint or seclusion of a person by an organisation providing services under the *Intellectually Disabled Persons' Service Act 1986*. Mechanical or chemical restraint can be used if it is necessary to prevent the person from causing injury to him or herself or to another person or to prevent the person from persistently destroying property. Use of restraint and seclusion must be reported to the Intellectual Disability Review Panel (IDRP) at the end of each month. A person can apply to the IDRP for a review of a decision to use restraint or seclusion and the panel may make a recommendation on this matter to the Secretary of the Department of Human Services. . However, the IDRP cannot make binding decisions.

Guardians

Because there is no legal framework for authorising compulsory care under the present system, a guardian is often appointed to consent to the care and treatment of a person with an intellectual

disability, whose behaviour places him or her or others at risk. Guardians are appointed by the Victorian Civil and Administrative Tribunal (VCAT). Before appointing a guardian, the Tribunal must be satisfied that the person, because of his or her disability, is unable to make reasonable decisions in their own best interests. A guardian may agree that the person should be placed in a particular facility or receive certain treatment. Sometimes, a guardian is appointed to make decisions on behalf of a person who is been found guilty of an offence and has served a sentence, but whose behaviour is believed to place him or her or others at risk of harm.

PROBLEMS WITH THE PRESENT SYSTEM

There are a number of problems with the present system, which are listed below.

- The rights of people with intellectual disabilities are not adequately protected. Legislation regulating compulsory care and treatment of people with intellectual disabilities, who have not been charged with criminal offences, deals only with restraint and seclusion.
- Although restraint and seclusion are regulated by legislation, there is uncertainty about which practices are covered.
- Except where the person is charged with or convicted of an offence or a guardian has been appointed to make decisions on behalf of a person, there is limited opportunity to challenge a decision that a person should be detained or treated without her or his consent.
- Under the present system, people may be treated as if they have consented to detention or treatment when they lack the capacity to consent or have not had the implications of treatment explained to them.
- Where a guardian is appointed to make decisions on behalf of a person with an intellectual disability, the guardian's decision must be in the best interests of that person.

PRINCIPLES UNDERPINNING A NEW SYSTEM

The Discussion Paper suggests a new framework for regulating compulsory care which should be underpinned by four broad principles:

- 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.
- Preventing exploitation and abuse of people with intellectual disabilities.
- Preventing harm to other members of the community.

The Discussion Paper asks people to comment on whether these provide an adequate basis for a legislative framework regulating compulsory care.

OPTIONS AND ISSUES

This Discussion Paper sets out the issues which will need to be considered in designing a legal framework to regulate compulsory care of people with intellectual disabilities and other cognitive impairments and puts forward options for comment.

Issue 1: Who Should be Covered by Legislation Authorising Compulsory Care

The Commission has been asked to consider compulsory care of people with intellectual disabilities and of ‘people with other cognitive impairment such as acquired brain injury and dual disability’ The Discussion Paper focuses on adults with intellectual disabilities or cognitive impairments and asks whether children should also be covered by any framework for authorising compulsory care, or whether this should continue to be dealt with under the *Children and Young Persons Act 1989*.

It is important to decide how ‘intellectual disability’ should be defined and whether there should be power to treat or detain people who do not have intellectual disabilities but have some other forms of cognitive impairment which may result in them harming themselves or others.

The legislation could allow compulsory care of people with a broad range of impairments who are at risk of harming themselves or others, or could have more limited operation. An alternative approach would be to limit compulsory care to people with intellectual disabilities or other specified disabilities. The Discussion Paper seeks comments on these questions.

Issue 2: What is Meant by Risk?

The Discussion Paper seeks comments on the criteria for compulsory care and on how risk to the person or others should be assessed. The law does not usually allow a person to be detained except as a result of criminal proceedings. However the Discussion Paper assumes that compulsory care for people with intellectual disabilities or cognitive impairments may be justifiable in some circumstances. The Discussion Paper asks questions about the types of factors which should be considered in deciding whether a person should be treated or detained without his or her consent. These factors could include the probability, imminence and seriousness of the risk that a person will harm him or herself or others, whether a person has already harmed others, and whether the risk of harm to self or others is caused by the intellectual disability or mental impairment. The Discussion Paper acknowledges that assessing future risk of harm is difficult, and puts forward some options for how this might be done.

Issue 3: Which Care and Treatment Practices Should the Law Regulate?

There may be some types of care where consent can be assumed and which do not require legal regulation. It may be appropriate for a person's guardian to authorise some other types of care, when a person is incapable of consenting. There may be some types of intervention where the rights of the person should receive greater protection. In these situations, the legislation could require compulsory care to be authorised by a specified person or statutory body. The Discussion Paper asks for comments about which types of care require regulation and also asks whether compulsory care should be permitted to prevent the person harming others, if the care is of no benefit to the person.

Issue 4: The Place of Care

The *Mental Health Act 1986* allows the compulsory care of people in the community, by making provision for 'community treatment orders' which apply to people with mental illnesses who refuse or are not able to consent to the necessary treatment. The Discussion Paper asks whether there should be provisions authorising compulsory care and treatment of people with intellectual disabilities or cognitive impairments, whose behaviour places them or others at risk, outside residential facilities. It also asks whether there is a need for more community-based care.

Issue 5: The Process for Authorising Compulsory Care

The Discussion Paper considers a number of frameworks for compulsory care. It discusses:

- who should be able to seek authorisation for compulsory care;
- who should assess the need for compulsory care;
- who should make the decision as to whether compulsory care is needed because the person is at risk to her or himself or others; and
- who should be responsible for managing compulsory care on a day-to-day basis?

It discusses the arguments for and against:

- allowing a suitably qualified individual to authorise compulsory care;
- extending the powers of an existing body (for example the Mental Health Review Board) to allow authorisation of detention and treatment;
- creating a new tribunal to authorise compulsory care; or
- giving power to a court to authorise compulsory care.

The Discussion Paper also examines whether there should be provision for appeals against and reviews of decisions authorising compulsory care. It seeks comments on the structure and processes for authorising and reviewing compulsory care.

Other practical issues which are covered include the processes for making interim and emergency decisions about compulsory care and making arrangements for leave of absence.

Issue 6: The Interaction Between the Criminal Justice System and the Human Services System

The Discussion Paper looks at whether changes are necessary to make the human services system which provides care for people with intellectual disabilities and cognitive impairments and the criminal justice system which deals with people who commit offences, interact more effectively.

Possibilities include:

- allowing the police or the Director of Public Prosecutions to refer people who are at risk to themselves or others, to the body which can authorise compulsory care, where it is unlikely that these people could be convicted of offences;
- giving magistrates power to make supervision orders, where a person does not have the capacity to be tried for an offence; and
- expanding sentencing options to require care of a person within a residential facility instead of a prison, in cases where justice plans are not appropriate.

Issue 7: Approval of Care Providers

The Discussion Paper examines options for regulating providers of services and care to people with intellectual disabilities or cognitive impairments.

Chapter 1

Introduction

SCOPE OF THE REFERENCE

- 1.1 People with intellectual disabilities (or a disability such as acquired brain injury which affects their reasoning capacity) sometimes behave in ways that exposes them or other people to the risk of harm. In these situations, it may be necessary to detain or treat these people to prevent them harming themselves or others. As we discuss below, courts have various powers to order detention and care of a person with a mental impairment who has been charged with or convicted of a criminal offence.¹ However, in cases where a person has not been charged, the existing law does not provide sufficiently clear guidelines on when a person with an intellectual disability or a cognitive impairment can be treated without his or her consent. There are also insufficient safeguards against inappropriate use of powers to treat or restrict the freedom of movement of people with intellectual disabilities without their consent.
- 1.2 This Discussion Paper examines whether changes should be made to the laws which regulate the detention, treatment and care without consent of a person with an intellectual disability or cognitive impairment, whose behaviour places her or him or others at risk. The terms of reference do not specifically refer to children with intellectual disabilities who are in need of care or who commit criminal offences. These issues, as they affect children, are covered in the *Children and Young Persons Act 1989*. For this reason, this Discussion Paper deals mainly with adults; however, Chapter 4 contains more detailed discussion of children at risk.

¹ This is possible under the *Crimes (Mental Impairment and Unfitness to Be Tried) Act 1997*. For detailed discussion of these provisions, see below paras 2.32–6..

1.3 Victorian law is underpinned by the principle that people should only be deprived of their liberty if they have received a fair trial, been found guilty² of a criminal offence and been sentenced³ by a court.⁴ Normally, a person cannot be detained without his or her consent on the basis of a prediction that he or she may endanger others in the future. However, in very exceptional circumstances, a court can find that a person is a serious offender and sentence her or him to imprisonment for an indefinite period.⁵ Another exception relates to people with mental illnesses. People with mental illnesses can be involuntarily detained and treated to prevent a deterioration in their condition, or for the protection of members of the public.⁶ As we discuss below, involuntary detention and treatment of people with mental illnesses is based on clear legislative criteria and subject to many safeguards. These safeguards do not apply to people with intellectual disabilities. This Discussion Paper considers the criteria which should apply to and the processes by which decisions should be made about the care of people with intellectual disabilities or cognitive impairments.

1.4 The legislation which regulates care and treatment of people with mental illnesses whose behaviour places them or others at risk is referred to as ‘involuntary detention and treatment’. In contrast, our terms of reference refer to ‘compulsory care and treatment’. We explain what ‘compulsory care and treatment’ means in more detail below. The following case studies provide examples of some of the situations which we will need to consider.

² One exception to the requirement of a finding that the person is guilty of an offence occurs if a person charged with an offence is found to be unfit to stand trial or not guilty because of mental impairment under the *Crimes Mental Impairment and Unfitness to be Tried Act 1997*: see below paras 2.32–6.

³ The options available under the *Sentencing Act 1991* include custodial orders (Part 3, Division 2), community-based orders (Part 3, Division 3), disqualification (Part 4, Division 3) and hospital orders (Part 5).

⁴ There are also provisions allowing a person to be held in custody pending trial for a criminal offence: see, for example, the provisions relating to remand warrants under *Magistrates’ Court Act* ss 79–82.

⁵ Where a person is found to be a ‘serious offender’ under the *Sentencing Act 1991* (ss 6B, 6C) the court ‘must regard the protection of the community from the offender as the principal purpose for which the sentence is imposed’ and may impose a longer sentence than would be proportionate to the gravity of the offence of which the person has been found guilty: s 6D. A court also has the power to order indefinite sentences if it is ‘satisfied, to a high degree of probability, that the offender is a serious danger to the community’: s 18B(1).

⁶ *Mental Health Act 1986* s 8(1). See below, paras 2.16–20.

Case Study 1

Bill is a 30-year-old man with a severe intellectual disability. Some years ago, he set alight 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 of the residence so that Bill cannot go outside without someone accompanying him. Bill is frustrated because he is rarely able to go outside. It also means that other residents cannot go outside without asking a staff member to unlock the door.

Case Study 2

Minh is a 34-year-old man with a brain injury acquired as a result of a car accident he was involved in when he was 20. Since his brain injury, Minh has sometimes been aggressive towards other people. At times, he lashes out violently and without warning, but he may go for several months without an episode of this kind. His doctor has prescribed tranquillisers for him, at the request of the residential service. The tranquillisers make it less likely that he will become angry and hard to manage. The tablets are given to him each morning and he takes them without objecting because he has been told that they will be good for him. It is not clear whether he understands the reason for taking them. Minh lives in staffed group home where the doors are locked and Minh is unable to leave without a staff person going with him. This frustrates Minh enormously. He has said on many occasions that he wants to be able to leave the house without a staff person going with him.

1.5 In each of these cases, a person's freedom of movement is restricted because of concern that he will injure himself or others. Minh is also receiving medical treatment for which he may not fully understand the purpose. In this Discussion Paper we examine how decisions should be made about this issue and what safeguards should exist in relation to these decisions.

WHY A REFERENCE ON COMPULSORY CARE AND TREATMENT?

- 1.6 The issue of compulsory care and treatment was referred to the Commission by the Victorian Attorney-General at the request of the then Minister for Community Services, the Honourable Christine Campbell MP. This request was based on a recommendation made by a review panel established by the Minister, to consider the operation of the Disability Services Statewide Forensic Service (SFS).⁷ The SFS is a service operated by the Victorian Department of Human Services to provide intensive care and treatment to people with intellectual disabilities who exhibit dangerous or anti-social behaviour. The SFS is responsible for several programs for people falling into this category, including an intensive residential treatment program (IRTP). In the IRTP, people are initially held in a locked residential facility. The aim of the program is to modify the person's behaviour so that she or he can eventually live in the community, and may continue to participate in treatment. The review panel made recommendations about the way in which clients of SFS are supervised and managed, and the use, reporting and monitoring of restraint and seclusion of these clients.
- 1.7 The report of the review panel, referred to as the Vincent Report, was released in September 2001. It drew attention to the lack of a clear statutory framework determining when compulsory treatment and care should occur, and how decisions about compulsory care and treatment should be reviewed.⁸ The Auditor-General, in his report *Services For People With An Intellectual Disability*, had also highlighted the need for tightening the framework protecting the rights of people with intellectual disabilities.⁹ The Vincent

⁷ *Report of the Review Panel Appointed to Consider the Operation of the Disability Services: Statewide Forensic Service* (hereafter the Vincent Report). The Panel was chaired by Justice Frank Vincent.

⁸ *Ibid* 12–13.

⁹ Auditor-General Victoria, *Services for People with an Intellectual Disability* (2000) para 4.59.

Report recommended that the Attorney-General refer this matter to the Victorian Law Reform Commission.¹⁰

1.8 The terms of reference, although arising out of the Vincent Report, raise broader issues about the compulsory care and treatment of people with intellectual disabilities or cognitive impairments, whose behaviour places them or others at risk. While some of these people will have come to the attention of the criminal justice system, others may not have been convicted of any offence, or may have completed a sentence for an offence.

1.9 While the Commission is undertaking work on this reference, the Department of Human Services will also be conducting a broader review of disability services legislation. In addition, the Victorian Government will soon be publishing a State Plan for the provision of disability services. This reference on compulsory care and treatment is being undertaken separately from these other policy reviews. However, in making our recommendations, the Commission will need to take account of broader policy developments in the area of intellectual disability.

TERMINOLOGY

1.10 The primary focus of this Discussion Paper is on people with intellectual disabilities whose behaviour places them or others at risk. However, the terms of reference also refer to people with other cognitive impairments such as acquired brain injury and dual disability (mental illness and intellectual disability). We discuss these terms below.

Intellectual Disability

1.11 The *Intellectually Disabled Persons' Services Act 1986* (IDPSA) regulates the management, provision, development and planning of services for people with intellectual disabilities. 'Intellectual disability' is defined in section 3 for a person over the age of 5 to mean:¹¹

¹⁰ Vincent Report, above n 7, Recommendation 2.

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.

1.12 The term ‘general intellectual functioning’ is measured by a standard intelligence (or IQ¹²) test. A score of 70 or below is seen as significantly sub-average.¹³ ‘Deficits in adaptive behaviour’ are measured by a functional assessment, administered by a psychologist. It is important to understand that the IQ score is an administrative tool which defines a cut-off point for eligibility for services under the Act.¹⁴ This means that it is not necessarily the only way of defining or understanding what we mean by intellectual disability in this Discussion Paper.¹⁵

1.13 If the law is to allow compulsory care and treatment of people with intellectual disabilities, we will need to consider whether the IDPSA definition should apply, or whether a broader view of intellectual disability would be more appropriate.¹⁶

Acquired Brain Injury

1.14 The term ‘acquired brain injury’ (ABI) generally refers to an injury to the brain acquired after a person has turned 18 years of age. People who suffer brain injuries after they turn 18 are not eligible for services under the IDPSA, even though the impact of the injury, in terms of the person’s intellectual and behavioural capacities, may be the same as the impact of an intellectual disability. As we discuss below, they may receive services under

¹¹ Note that a person under the age of 6 may have a ‘developmental delay’ which makes him or her eligible for the provision of services: s 8A.

¹² Intelligence quotient.

¹³ Section 8 of the Act defines the limit of eligibility in terms of the IQ score being ‘not higher than 2 standard deviations below the population average’: the population average IQ is 100 and a standard deviation is 15 IQ points.

¹⁴ Under s 7, an application may be made to the Secretary to assess eligibility for services. Section 8 sets out how the criteria in the definitions contained in s 3 are to be applied in the assessment for eligibility.

¹⁵ We recognise that the term ‘intellectual disability’ is applied less precisely in day-to-day conversation and often applied to anyone who seems to have more than typical difficulty in understanding things, in grasping concepts and applying them. That is, the term is likely to be used to describe people without knowing their IQ score or how they would perform on assessment to test adaptive behaviour.

¹⁶ In a sense there will be a reciprocal relationship between the *Intellectually Disabled Persons’ Services Act 1986* and the framework that we will recommend in our Report. That is, our recommendations will have to take into account the Act and our conclusions around compulsory care and treatment may have implications for definitions of eligibility under the Act or any new scheme proposed as a result of the Department of Human Services disability services legislation review.

the *Disability Services Act 1991* (DSA). The brain injury can be acquired in a number of ways, including trauma (such as a road accident, physical assault or a stroke), illness (such as a tumour or Alzheimer's disease) or substance abuse.

- 1.15 The impact of ABI on a person will vary, depending, in part, on what part of the brain is injured, and the seriousness of the injury. The injury might affect the person in any, or any combination, of a number of ways, including mobility, speech, sensory functions, cognitive abilities or personality. The term 'acquired brain injury', however, is not currently used in disability services legislation in Victoria.

Cognitive Impairment

- 1.16 The term 'cognitive impairment', like ABI, is not currently used in either the IDPSA or the DSA. Over recent years, however, it has been increasingly used as a way of describing a range of disabilities that have an impact upon a person's ability to understand and process information. It includes intellectual disability and ABI, but could also be defined more broadly to cover some forms of personality or autistic spectrum disorders. One of the issues which the Commission will have to consider is whether compulsory care and treatment of a person with a cognitive impairment that is not an intellectual disability should be permitted and, if so, in what circumstances. If the Commission recommended that compulsory care and treatment provisions should apply to people with some forms of cognitive impairment it would be necessary to define this expression.

Mental Illness

- 1.17 The *Mental Health Act 1986* (MHA) deals with the provision of services to people with mental illnesses and for their treatment on an involuntary basis in some situations. It may be useful to compare the way mental health and intellectual disability laws deal with this

issue. The terms of reference also require us to consider the situation of people with a ‘dual disability’, for example, both an intellectual disability and a mental illness.

- 1.18 ‘Mental illness’ is defined in Section 8(1A) of the MHA as: ‘a medical condition that is characterised by a significant disturbance of thought, mood, perception or memory’.¹⁷
- 1.19 The emphasis in the definition on ‘medical condition’ implies that mental illness has a physiological basis and that it can be treated to some extent through medical (particularly psychiatric) intervention.¹⁸ Some conditions, which are characterised by some significant disturbance of thought, mood, perception or memory, or volition, may not fit within the Act’s definition of mental illness. For example, some people who engage in self-harming behaviour do not come within the definition of mental illness. Similarly, some people with antisocial or borderline personality disorders¹⁹, whose behaviour may place others at risk, are not covered.²⁰
- 1.20 The terminology discussed above can be used differently in various contexts. Throughout this Paper, we have attempted to be as clear as possible when choosing the terms we use. Generally, we have used the term ‘intellectual disability’ when we are referring specifically to people who are eligible for services under the IDPSA. We use the term ‘cognitive impairment’ when we are talking more broadly about people who may or may not be eligible for services, but who experience some impaired or disordered mental functioning which may put them at risk or endanger others. However, consistent with our terms of

¹⁷ The Act also notes a number of circumstances that are not in themselves enough to qualify as a mental illness. This includes political or religious beliefs, sexual orientation, engaging in immoral or illegal conduct, having an intellectual disability, taking drugs or alcohol, having an antisocial personality, or belonging to a particular cultural, racial, or socio-economic group: s 8(2).

¹⁸ This requirement is one means of preventing misuse of the involuntary detention and treatment provisions.

¹⁹ An example is the case of Garry David (alias Webb) who had been remanded in custody but transferred to a secure psychiatric facility as an involuntary patient. While in this facility, he appealed to the Mental Health Review Board against his continued detention as an involuntary patient. The Board refused to rule that he had a mental illness and ordered that he return to prison: Hearing No. 230190:X01:300512. The Victorian Government enacted the *Community Protection Act 1990* to authorise the Supreme Court to make an order detaining Garry David beyond the period of his sentence. For a more detailed discussion of the circumstances of the case, see C R Williams, ‘Psychopathy, Mental Illness and Preventive Detention: Issues Arising from the David Case’ 16(2) *Monash University Law Review* (1990) 161.

²⁰ Personality disorders have posed a problem in terms of regulatory frameworks in the past. This is due, in part, to issues around diagnosis and the possibility of ‘treatment’. For a discussion of some of the implications concerning diagnosis see Barry Turner, ‘Mad, bad or dangerous to know?’, *New Scientist*, 30 March 2002, 46. The issues arising from conditions such as a personality disorder will be discussed in more detail below: see paras 4.8–13.

reference, when we use the term ‘cognitive impairment’ we do not intend to include people with a mental illness other than people with a dual disability.²¹

People who are at Risk to Themselves and the Community

1.21 The terms of reference mention two possible criteria for compulsory care. The first refers to the existence of an intellectual disability or a cognitive impairment. As we have seen, it will be necessary to define the meaning of these terms in legislation which provides for compulsory care. The second criterion refers to risk of harm to the person or others. As we discuss below, difficulties may arise in applying this criterion because there are many ways in which a person might be perceived to be at risk to her or himself and to the community. For example, people may be at risk to themselves because they will self-injure or because they are vulnerable to exploitation by others. They could also be a risk to themselves because their behaviour is annoying or offensive, and may result in others harming them. Alternatively, they may be perceived to create a risk to others because they engage, or are believed to have the potential to engage in, behaviour that is physically dangerous. In Chapter 4 we consider whether risk to self should be sufficient to justify compulsory treatment or whether it should be necessary to show that the person’s behaviour places others at risk. We also discuss the process for assessing risk and the processes for challenging a decision that a person is likely to behave in a way that creates a risk to him or herself or others.

Compulsory Care

1.22 The terms of reference refer to ‘care’ and ‘treatment’. For the sake of simplicity, we sometimes use the word ‘care’ in this Paper instead of ‘care and treatment’. Either term describes a range of interventions including:

²¹ Where the person with a dual disability may have a mental illness and a cognitive impairment, such as intellectual disability or acquired brain injury.

- ongoing placement in a residential facility (which may or may not be locked);
- use of various forms of restraint (for example, physical restraint by locking the door to a person’s room, or chemical restraint by medicating a person so that they are less likely to harm others);
- requiring a person, whether they live in a residential facility or not, to participate in a particular service program, such as a program designed to help them modify their behaviour;
- ongoing daily living support;²² and
- one-off, regular, or intermittent, treatment which has a therapeutic purpose, such as the use of medication.

1.23 The expression ‘compulsory care’ refers to care, or some aspect of care, that is provided without the real consent of the person concerned. In cases of severe or profound intellectual disability people may be incapable of consenting because their intellectual disability prevents them from making informed choices. In this case a guardian may, but is not always, appointed to make decisions on their behalf.²³ In other situations people may have the capacity to consent but in practice they do not have any real opportunity to participate in decision-making about their care. Sometimes a particular type of treatment may be against the stated wishes of the person. In using the expression ‘compulsory care’ we intend to cover all these situations.²⁴

1.24 This chapter has introduced some of the key concepts that are to be used in this Discussion Paper. Chapter 2 will examine the current arrangements with respect to the compulsory care of people with cognitive impairments.

²² This form of care may not require a detailed legislative framework: see below for a discussion of the forms of care and treatment that may be appropriate to be covered by any proposed framework: paras 4.41–5.

²³ For further discussion of guardianship see below paras 2.43–8.

²⁴ Some of the issues raised by the notion of consent, and the lack of consent, are discussed below paras 4.38–9.

Chapter 2

A Critical Look at Current Arrangements

INTRODUCTION

- 2.1 At present there is no clear legislative basis for the compulsory care and treatment of people with intellectual disabilities or cognitive impairments, except where they have been charged with criminal offences or guardians have consented to treatment on their behalf. As we discuss below, the *Intellectually Disabled Persons' Services Act 1986* (IDPSA) imposes some controls on 'restraint and seclusion' of people with intellectual disabilities, but provisions requiring authorisation of restraint and seclusion apply mainly to short-term and episodic controls on behaviour, rather than to on-going care and treatment without their consent. In this respect, the liberties of people with intellectual disabilities do not have the same level of protection as people with mental illnesses, for whom there is a detailed statutory framework regulating compulsory care.
- 2.2 In this chapter we discuss the legislation relevant to the care and treatment of people with intellectual disabilities and identify problems in the existing law.

THE CURRENT LAW

- 2.3 The existing legislation relevant to the treatment and care of people with intellectual disabilities or cognitive impairments falls into three main categories. First, legislation which provides for the provision of services on a voluntary basis to particular categories of people, but which in practice may allow care without consent in certain situations. Secondly, legislation relevant to people with intellectual disabilities or cognitive impairments who come to the attention of the criminal justice system. Thirdly, legislation which provides for a guardian to

consent on behalf of a person who, because of her or his disability,²⁵ is unable to make decisions about care and treatment.

People Receiving Care Within the Human Services System

2.4 Legislation regulating provision of services to people with intellectual disabilities or cognitive impairments includes

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

2.5 These Acts set up a regulatory framework for the provision of care and treatment of people who have the relevant disabilities, as defined by the legislation.²⁶ The IDPSA applies to people with intellectual disabilities.²⁷ Some people with cognitive impairments (for example, people who are brain injured after they turn 18) are eligible for services under the DSA,²⁸ while the MHA applies to people with mental illnesses. The IDPSA and the DSA are mainly concerned with the provision of care and treatment at the request of clients, their care-givers (for example, parents caring for their adult children with intellectual disabilities) or people who have been appointed as guardians. Care decisions may be made by a guardian as a substitute decision maker for a person with an intellectual

²⁵ Under *Guardianship and Administration Act 1986* 'disability' 'in relation to a person, means intellectual impairment, mental disorder, brain injury, physical disability or dementia': s 3.

²⁶ The *Mental Health Act 1986* lays out the objects of the Act. One of these objects is 'to facilitate the provision of treatment and care to people with a mental disorder': s 4(ab). See also the objectives set out in *Intellectually Disabled Persons' Services Act 1986*: s 4 (objects of the Act), s 5 (statement of principles) and s 6 (aims and objectives of the Department of Human Services).

²⁷ For the definition of intellectual disability see above para 1.11.

²⁸ The *Disability Services Act 1991* was enacted to enable transfer to the State Government of some services to people with disabilities that had been previously provided by the Commonwealth Government under the *Disability Services Act 1986*(Cth). The Victorian Act has no provisions for compulsory services. Under s 3 of the Victorian Act, 'disability':

'in respect of a person, means a disability-

(a) which is attributable to an intellectual, psychiatric, sensory or physical impairment or a combination of those impairments; and

(b) which is permanent or likely to be permanent; and

(c) which results in-

(i) a substantially reduced capacity of the person for communication, learning or mobility; and

(ii) the need for continuing support services; and

(d) which may or may not be of a chronic episodic nature.'

disability or cognitive impairment. Guardianship is discussed in more detail below.²⁹ The IDPSA and MHA provisions relevant to compulsory treatment are discussed below.

THE INTELLECTUALLY DISABLED PERSONS' SERVICES ACT 1986

- 2.6 The IDPSA enables the provision of services to people with intellectual disabilities in accordance with principles set out in section 5 of the Act. It requires the development of a general service plan for people eligible to receive, or who are receiving, services under the Act. A general service plan is a 'comprehensive plan prepared for an eligible person which specifies the areas of major life activity in which support is required and the strategies to be implemented to provide that support'.³⁰
- 2.7 The IDPSA is primarily concerned with voluntary care and does not contain general provisions authorising compulsory care or treatment of people with intellectual disabilities who may pose a risk to themselves or others, except where they have committed criminal offences.³¹ Similarly, there are no general provisions in the DSA allowing detention or treatment of people with cognitive impairments. However, the IDPSA places some controls on the use of 'restraint and seclusion'.

CONTROLS ON RESTRAINT AND SECLUSION

- 2.8 The IDPSA regulates the use of the seclusion³² or restraint³³ of a person who is eligible for services under IDPSA and is attending 'a residential institution, residential program, registered service, contracted service provider or a non-residential program'.³⁴ If a person being cared for under the IDPSA has 'mechanical or chemical' measures of restraint applied to him or her, the restraint must be necessary to prevent the person from either

²⁹ See below paras 2.43–8.

³⁰ Section 3.

³¹ The provisions relating to people who have committed offences are discussed below, paras 2.30–1.

³² Seclusion is defined as the 'sole confinement of a person in a room of which the doors and windows are locked from the outside': s 44(1).

³³ Restraint is not defined in the Act. DisAbility Services (part of the Department of Human Services) include, in their *Restraint and Seclusion Policy* (2001), definitions of both chemical restraint ('any chemical substance used to control or subdue a person's behaviour') and mechanical restraint ('manual methods or mechanical devices used to prevent, restrict or subdue movement of any part of the person's body') at 7.

³⁴ Section 44(2).

causing injury to him or herself or any other person; or to prevent the person from persistently destroying property.³⁵ The measures under the IDPSA do not, however, regulate restraint or seclusion outside these programs; for example, where a person is being cared for by their family, without any involvement from the Department of Human Services.

2.9 Under section 11 of the IDPSA, an individual program plan must be prepared for a person within 60 days of admission to a residential institution, residential program or non-residential program. Restraint can only be applied if it is included in the person's individual program plan and approved by an authorised program officer,³⁶ or, in the case of an emergency, authorised by the person in charge and notified to the authorised program officer without delay. Restraint is permitted for the time specified in the authorisation.

2.10 A person can be kept in seclusion if it is part of an individual program plan.³⁷ Seclusion is also possible in the case of an emergency, where it is necessary for the protection, safety or well-being of the person or other people with whom they may come in contact.³⁸ Emergency seclusions have to be authorised by the person in charge and notified to the authorised program officer without delay.³⁹ Seclusion can only occur for the period specified in the authorisation. The authorised program officer must send a report to the Intellectual Disability Review Panel (IDRP)⁴⁰ at the end of each month.⁴¹ The report must specify the cases where restraint or seclusion has been used, its effect on the person's

³⁵ Section 44(3).

³⁶ An authorised program officer means a 'person authorised for the purposes of this section by the Secretary' of the Department of Human Services (s 44(1)) such as the house supervisor in a community residential unit.

³⁷ Section 44(4)(a).

³⁸ Section 44(4)(a)(i).

³⁹ Section 44(4)(a)(ii).

⁴⁰ The Intellectual Disability Review Panel (IDRP) was established under the *Intellectually Disabled Persons' Services Act 1986* s 27.

⁴¹ Section 44(9).

behaviour, and the names of the people who approved the restraint and seclusion and who applied the restraint or seclusion.⁴²

2.11 Under the Act, a person can apply to either the IDR, or the Secretary of the Department of Human Services (DHS), for a review of a decision to admit a person to a residential institution, or a decision to use restraint or seclusion.⁴³ If the application is to the IDR, it may make a recommendation on the matter to the Secretary of DHS, who may accept or reject the recommendation.⁴⁴ Although these provisions provide checks on the use of some forms of 'restraint and seclusion' they do not cover all situations in which a person receives care or treatment without their consent.

LACK OF SAFEGUARDS

2.12 Decisions about the management of a particular client will often have to be made by a service which may have limited resources. The financial and other constraints within which services are provided may result in a person's rights and freedoms being restricted. One of these constraints is that providers have a duty of care to ensure that the person does not harm him or herself⁴⁵ or others.⁴⁶ Therefore, a person may have their liberty infringed in order to ensure that the provider complies with its duty of care to the other residents.⁴⁷ People may be placed in residential settings (either institutional or community-based) where the doors are locked or where, through some other means, they are prevented from coming and going as they please. People may be told that they are

⁴² Section 44(9)(a)–(c).

⁴³ Section 51. It has been noted that the IDR's review role is 'rarely exercised by residents of SFS': Vincent Report, above n 7, 22. Decisions that can be reviewed by the IDR are normally decisions that deny a person with an intellectual disability a place in a residential program. That possibility is supported by the statement in the Auditor-General's Report that there is a 'high level of unmet demand for accommodation': above para 5.11.

⁴⁴ Section 52(5). The Secretary must give reasons for rejecting any recommendation (s 52(6)) and the IDR may make a submission in the matter to the Minister (s 52(7)), who may take some action as he or she thinks fit (s 52(8)).

⁴⁵ There is a limited amount of case law that specifically relates to duties to protect others from self-harm. However, there are discussions of duties which may be useful, by analogy, that relate to the duty owed by parents to children: *Hahn v Conley* (1971) 126 CLR 276, *Robertson v Swincer* (1989) 52 SASR 356; the duty owed by employers to minimise the risk of harm to employees: *O'Connor v Commissioner for Government Transport* (1954) 100 CLR 225 (an experienced plumber who fell through an awning that could not sustain his weight), *McLean v Tedman* (1985) 155 CLR 306 (a garbage collector hit by a vehicle when crossing the road carrying rubbish); and the duty owed by authorities in respect of erecting warning signs: *Nagle v Rottnest Island Authority* (1993) 177 CLR 423.

⁴⁶ See, eg, *Smith v Leurs* (1945) 70 CLR 256, *Dorset Yacht Co Ltd v Home Office* [1970] AC 1004.

⁴⁷ The ease of compliance with the duty of care will also be affected by financial constraints.

‘not allowed’ to go out, ‘not allowed’ to do this or that and the person may simply comply with this instruction. They may be prescribed drugs in situations where it is not clear whether the purpose of the prescription is to treat or to control behaviour.

- 2.13 In cases where a guardian has been appointed, she or he may agree to treatment on behalf of the person. In other cases, the consent of the individual will simply be assumed. For example, people may ‘agree’ to services because they have no idea that they are entitled not to agree. Sometimes they will not understand to what they are agreeing. Sometimes they will actively resist. In the absence of genuine consent, and in the absence of a legislative mechanism for compulsory care where there is no consent, these practices may lack any clear basis in law. The lack of clear legislative authorisation for such practices is not confined to the management of people with intellectual disabilities, but may also apply to people with cognitive impairments. For example, a service provider caring for an elderly person with Alzheimer's Disease or someone with an ABI may also assume consent, simply because the person does not object to treatment.

LACK OF CONTROLS

- 2.14 In the section above we discussed the controls applicable to coercive treatment of people being cared for under the IDPSA. The controls on the use of restraint and seclusion only cover people with intellectual disabilities or cognitive impairments who receive services under the IDPSA. People may not receive these services either because they are not eligible under the IDPSA,⁴⁸ the limited resources are directed only to those with a high level of need, they have not chosen to access services, or they are unaware of the availability of those services. Some of the people who do not receive services under the IDPSA are cared for by their families at home. Where care responsibility is borne by family members or friends, carers might, whether or not they have the legal authority,

⁴⁸ That is, they may have a cognitive impairment that does not meet the criteria contained in s 3 of the Act.

make decisions on behalf of people with intellectual disabilities concerning medication and freedom of movement.

SUMMARY OF RELEVANT PROVISIONS

2.15 In the section above we examined the legislative criteria and safeguards for coercive care under the IDPSA. In summary:

- under the IDPSA, care may be provided without consent in a range of situations;
- there is no legislative framework for the provision of care without consent of a person with an intellectual disability who is receiving services under the IDPSA;
- there is no provision for appeal against management decisions of service providers, unless care measures amount to restraint or seclusion;
- use of restraint or seclusion must be reported to the IDRP. Unlike the Mental Health Review Board,⁴⁹ which can make binding decisions about involuntary treatment of people with mental illnesses, the IDRP can only make recommendations; and
- there is no legislative framework for the provision of care without the consent of a person with an intellectual disability who is not receiving services under the IDPSA (for example, a person who is being cared for at home).

THE MENTAL HEALTH ACT 1986

2.16 The *Mental Health Act 1986* (MHA) imposes much more stringent controls on care and treatment of people with mental illnesses⁵⁰ without their consent, than the controls applicable to compulsory care of people with intellectual disabilities under the IDPSA. Compulsory care (described as ‘involuntary care’ by the MHA) may include admission to a mental health service or an order to comply with a specified treatment regime (a

⁴⁹ The Mental Health Review Board is the review body under the *Mental Health Act 1986*. The powers and functions of the Board will be discussed in more detail below, para 2.20.

⁵⁰ For the definition of mental illness, see above para 1.18.

‘community treatment order’) within the community. The circumstances for involuntary admission to a mental health service are set out in section 8(1) of the Act:

A person may be admitted to and detained in an approved mental health service as an involuntary patient in accordance with the procedures specified in this Act only if:

- (a) the person appears to be mentally ill;⁵¹ and
- (b) the person's mental illness requires immediate treatment and that treatment can be obtained by admission to and detention in an approved mental health service; and
- (c) because of the person's mental illness, the person should be admitted and detained for treatment as an involuntary patient for his or her health or safety (whether to prevent a deterioration in the person's physical or mental condition or otherwise) or for the protection of members of the public; and
- (d) the person has refused or is unable to consent to the necessary treatment for the mental illness; and
- (e) the person cannot receive adequate treatment for the mental illness in a manner less restrictive of that person's freedom of decision and action.

2.17 Section 8(2) protects people from being detained and forced to undergo treatment simply because their views or behaviour do not conform to ‘mainstream’ views.⁵² The section also specifies that it is insufficient to show that a person has an intellectual disability,⁵³ for the involuntary detention provision to apply.

2.18 The circumstances for community treatment orders are set out in s 14(1A) of the Act:

- (a) the person appears to be mentally ill; and
- (b) the person's mental illness requires immediate treatment and that treatment can be obtained by making the person subject to a community treatment order; and
- (c) because of the person's mental illness, the person should be made subject to a community treatment order for his or her health or safety (whether to prevent a deterioration in the person's physical or mental condition or otherwise) or for the protection of members of the public; and
- (d) the person has refused or is unable to consent to the necessary treatment for the mental illness; and
- (e) the person cannot receive adequate treatment for the mental illness in a manner less restrictive of that person's freedom of decision and action.

A community treatment order may specify where the patient is to live, if this is necessary for the treatment of the patient's illness.⁵⁴

2.19 Provision is also made for a person who has been convicted of an offence to be made subject to a ‘restricted community treatment order’.⁵⁵ A restricted community treatment

⁵¹ See also the provisions allowing for the continued detention of a person who has been involuntarily admitted because of a mental illness, but who no longer satisfies the criteria in s 8(1), however, does have a ‘mental disorder’ (which may not be a mental illness): ss 12A–12D.

⁵² See above n 17.

⁵³ Section 8(2)(f).

⁵⁴ Section 14(2A).

order can be made if the person had been found guilty of an offence, has a mental illness and requires treatment and a court has made a hospital order under the *Sentencing Act 1991*.⁵⁶ If a hospital order has been made and the authorised psychiatrist believes that it is appropriate for the person, an application can be made to the chief psychiatrist for a restricted community treatment order.⁵⁷ The order must specify the psychiatrist who is to supervise the patient's treatment, where they are to receive it, the intervals at which they must attend for treatment, and the duration of the order.⁵⁸

2.20 The compulsory care and treatment provisions in the MHA contain a number of safeguards:

- Normally, involuntary detention is only permitted if the person requires 'immediate treatment' and if treatment is necessary to protect the person's health and safety or for the protection of members of the public.⁵⁹
- The provisions for involuntary treatment require that the person's mental illness is treatable and that appropriate treatment can be obtained through the proposed intervention.⁶⁰ In other words, detention in a psychiatric service, or a community treatment order, is not permitted if the intervention will not assist in the therapeutic treatment of the person's mental illness.⁶¹

⁵⁵ Section 15A. Where a person is subject to a hospital order under s 92 of the *Sentencing Act 1991* and she or he complies with the other criteria, then they can be subject to the 'restricted community treatment order' :s 15A(2).

⁵⁶ Sections 93. A hospital order requires the person's admission and treatment in an approved mental health service. The criteria for granting a hospital order are discussed in more detail below, paras 2.37–40.

⁵⁷ Section 15A(1). For a restricted order it is not necessary to show that the person's mental illness requires 'immediate' treatment. Restricted community treatment orders are not used frequently. There were only six initial reviews of such orders in the financial year 2000–01: Mental Health Review Board, *Annual Report* (2001).

⁵⁸ Section 15A(4).

⁵⁹ Where a person has been involuntarily detained under *Mental Health Act 1986* s 8, her or his continuing detention can be authorised if 'having regard to the person's recent behaviour, the person if not continued to be detained or treated, would cause serious physical harm to himself or herself. Continued detention can be authorised for up to three months and there is no limit on the number of three month extensions: s 12A–12D.

⁶⁰ Sections 12(2)(b), 14 (1A)(b), 15A(1)(a).

⁶¹ Some of the issues with respect to treatment under the MHA are discussed below, para 4.45.

- Involuntary detention of a person must be recommended by a medical practitioner following an examination of the person occurring not more than three days before admission.⁶²
- Within 24 hours of involuntary admission the person must be examined by a psychiatrist to determine whether the statutory criteria for involuntary admission are satisfied.⁶³
- Continued detention of a patient must be reviewed by the Mental Health Review Board (MHRB)⁶⁴ within eight weeks of the person's admission to hospital.⁶⁵
- A restricted community treatment order does not take effect, except for the purposes of an appeal or review, unless and until it has been approved by the MHRB.⁶⁶
- The MHRB must review any involuntary detention or renewal of a community treatment order at least once every 12 months.⁶⁷
- A patient, or a person acting on their behalf, can appeal at any time to the MHRB against involuntary detention or a community treatment order.⁶⁸
- The MHRB also has the power to hear appeals against the detention of involuntary and security patients.⁶⁹
- An extension of a community treatment order must be reviewed by the MHRB within eight weeks.⁷⁰

⁶² Section 9(1)(b).

⁶³ Section 12(1)(b).

⁶⁴ The MHRB is an independent tribunal established under the *Mental Health Act 1986 s 21*. The Board is constituted by a President and a number of other members. Many of the functions of the Board are the safeguards that are discussed in this section. The members, or the President, of the MHRB do not have to have specific qualifications in order to sit on the Board. However, the Minister must have regard, in nominating prospective members to the Governor-in-Council, to the need for the members to have the knowledge and experience necessary for the performing of the Board's functions: Schedule 1, s 2.

⁶⁵ Section 30(1)(a). Where a person's involuntary detention has been continued under s12C the Board must review the detention within 14 days of the decision of the Committee established to determine the application.

⁶⁶ Section 15A(9).

⁶⁷ Section 30(1)(b).

⁶⁸ Section 29.

⁶⁹ Section 22(1)(a).

⁷⁰ Section 30(1)(a) read with s 14(8).

Other provisions authorising compulsory care

2.21 There are other provisions for compulsory care in the *Health Act 1958* and the *Alcoholics and Drug-dependent Persons Act 1968*. These provisions can be applied to any person, but in certain situations they may provide a legal basis for compulsory care of people with intellectual disabilities or cognitive impairments who are not receiving care under the human services system. The safeguards applicable under these provisions are more extensive than those applicable under the IDPSA.

THE HEALTH ACT 1958

2.22 Section 121 of the *Health Act 1958* allows the restriction of a person's behaviour or movements for the purposes of the management and control of infectious diseases. Restrictive orders can only be made if the person has, or is reasonably likely to have, an infection which they are likely to transmit to others and which is a serious risk to public health. People dealt with under these provisions frequently have intellectual disabilities or cognitive disorders.⁷¹ If the Secretary of the DHS believes that this is the case, he or she may make an order requiring the person to be examined or tested for the disease. If the results of the test are positive and it is considered that the person is likely to transmit the disease and, further, that there is a serious risk to public health, a range of other orders may be made. These other orders include that people undergo counselling, that they stop engaging in particular behaviour that is likely to transmit the infection, or orders restricting their movement or isolating them to prevent the transmission of the infection to others. The *Health Act 1958* also provides that an isolation order must be reviewed after a period of not more than 28 days and the Act allows a person whose movement is

⁷¹ Information provided by Associate Professor David Green, School of Social Work, La Trobe University, former Public Advocate, personal communication, 10 May 2002.

restricted or who is isolated to apply to the Secretary for a review.⁷² Orders made by the Secretary may also be appealed to the Supreme Court.⁷³

THE ALCOHOLICS AND DRUG-DEPENDENT PERSONS ACT 1968

2.23 Under the *Alcoholics and Drug-dependent Persons Act 1968*, a complaint can be made to either the Supreme Court, County Court or Magistrates' Court by one of a number of specified people.⁷⁴ Where the complaint is accompanied by a certificate from a registered medical practitioner, the court can order that the person who is the subject of the complaint be admitted to an assessment centre. If, in the opinion of two medical practitioners and the medical officer in charge of the assessment centre, the person is suitable for treatment, they can be committed to the treatment centre.⁷⁵ A person committed to a treatment centre may appeal against the order.⁷⁶ The Commission has been advised that these provisions are rarely used and that many of the State Government institutions which had assessment facilities for people affected by alcohol or drugs have been closed down.⁷⁷

People who Come to the Attention of the Criminal Justice System

2.24 The previous section describes compulsory care provisions in legislation regulating the provision of services to people with disabilities. In this section we consider how the criminal justice system deals with people with intellectual disabilities or cognitive disorders whose behaviour may place them or others at risk. If people with intellectual disabilities or cognitive impairments commit criminal offences, they may be dealt with in a number of ways, which we discuss below.

⁷² Section 122(1).

⁷³ Section 122(3).

⁷⁴ Section 11.

⁷⁵ Section 12.

⁷⁶ Section 12(3).

⁷⁷ The institutions Pleasant View, Gresswell and Heatherton have all been closed: information provided by Dr Ruth Vine, Deputy Chief Psychiatrist, Mental Health Branch, Department of Human Services, 7 May 2002.

POLICE DISCRETION

2.25 The police may decide not to pursue charges because they do not believe that the prosecution would be successful (for example, because they do not believe that the person was capable of forming an intention to commit an offence).⁷⁸ In these circumstances, the police may tell carers or service providers that they are concerned about risks the person's behaviour may create for the person or others. As a result, the carer or service provider may limit people's freedom to come and go as they please, require them to participate in a behaviour management regime or ensure that they take medication. Such restrictions may occur even when a person's behaviour does not endanger others.

Case Study 3

Walter is a 25-year-old man with an intellectual disability. He lives in a staffed group house in the community. On a small number of occasions, he has sat on the front fence of the house masturbating. One of the neighbours notified police who attended Walter's house and spoke with him and the staff. The police decided not to lay charges because they believed that Walter was not able to understand that what he was doing was 'wrong' and that a conviction was therefore unlikely. They suggested to the staff, however, that they not permit Walter outside the residence unaccompanied. Because of low staffing ratios, and the support needs of other residents, there is often no one to accompany Walter when he wants to go outside. When this happens he must now stay indoors.

NO SPECIAL TREATMENT

2.26 People with intellectual disabilities may, and often are, convicted of offences and sentenced in the same way as other members of the community. Research into the

⁷⁸ This has been discussed in relation to the situation in New South Wales: New South Wales Law Reform Commission, *People with an Intellectual Disability and the Criminal Justice System*, Report 80 (1996) para 2.42.

sentencing outcomes for people with intellectual disabilities 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 intellectual disabilities within the prison system.⁷⁹ It is likely that there is a similar over-representation of people with cognitive disabilities. One explanation for the over-representation may be the lack of suitable services for the care and management of people with intellectual disabilities in the community. There may also be inadequate placement facilities for people who have committed offences.⁸⁰ People with intellectual disabilities who are inadequately cared for may move backwards and forwards between the criminal justice system and informal care networks provided by neighbours and family members.

COMPULSORY CARE

2.27 A court or in certain situations, the Adult Parole Board,⁸¹ may require people with intellectual disabilities to undergo compulsory care and treatment. In these situations people may have their freedom restricted because they have committed offences. There are several ways in which such a restriction may occur.

JUSTICE PLANS

2.28 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.⁸² The Act contains special provisions for people with intellectual disabilities who are convicted of offences. These provisions do not apply to people with other cognitive impairments, such as people with ABI. As a condition of a

⁷⁹ One New South Wales (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, above n 61, para 2.5.

⁸⁰ Ibid para 2.12.

⁸¹ See below para 2.41.

⁸² A penalty unit is currently \$100.

community-based order, the court may order that a person with an intellectual disability comply with services set out in a 'justice plan'.⁸³ The justice plan is drawn up by the DHS and sets out services that are designed to reduce the likelihood of the person committing further offences. Justice plans are not custodial orders; however a court can include, as part of the plan, a condition that the person live in a particular facility, or comply with a particular care regime, or both.⁸⁴ The court can order that a person comply with the services of the justice plan for a maximum of two years, or for the duration of the sentence that the person would otherwise have received, whichever is the shorter of the two.

2.29 The justice plan provisions do not apply unless the court considers that a community-based order would be appropriate. Another limitation is that these provisions apply only to people who are eligible for services under the IDPSA. The justice plan must be reviewed by the Secretary of DHS not later than one year after the sentence was imposed, and can be reviewed on application by the offender or the Secretary of the Department of Justice. If the court is satisfied that the justice plan is no longer appropriate, it can vary or cancel it. The Commission understands that the implementation of justice plans is not always effective, because of resource constraints in the disability service system.⁸⁵

TRANSFER FROM A PRISON TO A RESIDENTIAL INSTITUTION

2.30 If a person who is eligible for services under IDPSA has been convicted and sent to prison, the person may be transferred, as a 'security resident', from the prison to an appropriate residential institution.⁸⁶ 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

⁸³ Sections 80–3.

⁸⁴ If such a condition is breached, the offender will re-appear in court and may then be sentenced to a term of imprisonment. See, eg, *R v Glavocib* (Unreported, Supreme Court of Victoria, McGarvie, Beach and Ashley JJ, 5 September 1991).

⁸⁵ It has been found that there is a 'shortage of community based programs and community living support' (Disability Services' Criminal Justice Program, *Strengthening Service Provision* (2000) 12). These programs and supports are integral to the implementation of justice plans.

⁸⁶ Section 21.

Justice is satisfied that this is in the best interests of the person.⁸⁷ A security resident detained in a residential institution is subject to the security conditions considered necessary by the Secretary of the DHS.⁸⁸ The Intellectual Disability Review Panel (IDRP) must review the case of a resident within 12 months of the person becoming a security resident and thereafter at 12 month intervals.⁸⁹

2.31 A security order can be terminated by the Minister of Community Services at any time on the recommendation of the Secretary of DHS, or the IDRP.⁹⁰ If it is terminated and the person has not completed the prison sentence, they must be transferred to a prison.⁹¹ A person's status as security resident may also terminate at the end of the sentence, when they may be released.⁹² The person might, however, continue to live under the care of DHS on a voluntary basis after that period.⁹³ A guardian could consent to a person with an intellectual disability remaining under the care of DHS.⁹⁴

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

2.32 If a person has been found to be unfit to stand trial because of their 'mental impairment', or not guilty of a charge because they have a mental impairment, the court can make a range of orders to deal with that person. The *Crimes (Mental Impairment and Unfitness to Be Tried) Act 1997* (CMIA) attempts to balance the rights of people with mental impairments alleged to have committed offences and the need to protect other people. Under the

⁸⁷ Section 21(7). This subsection also specifies the matters which should be taken into account when making the decision.

⁸⁸ Section 38; see also s 41 which empowers the Minister to allow a security resident to be allowed leave of absence from the residential institution on the recommendation of the IDRP and s 42 which allows a security resident to apply to the Secretary for special leave of absence not exceeding 24 hours. If the Secretary refuses a special leave of absence, the person can apply to the IDRP for a review of the decision: s 42(4).

⁸⁹ Section 36.

⁹⁰ Section 37(1).

⁹¹ Section 37(2)(a).

⁹² Section 37(1)(b).

⁹³ If a person continues to be eligible under the *Intellectually Disabled Persons' Services Act 1986* after their security order has been terminated, the Secretary of the DHS must ensure that a general service plan is prepared for that person: s 37(4).

⁹⁴ See below paras 2.44–5.

CMIA, a person may have a mental impairment because they have a mental illness, an intellectual disability or a cognitive impairment.⁹⁵

2.33 Unfitness to stand trial⁹⁶ is determined by a jury specifically empanelled for that purpose on the basis of evidence put to it by both the prosecution and the defence, which can include expert testimony from an appropriate medical practitioner or psychologist.⁹⁷ A person who is tried for an offence must be acquitted if, at the time of the offence, they did not know the nature or quality of their conduct, or did not know that it was wrong.⁹⁸

2.34 Where a person is found unfit to stand trial, or found not guilty because of their impairment, the CMIA provides for two forms of supervision orders.⁹⁹ The first is a custodial supervision order where the person can be placed in an ‘appropriate place’,¹⁰⁰ or, if there is no other alternative, committed to custody in a prison.¹⁰¹ The person may also be released, under a non-custodial supervision order, on conditions specified by the court. The conditions could require the person to live in a particular place (which need not be a residential service provided under the IDPSA) or to undergo treatment.¹⁰²

⁹⁵ The Act does not define ‘mental impairment’, but instead sets out when a person is ‘unfit to be tried’ or must be found not guilty because of mental impairment.

⁹⁶ Section 6(1) states that:

‘a person is unfit to stand trial for an offence if, because the person’s mental processes are disordered or impaired, the person is or, at some time during the trial, will be-

(a) unable to understand the nature of the charge; or

(b) unable to enter a plea to the charge and to exercise the right to challenge jurors or the jury; or

(c) unable to understand the nature of the trial (namely that it is an inquiry as to whether the person committed the offence);

or

(d) unable to follow the course of the trial; or

(e) unable to understand the substantial effect of any evidence that may be given in support of the prosecution; or

(f) unable to give instructions to his or her legal practitioner’.

⁹⁷ Section 7. If a jury finds that a defendant is fit to stand trial, the judge then determines whether the defendant is likely to be fit to stand trial within the next 12 months. If the judge determines that the defendant will be fit, he or she may grant the defendant bail or remand the defendant in custody in either an ‘appropriate place’ or a prison, depending on the circumstances: s 12(2). If the judge determines that the defendant is not likely to be fit to stand trial within 12 months, the court must proceed to a ‘special hearing’ under Part 3 of the Act: s 12(5). The available findings at a special hearing are ‘not guilty of the offence charged’, ‘not guilty of the offence because of mental impairment’ and that the defendant ‘committed the offence charged or an offence available as an alternative’: s 17(1). A finding at a special hearing that the defendant committed the offence constitutes a ‘qualified finding of guilt’: s 18(3). If the jury makes such a finding, the judge must either declare that the defendant is liable to supervision orders under Part 5 of the Act or order that the defendant be released unconditionally: s 18(4).

⁹⁸ Section 20.

⁹⁹ The provisions relating to supervision orders are contained in Part 5.

¹⁰⁰ Section 26(2)(a). An ‘appropriate place’ is defined as a residential service (for people with intellectual disabilities) or an approved mental health service (for people with a mental illness): s 3.

¹⁰¹ Section 26(4).

¹⁰² Section 26(2)(b).

2.35 A person with an intellectual disability is known as a ‘forensic resident’ if, under the CMIA, she or he is ordered by the court to be detained in a residential service that is provided under the IDPSA, or is transferred to such a service from prison.¹⁰³ Forensic residents will be detained at the Plenty Residential Service in the long-term rehabilitation program. Where a person with a mental illness is detained under the CMIA in an approved mental health service, the person is known as a ‘forensic patient’.¹⁰⁴ Forensic patients will usually be detained at Thomas Embling Hospital in Fairfield, the primary forensic care facility for people with mental illnesses.

2.36 A supervision order, whether it be a custodial or non-custodial supervision order, is for an indefinite term.¹⁰⁵ However, there are 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 for which the person had been charged.¹⁰⁶ Either the person against whom the supervision order is made, or the Director of Public Prosecutions, can appeal against a supervision order.¹⁰⁷ The provisions requiring review of the supervision order provide important protection for people with mental impairments.

¹⁰³ Section 3. According to the Vincent Report, ‘provisions for the care of security residents have not been used since the three residents, previously detained at the Governor’s Pleasure came under the operation of the CMIA in April 1998 and were transferred to another facility’, above n 7, 27.

¹⁰⁴ Section 3.

¹⁰⁵ Section 27(1). Under new amendments to the CMIA (*Forensic Health Legislation (Amendment) Act 2001*) which, as of 1 May 2002 have not come into operation but must do so by 1 July 2002 (*Forensic Health Legislation (Amendment) Act 2001 s 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: s 27(2).

¹⁰⁶ For a murder offence, 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 murder, manslaughter, rape and kidnapping) 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: s 28.

¹⁰⁷ Section 26(5). Under the amendments in the *Forensic Health Legislation (Amendment) Act 2001*, s 26(5) is to be repealed. However, the appeals procedures are included in a new s 28A. In this section, the person who is subject to the order and the Director of Public Prosecutions retain the right to appeal. In addition, the Attorney-General and the Secretary of DHS are also given the right to appeal. The provisions in these amending sections were not in operation as of 1 May 2002, but must be in operation by 1 July 2002: s 2.

HOSPITAL ORDERS

- 2.37 Hospital orders are a sentencing option under the *Sentencing Act 1991* for people with mental illnesses who have been found guilty of offences.¹⁰⁸ Because the offender must have a mental illness,¹⁰⁹ they do not apply to a person with an intellectual disability, except where the person has a mental illness as well. A hospital order can only be made if the person has a mental illness and requires treatment, the treatment can be obtained by detaining the person in an approved mental health service and admission and detention is necessary for the person's health or safety 'whether to prevent deterioration in the person's physical or mental condition or otherwise or for the protection of members of the public'.¹¹⁰ There are two forms of such orders, hospital orders and hospital security orders.¹¹¹
- 2.38 Where an offender is made subject to a hospital order, the court, 'instead of passing sentence',¹¹² will direct the offender to be admitted to an approved mental health service for detention as an involuntary patient. The offender is then subject to the mental health care system and does not need to return to the court. The purpose of hospital orders is therapeutic¹¹³ and such orders last for an indeterminate period. These orders are used sparingly because the court has no further role to play once the order has been made, when the general provisions relating to discharge of involuntary patients apply.¹¹⁴
- 2.39 As an alternative, an offender can be made subject to a hospital security order 'by way of sentence', if, but for the mental illness of the person, the court would have sentenced the

¹⁰⁸ *Sentencing Act 1991* s 93(1).

¹⁰⁹ As such, they are not available for offenders who have intellectual disabilities. However, hospital orders are discussed here to provide more background as to the manner in which compulsory care can be applied in Victoria currently.

¹¹⁰ *Sentencing Act 1991* s 93(1)(b)(iii).

¹¹¹ *Sentencing Act 1991* s 93(1)(d), 93(1)(e). There are also assessment orders (s 90) which last for up to 72 hours that are solely for the purpose of assessment and there are diagnosis, assessment and treatment orders (s 91) which can be up to three months in duration.

¹¹² *Sentencing Act 1991* s 93(1)(d).

¹¹³ Richard Fox and Arie Freiberg, *Sentencing—State and Federal Law in Victoria* (2nd ed, 1999) para 10.206.

¹¹⁴ *Ibid.*

offender to a term of imprisonment.¹¹⁵ A hospital security order must not be for a longer period than the period of imprisonment would have been if the offender had been sentenced to detention.¹¹⁶ If a person subject to a hospital security order is discharged as a security patient, that is, if they are no longer considered to have a treatable mental illness, then they have to serve the unexpired portion of the sentence in a prison.¹¹⁷

2.40 The hospital order provisions applicable to people with mental illnesses may be contrasted with the provision for justice plans which apply to people with intellectual disabilities. Justice plans cannot operate for longer than two years. People on hospital orders may be detained for longer periods. However, in the case of those on hospital security orders the detention cannot exceed the sentence they would otherwise have received and in the case of those on hospital orders who are detained indefinitely, the MHA safeguards apply.

PAROLE CONDITIONS

2.41 Section 74 of the *Corrections Act 1986* allows the Adult Parole Board to set terms and conditions when any prisoner is released on parole. When the prisoner is a person with an intellectual disability or a cognitive impairment, those terms and conditions could include an order that she or he resides in a particular place or complies with a particular service regime.¹¹⁸ The terms and conditions will expire when the parole period comes to an end. A person may continue to live at the residential facility, or to comply with the service regime, on a voluntary basis, once the parole period has been completed. A guardian might consent to this. However, if no guardian is appointed and the person refuses treatment, the person cannot be detained or treated without consent, even if the

¹¹⁵ *Sentencing Act 1991* s 93(2).

¹¹⁶ *Sentencing Act 1991* s 93(3).

¹¹⁷ *Sentencing Act 1991* s 93(5). The *Mental Health Act 1986* has been amended by the *Forensic Health Legislation (Amendment) Act 2001* with respect to the clinical guidelines for the discharge of security patients. The details of these amendments are not significant to this Discussion Paper. In addition, *Sentencing Act 1991* s 93(4) and (6) relate to the parole provisions for offenders subject to a hospital security order.

¹¹⁸ Vincent Report, above n 7, 8.

behaviour places him or her or others at risk, unless they come within the MHA provisions allowing involuntary treatment.

COMPULSORY CARE AFTER THE COMPLETION OF A SENTENCE

2.42 There are no provisions for the continuation of compulsory care after the expiry of the sentence for offenders with intellectual disabilities or cognitive impairments which are not mental illnesses.¹¹⁹ In other words, their position is the same as that of other offenders who have served their sentences. For offenders who have mental illnesses, the provisions for hospital orders¹²⁰ and the provisions of the MHA can be applied to ensure that they continue to receive necessary treatment, in order to reduce the risk of them harming themselves or others.

The Guardianship and Administration Act 1986

2.43 So far, we have discussed the controls applicable to restraint and seclusion under the IDPSA and how the criminal justice system provides for compulsory care of people with intellectual disabilities or cognitive impairments. Care and treatment may also be authorised by a guardian.¹²¹ Guardians are appointed under the *Guardianship and Administration Act 1986* (GAA), following an application to the Victorian Civil and Administrative Tribunal (VCAT).¹²² Guardians act as substitute decision makers for people who, because of disabilities,¹²³ need assistance in making decisions. For example, a guardian may consent to hospitalisation or medical treatment on behalf of a person who lacks the capacity to consent. A member of the person's family, a friend, another member

¹¹⁹ If a person with a mental impairment is sentenced to an indefinite sentence (*Sentencing Act 1991* s 18A), the compulsory 'care' of the offender would extend past the term of imprisonment that would usually be enforced for the offence committed.

¹²⁰ See above paras 2.37–40.

¹²¹ For example, Part 4A of the Act outlines the provisions for the authorisation of medical and other treatment.

¹²² Section 19(1). The application is heard in the specialist guardianship list of the human rights division of the Tribunal: Victorian Civil and Administrative Tribunal Rule 2.03. The Tribunal is constituted by a President (who must be a judge of the Supreme Court) (*Victorian Civil and Administrative Act 1998* s 10), Vice Presidents (who must be judges of the County Court) (s 11), Deputy Presidents (who must have been admitted to legal practice in Victoria for not less than five years) (s 12), senior members (who must have been admitted to legal practice in Victoria for not less than five years or who have extensive knowledge or experience in an area that is subject to the Tribunal's jurisdiction) (s 13) and ordinary members (who must be legal practitioners in Victoria or who must have special knowledge in an area that is subject to the Tribunal's jurisdiction) (s 14).

¹²³ In s 3 of the Act, 'disability' in relation to a person means intellectual impairment, mental disorder, brain damage, physical disability or dementia.

of the community or the Public Advocate may apply to the VCAT for appointment as a guardian.

Case Study 4

Abdul is a 24-year-old-man who has a mild intellectual disability. He has very poor impulse control as well as poor capacity to appreciate the possible consequences of his actions. Abdul has had a tendency to put himself in situations where he is extremely vulnerable to assault and other forms of abuse. He will, for example, go into pubs and fight with people, without any real sense of the danger in which he is putting himself. As a result, he has been quite seriously injured on several occasions. Abdul's parents therefore made an application to the VCAT, where a decision was made to appoint the Public Advocate as his guardian with power to make decisions regarding Abdul's accommodation. The only secure accommodation that is available for Abdul is an institution. In the interests of Abdul's own safety, but despite Abdul's vocal refusal to go of his own accord, the Public Advocate, as Abdul's guardian, consented to his placement in the institution.

2.44 A guardianship order can only be made if the VCAT is satisfied that the person in respect of whom the application is made has a disability, and is unable by reason of the disability to make reasonable judgments in respect of all or any of the matters relating to his or her person or circumstances.¹²⁴ The appointment must be in the best interests of the person with the disability.¹²⁵ The order may limit the powers of the guardian to particular life areas (a limited guardian), such as housing or health care.¹²⁶ Alternatively, the guardianship order may give the guardian the same decision-making powers that a parent would have over her or his child (a plenary guardian).¹²⁷

¹²⁴ Section 22(1).

¹²⁵ Section 22(3).

¹²⁶ Section 25.

¹²⁷ Section 24.

- 2.45 In some cases, the main purpose of appointing the guardian is to deal with the behaviour of people with intellectual disabilities or cognitive impairments which is placing them or others at risk. A guardian may consent to medical treatment, for example the prescription of sedatives, on behalf of the person.¹²⁸ Guardians may also decide that people should be placed in residential facilities, because they cannot look after themselves or because they may harm others without proper supervision. A guardianship application could also be made when a person with an intellectual disability is being released from prison after have serving a sentence for an offence, because it is believed that the person should be placed in a residential facility to prevent her or him harming others.
- 2.46 In these situations, the VCAT may appoint a guardian for the purposes of consenting to the services, and to a particular care regime, on behalf of the person. This may mean that the outcome for the person is that they may be living in a residential setting, or be receiving some form of medication or physical restraint, to which they have not consented but to which the guardian has consented on their behalf. The person's formal status, however, will be as a voluntary client of those services.
- 2.47 A guardian can only be appointed if the person has a disability, which covers an 'intellectual disability, mental disorder, brain injury, physical disability or dementia'.¹²⁹ People with some types of cognitive impairment (for example, some types of personality disorder) may not satisfy this criterion, even though their behaviour places them or others at risk. Concerns have also been expressed about the use of guardians to make decisions

¹²⁸ If the dosage of the sedative does not amount to chemical restraint then it does not have to be reported to the IDRP (if the person has not been assessed as being eligible under the *Intellectually Disabled Persons' Services Act 1986* there is no need for reporting at all). See below paras 2.50–1 for discussion of 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 the *Guardianship and Administration Act 1986* Part 4A.

¹²⁹ Section 3.

about involuntary treatment and detention¹³⁰ where the main purpose of the treatment is to prevent others being harmed.

2.48 There may be a conflict between acting in the best interests of the person with an intellectual disability and making decisions which are primarily designed to protect the community. For example, a guardian may be placed in an invidious position if he or she is 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 them from harming other people in the residential facility, because staff shortages make it difficult to adequately supervise clients. Similar difficulties arise where the primary motivation for confining a person is because they are difficult to manage and there are no other ways in which they can be supervised.¹³¹

SOME PROBLEMS WITH THE PRESENT SYSTEM

2.49 In this section we identify some gaps, limitations and inconsistencies in the current legal system, which are relevant to people with intellectual disabilities or cognitive impairments, who may be at a risk to themselves and others. These include:

- lack of clear legislative criteria to determine when regulating compulsory care and treatment of people with intellectual disabilities or cognitive disorders, is appropriate;
- limited provision for challenging decisions about compulsory care or treatment of people with intellectual disabilities or cognitive disorders;
- inconsistencies in the treatment of people falling into different diagnostic categories who are at risk of harming themselves or others, under the criminal justice and human services systems;

¹³⁰ According to the Vincent Report, the GAA is 'under-developed in relation to the compulsory treatment and care of people with an intellectual disability': above n 7, 12.

¹³¹ See below for further discussion about the problems associated with the current guardianship framework, paras 2.57–60.

- questions about the use of guardianship to deal with compulsory care and treatment issues;
- reliance on consent which is not true consent; and
- conflicting obligations of service providers.

Each of these issues is briefly discussed below.

Lack of Clear Legislative Criteria

2.50 Unlike the MHA, the IDPSA does not contain criteria indicating when compulsory care of people with intellectual disabilities is permitted. The only controls on care without consent are the requirement for preparation and approval of individual program plans and the controls on use of ‘mechanical and chemical’ means of restraint and or seclusion.¹³² Although the DHS has guidelines for the use of restraint and seclusion,¹³³ the only legislative safeguard applicable to use of mechanical or chemical restraint is that it must be reported to the IDRP at the end of each month.¹³⁴ The term ‘restraint’ is not clearly defined. As a result, service providers may lack a clear understanding of what controls amount to restraint within the Act and may make inconsistent decisions about the use of restraint and the requirement to report it.¹³⁵

Case Study 5

Sunny Hills is a staffed group home for people with intellectual disabilities. Six adults live there. Two of the residents have aggressive behaviours that require them to be restrained from time to time, and prevented from leaving the house. When this is the case, the staff lock the doors of the

¹³² *Intellectually Disabled Persons’ Services Act 1986* s 44.

¹³³ See above n 33.

¹³⁴ See above para 2.10.

¹³⁵ It has been noted by Sue Tait, President of the Intellectual Disability Review Panel, and John Lesser that ‘there is no “Chief Psychiatrist” or “Senior Clinician” in the disability system to provide expert professional advice, leadership or mentoring for service providers. There is no system for auditing intellectual disability services. Unlike the *MHA* and the *Health Services Act 1988*, there are no quality assurance provisions in the *IDPSA*’. Sue Tait and John Lesser (President of the Mental Health Review Board), ‘Disability Law Reform’, (unpublished paper based on a conference presentation at the Guardianship and Administration National Conference, Melbourne, 19 October 2001).

house so that no one is able to leave. They always report this to the IDRP, but only with respect to the person for whom they are locking the doors. No report is submitted for the remaining residents, even though they are also being restrained in the same way.

2.51 The term ‘chemical constraint’ is also ambiguous. Drugs can be prescribed for the purpose of reducing a person’s agitation or for the purpose of sedating a person who is ‘a nuisance’ to manage in a residential context. If the person has a mental illness as well as an intellectual disability, treatment could include the prescription of anti-psychotic drugs, which may have the effect of modifying behaviour. So long as this is described as treatment, it need not be reported to the IDRP. If it is characterised as ‘chemical restraint’ the reporting obligation applies.

2.52 Current processes for caring for people with intellectual disabilities lack transparency and fail to consider how the rights and liberties of people are affected. People with intellectual disabilities lack access to the protections, advocacy and rights of review that are normally available to those who are at risk of having their liberties restricted. This may be contrasted with the situation of people who have mental illnesses, where a clear process for involuntary care and treatment is set out in the MHA. The Vincent Report commented that it is ‘essential that any restrictions on a person’s liberty is governed by a clear statutory framework that ensures a person’s rights are preserved’.¹³⁶

Lack of Independent Review of Treatment and Detention Decisions

2.53 As we have seen, current legislation provides for independent review of decisions to detain or compulsorily treat people with mental illnesses or infectious diseases. Mechanisms for review prevent such powers being abused and safeguard people against deprivation of their freedom without justification. The recent review by the Auditor-General indicated that the IDRP does not provide the level of active monitoring

¹³⁶ Above n 7, 12.

necessary to provide adequate safeguards for the use of restraint and seclusion. Although a person can apply for a review of a decision relating to detention or care, or admission to use restraint or seclusion, relatively few applications are made.¹³⁷ In addition, there is no power under the IDPSA for the IDRPs to initiate its own reviews. The Auditor-General has also suggested that review procedures as they are do not provide an adequate monitoring process.¹³⁸ In any event, the IDRPs does not have determinative powers and when hearing a review can only make recommendations to the Secretary of DHS.¹³⁹ In other words, there is no effective review of compulsory care decisions relating to people with intellectual disabilities, except where the compulsory care has been ordered under the provisions of the *Crimes (Mental Impairment and Unfitness to Be Tried) Act 1997* (CMIA) or the *Sentencing Act 1991*.¹⁴⁰

Inconsistencies in the Treatment of People in Different Diagnostic Categories

2.54 The current disability services and criminal justice systems deal differently with people on the basis of the clinical diagnosis of their impairment. The following are examples of differences arising from diagnostic categories.

- Justice plans apply only to people who are eligible for intellectual disability services because they come within the IDPSA definition. People who fall outside this definition are not entitled to justice plans, although they may have similar behaviour management needs to people with intellectual disabilities.
- People with an acquired brain injury and people with autistic spectrum disorder¹⁴¹ may not be eligible for services under the IDPSA or the MHA, because they do not have a

¹³⁷ Auditor-General's Report, above n 9, para 4.54.

¹³⁸ Ibid para 4.56.

¹³⁹ Vincent Report, above n 7, 23.

¹⁴⁰ See discussion of the CMIA, above paras 2.32–6. An exception to this is where the person with an intellectual disability also has a mental illness. If that person is receiving treatment for the mental illness under the *Mental Health Act 1986*, the review procedures for treatment under the Act would apply.

¹⁴¹ Autistic spectrum disorder has been described in the High Court as 'the presence of markedly abnormal or impaired development in social interaction and communication and a markedly restricted repertoire of activity and interests': *DP v*

mental illness or an intellectual disability. However, their behaviour may involve risk to themselves or others. The current system is also ill-equipped to deal with people with dual disabilities.¹⁴²

- There is clear legislative authorisation for compulsory detention and treatment of people who have mental illnesses and who have not been charged with criminal offences, but no similar authorisation for compulsory detention and treatment of people with intellectual disabilities, even if their behaviour involves risk to themselves or others.¹⁴³
- Where a person with an intellectual disability is convicted of an offence involving harm to others, there is no legal framework for detaining or treating the person without consent, other than the provisions relating to justice plans. By contrast, a hospital order can be made allowing a person whose mental illness places them at risk of harming others to be involuntarily detained or treated.
- There is no framework for detaining or treating people with intellectual disabilities or cognitive impairments without their consent after they have served sentences for offences, other than the provisions permitting appointment of guardians.

2.55 The differences in treatment of people with mental illnesses and people with intellectual disabilities is the result of policy changes made in the 1980s.¹⁴⁴ Lobby groups and policy-makers sought to change community perceptions that mental illness and intellectual disability were the same thing. Service providers aimed to integrate people with intellectual disabilities into the community, to care for them outside institutions and to

Commonwealth Central Authority; JLM v Director-General NSW Department of Community Services [2001] HCA 39, para 47, citing American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* (4th ed, 1994).

¹⁴² It has been noted that the needs of people with intellectual disabilities and mental illnesses are 'often ignored because they fall between [the] two areas of service delivery': Human Rights and Equal Opportunity Commission, *Human Rights and Mental Illness*, Report of the National Inquiry into the Human Rights of People with Mental Illness (1993) 660 (also referred to as the Burdekin Report).

¹⁴³ In the development of the *Intellectually Disabled Persons' Services Act 1986* there was clear consideration of this issue, where it was argued that issues of a risk of harm to a person with an intellectual disability are most appropriately dealt with through guardianship. See *Report of the Committee on a Legislative Framework for Services to Intellectually Disabled Persons* (1984) 150–7.

¹⁴⁴ For a discussion of the recent history of service development in this area, see the Auditor-General's Report, above n 9, paras 2.5–6, Table 2A and Tait and Lesser, above n 135.

ensure that intellectual disability was no longer treated simply as a medical condition. As a result of these changes, different service requirements and different safeguards came to apply to people with mental illnesses and people with intellectual disabilities, though sometimes individuals in different diagnostic categories have similar needs.

2.56 In some situations it will be appropriate for people with different conditions to be dealt with separately, because they have different needs. In addition, people with mental illnesses or intellectual disabilities may have very different reasons for failing to consent to treatment. In Chapters 4–6 we consider the extent to which it is appropriate to distinguish between the safeguards applicable to compulsory care of people who fall into different diagnostic categories.

Case Study 6

Christopher and Jamie are both in their mid thirties and have been friends since they were children. Their behaviour causes concern about their own safety and the safety of others. They spend a lot of time on the streets, are often homeless, and have at times threatened other members of the community in quite aggressive ways. Jamie has generally been the leader in these incidents, telling Christopher that other people are out to get them and if they do not defend themselves they are likely to be harmed. Christopher generally does what Jamie suggests, without giving much thought to what he is telling him.

It is only after their behaviour is eventually brought to the attention of the police that both Jamie and Christopher are formally assessed. Jamie is found to have schizophrenia and to be in need to medical treatment to stabilise his illness. Christopher, on the other hand, is diagnosed as having a mild intellectual disability and is seen to require some support and behaviour management programs to enable him to develop more independent living skills. Neither Jamie nor Christopher wish to comply with these service options.

Because Jamie's diagnosis is one of mental illness, he may be involuntarily detained and treated if that is likely to assist in the treatment of his mental illness. Even though it is likely that a behaviour management program might assist Christopher, there are no provisions for that to be provided without his consent, or the consent of a guardian appointed to make decisions on his behalf. There is an inconsistency between the law's response to Jamie and its response to Christopher, where the only actual difference between their circumstances is the nature of their diagnoses.

Use of Guardianship

2.57 We have already noted some potential problems about the current practice of using guardianship as a means of compelling a person to comply with a care regime.¹⁴⁵ It is arguable that the use of guardianship to enforce a care regime because of the potential risk that the person poses to others rather than to him or herself, is an inappropriate use of guardianship and one that lies outside of the intent of the GAA.

2.58 It can, of course, be argued that such a decision *is* in the best interests of the person as it would be against their best interests to be convicted and sentenced for an offence. However, many people in the community, whether or not they have a cognitive impairment, commit offences without coming to the attention of the police. Further, as we noted above, police already exercise their discretion not to charge people with intellectual disabilities for minor offences.¹⁴⁶ Whatever view is taken on this question, it illustrates the difficulty arising for a guardian who is appointed to make decisions in the best interests of the person with the mental impairment, but who has to weigh those interests against other, potentially conflicting, interests.

2.59 Problems also arise where a person's behaviour puts them at risk. For example, where people engage in behaviour that puts them at considerable risk of physical or sexual

¹⁴⁵ See above paras 2.47–8.

¹⁴⁶ See above para 2.25.

assault. On the basis of existing resources, the only way of ensuring their safety might be for them to be placed in a secure living environments where their freedom is restricted and they are unable to have unsupervised access to the community.

2.60 In this scenario, it is clearer that the guardian is acting in the person's best interests. However, it is also arguable that the need for that decision to be made arises because the service system has been unable to offer the person an option that is both acceptable to them and safe. A person's refusal to live in a secure facility may be reasonable in this situation. This creates conflicts and tensions for the guardian who is in a position of being required to consent to compulsory care not so much because of the person's lack of decision-making capacity, but because of the inadequacies of the service system.

Reliance on 'Voluntary' Consent

2.61 It has been argued that the 'voluntariness' of the framework in place under the IDPSA is 'fictional'.¹⁴⁷ At present in Victoria, there are thousands of people who have been identified by service providers as having little or no effective communication.¹⁴⁸ When people with intellectual disabilities cannot effectively communicate their desire not to receive treatment or participate in programs, their silence does not mean consent. In circumstances where a person with an intellectual disability cannot communicate and they do not have a legally appointed guardian, there is no system for the protection of their rights.¹⁴⁹

¹⁴⁷ Tait and Lesser, above n 135.

¹⁴⁸ The figure supplied by service providers in May 1999 was 4865: Disability Service Branch, Department of Human Services, *Victorian Services for People with Disabilities 1999* (2000) 60. This figure is not limited to people with intellectual disabilities.

¹⁴⁹ Tait and Lesser, above n 135.

Conflicting Obligations of Service Providers

2.62 Similarly, there can be considerable confusion and tension between the various roles that a service provider might be required to play in relation to compulsory care. Such a conflict may arise where:

- a person is subject to a justice plan and the service provider is required to support them as well as to monitor compliance with the plan; or
- an officer of the service provider authorises the use of restraint and seclusion under the IDPSA because of obligations to other clients.

2.65 The Commission will be seeking views on the extent to which these apparent tensions create practical problems.

Chapter 3

Principles and Policy Issues

PRINCIPLES UNDERPINNING A NEW SYSTEM

3.1 In recommending changes to the laws regulating compulsory care for people with intellectual disabilities or cognitive impairments, it is important to identify the principles on which the new system should be built. In some countries, human rights principles are included in a Bill of Rights. Australia does not have a Bill of Rights. However, there are a number of other possible sources of guidance. These include:

- international human rights instruments, such as the *Declaration on the Rights of Mentally Retarded Persons*,¹⁵⁰ the *Declaration on the Rights of Disabled Persons*¹⁵¹ and the *International Covenant on Civil and Political Rights*,¹⁵² and
- Victorian legislation, including the *Intellectually Disabled Persons' Services Act 1986* (IDPSA), the *Disability Service Act 1991* (DSA) and the *Mental Health Act 1986* (MHA).

3.2 Provisions regulating compulsory care and treatment should also be consistent with the policy principles set out in the Draft State Disability Plan. The Final State Disability Plan will provide a comprehensive framework for the future provision of disability supports in Victoria.

3.3 The international instruments and legislation mentioned above suggest that compulsory care and treatment laws should be based on four broad principles:

¹⁵⁰ Proclaimed by the United Nations General Assembly, Resolution 2856 (XXVI), 20 November 1971, incorporated into Australian law by the *Human Rights and Equal Opportunity Commission Act 1986* (Cth), Schedule 4.

¹⁵¹ 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), Schedule 5.

¹⁵² 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, December 1988.

- 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;
- preventing exploitation and abuse of people with intellectual disabilities or cognitive disorders; and
- preventing harm to other members of the community.

Maximising Social Participation and Ensuring Quality of Life

3.4 Both the *Declaration on the Rights of Mentally Retarded Persons* and the IDPSA recognise that people with intellectual disabilities should have access to resources to enable them to exercise their capacities to the fullest extent possible and to participate meaningfully in the life of the community. For example, the IDPSA recognises that:¹⁵³

- every person with an intellectual disability has a capacity for physical, social, emotional and intellectual development and is entitled to exercise maximum control over every aspect of his or her life;
- the needs of intellectual disabled persons are best met when the conditions of their every day life are the same as, or as close as possible to, norms and patterns which are valued in the general community, and
- services should promote physical and social integration of people with intellectual disabilities into the community.

3.5 Similar principles apply to people with cognitive impairments under the *Declaration on the Rights of Disabled Persons*. The Declaration provides that people with disabilities 'have the same fundamental rights as their fellow citizens of the age, which implies ... the right to

¹⁵³ Section 5.

enjoy a decent life, as normal and full as possible'.¹⁵⁴ The Draft State Disability Plan, through its guiding principles of 'equality, dignity and self-determination, diversity and non-discrimination' also recognises the right of people with disabilities to participate fully in the life of the community.¹⁵⁵

- 3.6 It follows from these principles that people with intellectual disabilities or cognitive impairments should, to the fullest extent possible, be able to make their own decisions about such matters as their medical treatment, where they will live, and how they will participate in the life of the community. In situations where compulsory care is justified because the person's behaviour places him or her or others at risk, they are entitled to an appropriate standard of care and to participate to the full extent of their capacity in decision making.

Recognising and Safeguarding Rights and Liberties

- 3.7 Both the *Declaration on the Rights of Mentally Retarded Persons*¹⁵⁶ and the *Declaration on the Rights of Disabled Persons*¹⁵⁷ provide that people with disabilities are to have the same civil and political rights as all other people.¹⁵⁸ Under the *International Covenant on Civil and Political Rights* (ICCPR) these civil and political rights include the right to liberty and security of the person.¹⁵⁹ A person is not to be deprived of his or her liberty except on such grounds and in accordance with such procedures as are established by law. The ICCPR also requires that people deprived of their liberty should be treated with humanity and with respect for the inherent dignity of the human person.¹⁶⁰

¹⁵⁴ *Declaration on the Rights of Disabled Persons*, cl 3.

¹⁵⁵ Department of Human Services, Victoria, *Draft State Disability Plan* (2001) 27–8.

¹⁵⁶ *Declaration on the Rights of Mentally Retarded Persons*, cl 1.

¹⁵⁷ *Declaration on the Rights of Disabled Persons*, cl 4.

¹⁵⁸ The *Declaration on the Rights of Mentally Retarded Persons* clause includes the qualification: 'to the maximum degree of feasibility'.

¹⁵⁹ Article 9.

¹⁶⁰ Article 10.

3.8 In the past, the common law has permitted care or treatment of people without their consent, in order to protect them from harm.¹⁶¹ Human rights principles also allow a person's rights and liberties to be restricted in order to protect him or her or others from harm, as long as the measures do not go beyond what is necessary and reasonable in the circumstances in order to prevent the individual or to safeguard the rights and liberties of others.¹⁶² For example, in a decision considering the effect of Article 5 of the *European Convention of Human Rights*,¹⁶³ the European Court of Human Rights recognised that people may be deprived of their liberty

either in order to be given medical treatment or because of considerations dictated by social policy, or on both medical and social grounds ... a predominant reason why the Convention allows the persons mentioned in paragraph 1(e) of Article 5 to be deprived of their liberty is not only that they are dangerous for public safety but also that their own interests may necessitate their detention.¹⁶⁴

3.9 In a similar way, the *Declaration on the Rights of the Mentally Retarded Persons* recognises that people may be unable to exercise all their rights in a meaningful way because of the severity of their handicap and that it may become necessary to restrict or deny some of those rights.¹⁶⁵

3.10 However, where this is the case, the restriction should be as limited as possible. This principle is reflected in the IDPSA and the MHA, which provide that where a restriction

¹⁶¹ The state, under the doctrine of *parens patriae* (literally translated as 'parent of the country'), had an obligation to protect people who cannot look after themselves, including children and mentally incapacitated adults. The origin of the doctrine is said to be the 'sovereign's feudal obligation ... to protect the person and property of his subjects, particularly those unable to look after themselves': *Fountain v Alexander* (1982) 150 CLR 615, 633, Mason J. Some United States decisions in the area also discuss *parens patriae*, eg, *Cruzan v Director, Missouri Department of Health* (1990) 497 US 261, 281. English courts have also discussed the doctrine of necessity with respect to the making of decisions to protect the welfare of mentally incapacitated adults: see, eg, *In re F (Adult: Court's Jurisdiction)* [2000] 3 WLR 1740.

¹⁶² The United States Supreme Court has considered the constitutionality of various State laws under the Fifth Amendment to the United States Constitution which provides that 'No person shall ... be deprived of life, liberty, or property, without due process of law'. Most cases are concerned with 'procedural due process' rather than the substance of the relevant law which prevents deprivation of liberty. See, however, *Foucha v Louisiana* 504 US 71, 86 (1992) which indicated that with 'freedom from restraint being a fundamental right, the State must have a particularly convincing reason' to restrict these liberties. In a decision based on the incarceration of an individual with an IQ of between 8–10, the United States Supreme Court reinforced the notion that under the substantive aspect of the due process clause, restrictions on liberty could be constitutional if they 'were reasonably related to legitimate government objective and not tantamount to punishment': see *Youngberg v Romeo* 457 US 307, 320 (1982). See also *Kansas v Hendricks*, 521 US 346, 356–7 (1997) and *United States v Salerno et al*, 481 US 739, 746 (1987) for discussions of substantive due process.

¹⁶³ Article 5.1 of the *European Convention on Human Rights*, in part, reads: 'Everyone has the right to liberty and security of person. No one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law'. Six exceptions are listed. The exception contained in 5.1(e) reads: 'the lawful detention of persons for the prevention of the spreading of infectious diseases, of persons of unsound mind, alcoholics or drug addicts or vagrants'.

¹⁶⁴ *Koniarska v United Kingdom* (no. 33670/96 Unreported, 12th October, 2000).

¹⁶⁵ Clause 7.

on the rights or opportunities of a person is necessary, the means chosen should be the least restrictive of the available alternatives consistent with effective care.¹⁶⁶

3.11 Under the Victorian legal system, people cannot be deprived of their liberty without proper legal process. People can only be detained or treated without consent in exceptional circumstances. Usually a predicted risk that they may harm themselves or others is insufficient to justify detention. The history of human rights abuse of people with intellectual disabilities makes it particularly important to ensure that their rights are protected and that they are not treated more harshly than people who do not have intellectual disabilities. For example, in the past, the practices of the institutionalisation of people with intellectual disabilities, or sterilisation and other medical treatment without consent were sometimes based on a belief in eugenics or to control the behaviour of people believed to have no social value.¹⁶⁷ If care without consent is to be permitted, the criteria must be transparent, to prevent arbitrary decision-making.

3.12 Protection of the human rights of people with intellectual disabilities or people with cognitive impairments requires that the procedures used for the restriction or denial of rights:

contain proper legal safeguards against every form of abuse. The procedure[s] must be based on a valuation of the social capability of the mentally retarded person by qualified experts and must be subject to periodic review and to the right of appeal to higher authorities.¹⁶⁸

3.13 When people are deprived of their freedom, the legal system normally requires that they receive 'natural justice'. The principle of natural justice requires them to have an opportunity to present their case to an impartial decision-maker, to have a decision made on the basis of evidence that is open to scrutiny, challenge and verification and to have the opportunity to challenge the decision.¹⁶⁹ The principle of natural justice should apply to people with intellectual disabilities, as it does to people who do not have disabilities.

¹⁶⁶ *Intellectually Disabled Persons' Services Act 1986* s 5(n) and *Mental Health Act 1986* s 4(2)(b).

¹⁶⁷ *Secretary, Department of Health and Community Services v J. W. B. and S. M. B* (Marion's Case) (1992) 175 CLR 218, 275, Brennan J.

¹⁶⁸ *Declaration on the Rights of Mentally Retarded Persons*, cl 7.

¹⁶⁹ See, eg, *FAL v Winneke* (1981) 151 CLR 342, *Kioa v Minister for Immigration and Ethnic Affairs* (1985) 159 CLR 550.

Therefore, any framework we propose should include mechanisms that comply with the principles of natural justice.

Protection Against Exploitation and Abuse

- 3.14 Sometimes the severity of a person's disability may mean that they are vulnerable to abuse or exploitation and cannot exercise their rights in a meaningful way. People with intellectual disabilities may be unable to communicate their desires or express their preferences.¹⁷⁰ Some will be unable to make informed choices because of their level of disability. Compulsory care must be provided in an environment which prevents abuse and exploitation. It is important to ensure that safeguards against improper use of compulsory care do not result in a reduction of the services and care which people may need. Laws designed to protect people against unjustified invasion of their rights must be supported by adequate resources. Otherwise the statutory commitment to provide care with the least possible restriction could result in harm to the person or other people.
- 3.15 In practice there are tensions between preventing abuse and exploitation and maximising the social participation of people with intellectual disabilities. Over the past 15 years, a 'framework of de-institutionalisation'¹⁷¹ has resulted in people moving out of large institutions to live in the community. If these policies coincide with reductions in resources, people with intellectual disabilities who are living in the community may be particularly vulnerable to exploitation and abuse.¹⁷² For example, they may be exposed to drug use, or sexual or financial exploitation. A framework for compulsory care needs to balance the benefits of living in the community against the need to ensure that people are not exploited.

¹⁷⁰ For a discussion of consent, see below paras 4.38–9.

¹⁷¹ Tait and Lesser, above n 135. The rationale for this de-institutionalisation was given as including 'an acknowledgement of advances in drug therapy which reduced the need for long stays in hospital, an acceptance of the concept of normalisation and the emergence of human rights issues for people with a disability'.

¹⁷² As evidenced by the need for legal frameworks with respect to guardianship and the provisions in some legislation which explicitly states that an inability to guard against exploitation is a requirement for the provision of compulsory care: see, eg *Mental Health Act 1963* (Tas) s 4.

Protecting the Community

3.16 The issue of risk to others posed by people with cognitive impairments is integral to our terms of reference. International instruments such as the *Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care*¹⁷³ recognise that the rights and liberties of the people with cognitive impairments are to be weighed against the safety of the community as a whole.¹⁷⁴ Balancing protection of the liberty of a person with an intellectual disability or cognitive impairment against the prevention of harm to someone else in the community is the essence of the Commission's project. Both sets of interests must be considered in designing a new system regulating the compulsory care of people with cognitive impairments.

SOME PRACTICAL ISSUES

3.17 In addition to the broad principles set out above, the new system will need to take account of some practical issues. These include the following.

Flexibility and Responsiveness

3.18 The provisions for compulsory care and treatment will need to be sufficiently flexible to deal appropriately with people with a wide range of capacities, in a variety of situations, ranging from emergencies requiring an immediate response to cases requiring long-term management and care.

Reducing Inconsistencies

3.19 We have seen that people falling into different diagnostic categories are dealt with differently under the current system. In any new system, these differences in treatment should reflect conscious policy choices, rather than historical anomaly.

¹⁷³ Adopted by the United Nations General Assembly Resolution 46/119, 17 December 1991

¹⁷⁴ Principle 16, with respect to the involuntary admission of people with mental illnesses, states that a serious likelihood of immediate or imminent harm to that person or to other persons is an appropriate ground for compulsory treatment.

Ensuring Appropriate Interaction Between Disability Services and the Criminal Justice System

3.20 At present some people with intellectual disabilities cycle between the disability services system and the criminal justice system. The new provisions regulating compulsory care and treatment should strive to reduce inconsistency in the approaches taken in the area of human services provision, the guardianship system and the criminal justice system. Provisions for compulsory care should recognise that people with intellectual disabilities or cognitive disorders often move between systems and should provide appropriate levels of care for people, regardless of the means by which they come to attention.

Quality Practices

3.21 Resource constraints will affect the operation of any new framework for compulsory care. Any proposed system of regulation will require resources, whether those resources are secure facilities for the protection of the community or improved infrastructure for the provision of services to those people with cognitive impairments. However, it is important that proposals for change should improve practices in the care of people with intellectual disabilities. In particular, the system should require that people who are responsible for the day-to-day management of the compulsory care have the appropriate expertise and that services providing compulsory care are of an adequate standard.

Question

1. Are the principles of:
- maximising social participation and ensuring quality of life;
 - recognising and safeguarding rights and liberties;
 - protection against exploitation and abuse; and
 - protecting the community.

appropriate for the regulation of compulsory care?

2. The Discussion Paper suggests the following practical issues need to be taken into account in any new regulatory system:

- flexibility and responsiveness;
- reducing inconsistencies;
- ensuring appropriate interaction between disability services and the criminal justice system; and
- quality practices.

Are there any issues we have not identified that need to be considered in designing a system of regulation for compulsory care for people with cognitive impairments?

Chapter 4

Who and What are we Talking About?

4.1 In Chapter 3 we discussed the principles which should underpin a legal framework for the compulsory care of people whose behaviour places them or others at risk. In this chapter we identify some central questions which arise in designing a new system and consider some possible approaches.¹⁷⁵ The chapter considers:

- who should be covered by the legislation;
- whether the criteria for care should cover both risk to self and risk to others;
- the types of risks to self and community which need to be addressed; and
- the types of care and treatment practices which should be regulated in the system.

WHO SHOULD BE COVERED BY THE LEGISLATION?

4.2 A fundamental question raised by this reference is whether it is justifiable to detain or treat people without their consent simply because there is a risk that they may harm others. Though some countries have laws allowing indefinite detention of people considered to be dangerous, such provisions have been extensively criticised.¹⁷⁶ One criticism is based on the difficulty of predicting risk. Even experts who have received specialised training in the relevant fields cannot accurately predict levels of risk.

“Dangerousness” is both very difficult to predict and tends to be considerably over-

¹⁷⁵ Many of the options that are included in this and the following two chapters are drawn from compulsory care regimes that are in place, or are proposed in other jurisdictions in Australia and around the world. Not all of these regimes apply to people with intellectual disabilities. They all do, however, regulate compulsory care. It is the checks and balances that are built into these frameworks that are of interest in this Discussion Paper, irrespective of whether the framework in the jurisdiction where it comes from is applied to people with intellectual disabilities.

¹⁷⁶ See, eg, *Veen v The Queen* (1979) 143 CLR 458, 477–8, Jacobs J. for a discussion of the problems with indeterminate sentences of life imprisonment for an offender with a mental dysfunction. See also Justice Michael Kirby's ‘Intellectual Disability and Community Protection: Community Protection Bill 1994 (NSW)’ (1994) 1(1) *Australian Journal of Human Rights* 398, C R Williams, ‘Psychopathy, Mental Illness and Preventative Detention’ 16(2) *Monash University Law Review* (1990), 161, 180–2.

predicted”.¹⁷⁷ One study indicated that ‘only one in three positive predictions of violence made by mental health professionals was accurate’.¹⁷⁸ It would be a substantial incursion on human rights to deprive people of their freedom on the basis of risk assessments that may not be accurate.

- 4.3 The terms of reference refer to compulsory care of people with intellectual disabilities or cognitive impairments, including ABI and dual disability. The Commission is not required to consider laws allowing detention or treatment of all people whose behaviour places others at risk. In the course of making our recommendations, however, it will be necessary for us to consider the circumstances in which it is justifiable to treat people with disabilities from those who do not have disabilities. That is, in making the recommendations we will have to bear in mind the principle that people with intellectual disabilities should be able to exercise their capacities to the fullest extent possible and to participate meaningfully in the life of the community.

Children

- 4.4 Our terms of reference do not make it clear whether the framework should apply to both children and adults with cognitive impairment. The *Children and Young Persons Act 1989* deals with children who are in need of care or who have committed criminal offences. Under the Act, a child who is at immediate substantial risk of harm may be placed in a secure welfare service.¹⁷⁹ The Children's Court can make a variety of orders providing for

¹⁷⁷ Intellectual Disability Rights Service (NSW), *The Framework Report* (2001) s 4.14.

¹⁷⁸ John Monahan, *Crime and Delinquency Issues* (1981), cited in Maclean Committee, *Report of the Committee on Serious Violent and Sexual Offenders* (2000) para 2.19. The Report did acknowledge that ‘risk assessment has developed markedly in recent years [and] it is likely to develop still further’: para 2.16. This suggests that the Monahan figures may not be an accurate description of current rates of success, however, there is no evidence that we have found to suggest that accuracy rates of risk prediction are anywhere near perfect.

¹⁷⁹ Sections 69, 73, 74. Section 74(1)(e) in particular allows for interim accommodation orders if there is a substantial and immediate risk of harm to the child. The duration of an interim accommodation order cannot exceed 21 days: s 75. An interim accommodation order under s 74(1)(e) can, however, be extended for up to another 21 days, but only if the court is satisfied that exceptional circumstances exist which justify the extension: s 78(2)(b).

the care of the child.¹⁸⁰ Children who commit criminal offences must normally be tried in the criminal jurisdiction of the Children's Court and can be remanded in custody pending the hearing of the case.¹⁸¹ If children are convicted they may be ordered to serve a period of detention by way of sentence.¹⁸²

4.5 There is no provision in the *Children and Young Persons Act 1989* allowing children to be deprived of their freedom, except in the context of criminal proceedings. There is also no provision in the Act allowing children to be given medical treatment without their consent, simply because their conduct endangers others, unless it also places them at risk of harm.¹⁸³ Nor is there any Victorian legislation which specifies the age at which a child can consent to medical treatment.¹⁸⁴ This means that children's capacity to consent is based on the common law, which assesses capacity to consent by reference to the child's ability to understand the nature and consequences of the treatment.¹⁸⁵ In the case of a child who cannot consent because of age or intellectual disability, a parent or guardian may consent on her or his behalf to most forms of medical treatment¹⁸⁶ or to the child's placement in secure accommodation.

4.6 For the purposes of this reference it will be necessary to decide whether any proposed legislation dealing with compulsory care should be confined to adults. If this were the case, it would leave children whose behaviour places them or others at risk to be dealt

¹⁸⁰ These protection orders are laid out in s 85 of the *Children and Young Persons Act 1989* and include supervision orders, custody to third party orders, supervised custody orders, custody to Secretary orders, guardianship to Secretary orders and interim protection orders. Section 63 defines the circumstances where a child is considered to be in need of protection.

¹⁸¹ *Children and Young Persons Act 1989* s 16. The Act does include provision for child offenders with intellectual disabilities to the extent that if the child is eligible for services under the *Intellectually Disabled Persons' Services Act 1986*, the pre-sentence report must include reference to the services available that are appropriate for the child and which are designed to reduce the likelihood of the child committing further offences: s 52(3).

¹⁸² Subsections 137(i) and (j) include the provision for detention in either youth residential or youth training centres.

¹⁸³ There is however provision in the *Children and Young Persons Act 1989* for the Secretary of DHS to order that a person in the care or custody of the Secretary undergo medical examination and treatment: s 271.

¹⁸⁴ Compare the situation in South Australia where the *Consent to Medical Treatment and Palliative Care Act 1995* (SA) provides that a person of or over 16 years of age may make decisions about his or her own medical treatment as validly and effectively as an adult: s 6.

¹⁸⁵ See for example, *Gillick v West North AHA* [1985] 3 WLR 830, 858, Lord Scarman, where it is stated that a minor no longer needs his or her parent's consent for medical treatment when the minor 'achieves a sufficient understanding and intelligence to enable him or her to understand fully what is proposed'.

¹⁸⁶ Sterilisation of a child, however, requires a court order: *Secretary, Department of Health and Community Services v J. W. B. and S. M. B* (Marion's Case) (1992) 175 CLR 218.

with under the *Children and Young Person Act 1989*. Alternatively, any legislation that may be proposed could also apply to children.

Questions

3. Are the current provisions of the *Children and Young Person Act 1989* adequate to deal with children and young people with intellectual disabilities or cognitive impairments?

4. Should the provisions regulating compulsory care apply to children as well as adults with intellectual disabilities or should children with intellectual disabilities continue to be dealt with under the *Children and Young Person Act 1989*?

4.7 Irrespective of whether children with cognitive impairments should be covered by any proposed framework, there are two possible approaches that could be taken in determining the people to which the compulsory care provisions should apply:

- The legislation could apply to all people with a broad range of mental conditions which affected their reasoning capacity. It would be necessary to define these mental conditions. As one example of a definition, the legislation could cover those with impaired decision-making capacity who need assistance in caring for themselves.¹⁸⁷
- As is currently the case, different compulsory care regimes could continue to apply, depending on the nature of the disability. For example, there could be provisions specific to people with intellectual disabilities or dual disabilities¹⁸⁸ or provisions specific to people with specified cognitive impairments such as ABI.

The Broad Approach

4.8 Under an approach which we will refer to as the 'broad' approach, there would be no difference between the compulsory care and treatment provisions applicable to people with intellectual disabilities and those which apply to people with other forms of mental disorder. A number of jurisdictions cover a broad range of mental conditions or include

¹⁸⁷ If this broad decision-making capacity test were used it would still be necessary to satisfy criteria relating to risk to self and others before compulsory care could be provided.

¹⁸⁸ If people with dual disabilities were included, the issues of the framework's impact upon, and relationship to, the involuntary treatment provisions of the *Mental Health Act 1986* would need to be addressed.

people with intellectual disabilities within their mental health legislation. For example, the *Mental Health (Treatment and Care) Act 1994* (ACT) covers people with a ‘mental dysfunction’ which is defined as a ‘disturbance or defect, to a substantially disabling degree of perceptual interpretation, comprehension, reasoning, learning, judgement, memory, motivation or emotion’.¹⁸⁹ In Scotland, the *Mental Health (Scotland) Act 1984* uses the term ‘mental disorder’ which is defined, in part, as ‘mental incapacity however caused or manifested’.¹⁹⁰ The *Alberta Dependent Adults Act 2000* (Canada) covers ‘an adult who is repeatedly or continuously unable to care for himself and unable to make reasonable judgements’.¹⁹¹ Other examples of definitions which could be used are set out in Appendix 2.¹⁹²

4.9 The advantages of this approach include:

- providing a framework for responses to the treatment needs of people whose behaviour places them at risk, regardless of their diagnostic category;
- in the case of people whose behaviour places others at risk, applying the same laws to all people with mental disorders, thus reducing the possibility of inconsistencies of treatment arising because people fall into different disability categories; and
- extending the existing protections applicable to compulsory care of people with mental illnesses (possibly with some adaptations) to people with intellectual disabilities.

4.10 There are also arguments against this approach. Depending on the definition adopted, it could result in a much larger number of people being at risk of having their freedom

¹⁸⁹ Section 4.

¹⁹⁰ Section 1. The definition has recently been amended to include ‘personality disorder’: *Mental Health (Public Safety and Appeals)(Scotland) Act 1999* s 3. With the difficulties associated with accessing up-to-date international legislation, the overseas Acts referred to in these Appendices may not be fully current. However, the legislation included here is intended as a guide only for possible changes in Victoria.

¹⁹¹ Section 7(1).

¹⁹² In terms of neutrality of language and breadth of sweep of definition, the South African Mental Health Care Bill 2001 is a prime example. The Bill regulates access to, and the provision of, mental health care, treatment and rehabilitation to voluntary, assisted and involuntary mental health care users. Mental health care users are defined as people receiving care, treatment and rehabilitation services aimed at enhancing the mental health status of a user. Mental health status is, in turn, defined as the level of mental well-being of an individual as affected by physical, social and psychological factors.

restricted.¹⁹³ The existing services system lacks the resources to provide proper care to a larger pool of people, and may be unable to provide the diversity of services necessary to deal with people with quite different needs, for example, those with mental illnesses, intellectual disabilities or personality disorders. The result could be that people with different needs are housed together in circumstances where vulnerable people are more likely to be harmed. However, it should be recognised that some of these people may already be being treated without their valid consent and it may be preferable to regulate their treatment by legislation than to leave it outside legal control.

4.11 This approach could be modified by applying a broad category, such as ‘mental incapacity however caused or manifested’ but excluding particular conditions. For example, people suffering from anti-social personality disorders, autistic spectrum disorders and age-related mental incapacities could be excluded from provisions establishing a legal framework for compulsory care. The terms of reference do not explicitly include people with these conditions, however, they do require the Commission to investigate the relevance of the framework to people with other cognitive impairments.

4.12 People with personality or autistic spectrum disorders¹⁹⁴ need to be considered as they are liable to fall between the gaps of most legislative frameworks.¹⁹⁵ That is, because they may not have a ‘treatable’ condition, they may not have mental illnesses.¹⁹⁶ If an IQ test is the test for intellectual disability then many of them would not be considered to have an intellectual disability. Some of them may, however, pose a risk, due to their condition, to

¹⁹³ See above n 187.

¹⁹⁴ In *New Directions: Report in the Review of the Mental Health (Scotland) Act 1984* (2001) (the Millan Committee Report), it was recommended that people with autistic spectrum disorder be brought under the regulatory framework: Recommendation 4.9.

¹⁹⁵ There have been previous attempts to remedy this situation in Victoria. The former Law Reform Commission of Victoria recommended that the definition of mental illness in the *Mental Health Act 1986* did ‘not prevent a person who is suffering only from anti-social personality disorder from being considered to be mentally ill’: *The Concept of Mental Illness in the Mental Health Act 1986*, Report 31 (1990) proposed section 3 of Draft Bill.

¹⁹⁶ The MHRB has decided in the past that a person with a ‘borderline personality disorder’ does fall within the meaning of ‘mental illness’ for the purposes of the *Mental Health Act 1986: The Appeal of KMC*, quoted in Law Reform Commission of Victoria, *ibid*, para 4). The decision, however, was based on the severity of the condition (‘borderline’ meant that the person was bordering on the psychotic) and therefore most people with a personality disorder have not been considered to be subject to the Act on the sole basis of that disorder.

themselves or others.¹⁹⁷ People with personality or autistic spectrum disorders may come under a proposed framework if the broad approach is adopted, however, as one of the other criteria for the authorisation of compulsory care will be ‘risk to self and others’ many people with these conditions would not be subject to compulsory care.

- 4.13 If the broad approach were taken it would be necessary to reconsider how the new provisions should be integrated with the involuntary care and treatment provisions of the *Mental Health Act 1986* (MHA). A problem which may arise in combining compulsory care provisions for people with mental illnesses and people with intellectual disabilities is that treatability is an important criterion for the involuntary care provisions of the MHA. By contrast, people with intellectual disabilities have a life-long condition, but are not ill and cannot be ‘treated’ in the clinical, medical sense of the word. The term ‘treatment’ may be used more expansively to include psychological and social interventions designed to reduce the effects of the intellectual disability or other cognitive impairment.¹⁹⁸ In this sense, it may be as applicable to a person with an intellectual disability, or other cognitive impairment, as it is to a person with a mental illness. However, a broad legislative framework which combined compulsory care for people with mental illness and intellectual disabilities would need to recognise the different forms of treatment and management which apply to people with different disabilities.

The Categorical Approach

- 4.14 Under an approach which we will call the ‘categorical’ approach, the compulsory care provisions would be specific to people with intellectual disabilities and possibly some other specified disabilities, for example, ABI. This would be consistent with the current

¹⁹⁷ For further discussion on the issue, see David McCallum, ‘Law, Psychiatry and Antisocial Personality Disorder: A Problem of Government’ 15(1) *Law in Context* (1997) 29 and the United Kingdom Home Office and Department of Health, White Paper, *Reforming the Mental Health Act*, Part 2: High Risk Patients (2000). The conclusion from the discussion in the White Paper was that people with personality disorders that were a risk to themselves or others should be brought under the compulsory care provisions of any mental health legislation that supersedes the *Mental Health Act 1983* (England).

¹⁹⁸ As in the *Mental Health Act 1986* definition of treatment s 3, see below para 4.47.

Victorian provisions. If this approach were adopted it would be necessary to consider whether intellectual disability should be defined in the same way as in the existing legislation,¹⁹⁹ or more broadly.²⁰⁰ As was the case with the broad approach discussed above,²⁰¹ the result of widening of the definition of ‘intellectual disability’ may include people who are not already covered and who should arguably not be included.

4.15 In determining the appropriate legislative framework it will be necessary to balance the need to ensure coverage of people for whom compulsory care and treatment may be required, against concerns about restriction of liberties. It also should be borne in mind that the criteria for the application of the framework will need to take into account the disability services legislation review currently being undertaken by the Department of Human Services.

Questions

5. To whom should legislation authorising compulsory care apply?
- Should it apply to people with a broad range of mental disorders?
 - Should it apply to people with intellectual disabilities and specified forms of cognitive impairments, including dual disabilities? If so, which forms of cognitive impairment should be covered?

Whichever criteria is chosen, how should the relevant conditions be defined?

THE CRITERION OF RISK

4.16 The terms of reference require us to consider care of people who are ‘at risk to themselves and the community’. There are a large number of ways in which a person

¹⁹⁹ Such as through the use of the definition of ‘intellectual disability’ in the *Intellectually Disabled Persons’ Services Act 1986* (IDPSA), above para 1.11, or reference to the relevant components of the definition of ‘disability’ in the *Disability Services Act 1991*, above n 28. The definition included in the IDPSA could be amended to include a margin of variation in the IQ score component of the test. For example, the definition could limit intellectual disability to an IQ score of 70 ± 5 . The New Zealand Intellectual Disability (Compulsory Care and Rehabilitation) Bill includes in its definition of intellectual disability the provisions that the ‘quotient may be expressed within an accuracy of plus or minus 5 points’: s 7(2)(b). It has been suggested, however, that a ‘specific difficulty with strict reliance on IQ scores is that it does not well cater for some well recognised developmental disabilities, in particular autism. In various United States jurisdictions, the focus for eligibility for services is on developmental disability rather than intellectual disability’, Intellectual Disability Rights Service (NSW), *The Framework Report* (2001) s 2.2.

²⁰⁰ See eg a definition ‘including arrested or incomplete development of mind and any other disorder or disability applied, however caused or manifested’ included in the *Mental Health (Scotland) Act 1984* s 1.

²⁰¹ See above paras 4.8–13.

might be seen to be at risk. For example, people may be at risk to themselves, or to others for any one of a number of reasons, including because:

- they are physically incapable of caring for themselves;
- they might self-injure;
- they are confused and unaware of the consequences of what they are doing (for example, a patient with Alzheimer's disease who has a tendency to wander);
- they engage in behaviour that makes them vulnerable to being abused or exploited by others (such as a person who engages in sexually uninhibited behaviour, or who is vulnerable to financial exploitation);²⁰²
- they are annoying, disruptive or offensive, which could perhaps result in others harming them;
- they have damaged property in the past and attempts to control their behaviour have failed;
- they have threatened or injured people in the past and attempts to control their behaviour have failed; or
- they are believed to have the potential to harm other people in the future.

4.17 Not all of the above necessarily justify compulsory care. For example, it may not be appropriate to restrict a person's freedom of movement simply because they annoy others or have damaged property in the past. It is important that the law contain clear criteria for determining when the compulsory care provisions should apply.²⁰³

²⁰² The Tasmanian *Mental Health Act 1963* includes, in the definition of 'severe subnormality' (a pre-requisite for compulsory care), reference to an inability to guard 'against serious exploitation': s 4(2).

²⁰³ One of the more comprehensive descriptions of the possibility of risk is in the Ontario *Mental Health Act 1990* (Canada). An application can be made for an assessment where a physician, after an examination of the person, has:

'reasonable cause to believe that the person, (a) has threatened or attempted or is threatening or attempting to cause bodily harm to himself or herself; (b) has behaved or is behaving violently towards another person or has caused or is causing another person to fear bodily harm from him or her; or (c) has shown or is showing a lack of competence to care for himself

Who Should be Covered by the Compulsory Care Regime?

- 4.18 It is not clear from the terms of reference for this project whether risk to self and risk to others are alternatives, or whether it should necessary to show risk of harm to others as well as self before compulsory care can be authorised. For example, should any legislative safeguards which the Commission may recommend if a person is to live in a locked residential facility apply to people with Alzheimer's disease or intellectual disabilities, who may 'wander' if they are not accompanied when they leave the facility, but who do not represent any threat to others?
- 4.19 In New Zealand, proposed compulsory care legislation regimes apply only to people whose behaviour places others at risk.²⁰⁴ A recent report of the New Zealand Law Commission does, however, recommend that there be coercive powers introduced into the *Protection of Personal and Property Rights Act 1988* (New Zealand) which covers those people unable to care for themselves.²⁰⁵ It is more common for compulsory care legislation to cover both kinds of risk.²⁰⁶ In our view it is appropriate to examine the safeguards that should apply to compulsory care in situations where a person's behaviour does not involve any risk to others. Such provisions may be particularly important in authorising care of people who are incapable of consenting to care because of their mental incapacity. However, this does not necessarily mean that exactly the same safeguards should apply regardless of whether the risk is to the individual or to other people.

or herself; and if in addition the physician is of the opinion that the person is apparently suffering from mental disorder of a nature or quality that likely will result in, (d) serious bodily harm to the person; (e) serious bodily harm to another person; or (f) serious physical impairment of the person: s 15(1).

²⁰⁴ The New Zealand Intellectual Disability (Compulsory Care and Rehabilitation) Bill limits its provisions to those people who are a risk to others. That is, the Bill is to apply only to those who have been charged with, or convicted of, an offence: s 3(a). The distinction between risk to self and risk to others is more common in other areas of law. Legislation relating to the criminal justice system, for example, generally applies only to circumstances where safety of others is at risk. Guardianship legislation, on the other hand, is generally concerned only with the protection of the best interests of the represented person, rather than the protection of the wider community.

²⁰⁵ Law Commission (New Zealand), *Protections Some Disadvantaged People May Need*, Report 80, (2002) para 28.

²⁰⁶ For example, the *Mental Health (Treatment and Care) Act 1994* (ACT) s 26(2)(b), *Alberta Dependent Adults Act 2000* (Canada) s 11(3)(a), and (c) and the Newfoundland *Mental Health Act 1990* s 5(1) (Canada).

4.20 The two main approaches which could be taken in relation to the compulsory care provisions are as follows:

- a single process could be introduced for handling all applications and authorisation for compulsory care and treatment, regardless of who is at risk; or
- there could be a different process for handling compulsory care and treatment where a person is a risk to others than the process applicable where a person is a risk only to her or himself. For example, guardians could be appointed to make decisions about the care of a people at risk of injuring themselves,²⁰⁷ while a different regime would apply to deal with people whose behaviour endangers others.

4.21 A separation of provisions regarding risk to self from provisions regarding risk to others is not commonly made in compulsory care and treatment legislation. For example, under the MHA a person may be involuntarily detained for their own health or safety or for the protection of members of the public²⁰⁸ (as long as the other criteria required by the legislation are satisfied) and the same rights of appeal apply regardless of whether the ground for detention was risk to the person or others. The argument that the two processes are as essentially different from one another arises from a view that decisions made for the protection of a person's own safety are essentially benevolent and should, therefore, be made differently from decisions for the protection of others. However, except in the case of people with severe anti-social personality disorder, people whose behaviour places others at risk are usually also at risk of harming themselves.²⁰⁹ It follows that establishing a separate process depending on the nature of the risk may make the system unnecessarily complex. It must also be recognised that compulsory care decisions

²⁰⁷ It is arguable that guardianship is a more appropriate way of approving care for people who are a risk only to themselves. This is the situation under the Netherlands *Psychiatric Hospitals (Compulsory Admissions) Act 1994* s 2. This provision does apply, in certain circumstances to the 'mentally handicapped'.

²⁰⁸ For the other criteria which must be satisfied, see above paras 2.16–17.

²⁰⁹ Information provided by Dr Ruth Vine, Deputy Chief Psychiatrist, Mental Health Branch, Department of Human Services, personal communication, 7 May 2002.

may involve similar restrictions of a person's freedom, whether they are based on risk to self or others.²¹⁰

4.22 As an alternative to putting in place a distinction based on whether the person is at risk of harming her or himself or others, it may be preferable for legal safeguards to be based on the degree of coercion that might be required in order to enforce any compulsory care and treatment. This issue is discussed below where we examine the compulsory care and treatment practices that need to be regulated by a new legal framework.

Questions

6. Should there be a single process for authorising compulsory care, regardless of who is at risk, or should there be one process when a person is a risk to others and another process when a person is a risk only to themselves?

SOME POSSIBLE CRITERIA FOR RISK ASSESSMENT

4.23 How should the law define risk so as to prevent unnecessary restriction of a person's liberties? Some factors that will need to be considered include:

- where the justification for compulsory care is risk to others, should there be evidence that the person has already harmed others or is a predicted risk of harm sufficient;
- if the basis is risk of harm to self or others, what probability and imminence of risk is required;
- if the basis is risk of harm to self or others, how serious must be the seriousness of the risk; and
- if the basis is risk of harm to self or others, does there need to be a demonstrable causal link between the person's disability and the risk.

²¹⁰ See, for example, Case Study 4, above para 2.43.

4.24 Each of these factors is discussed below. The Commission would welcome suggestions as to any other factors which should be considered.

Predicted or Actual Risk of Harm to Others?

4.25 As we have seen, the criminal law does not generally²¹¹ allow people to be detained or to have their liberties restricted against their will, unless they have been convicted of criminal offences, or unless a court has ordered that they be remanded in custody while they are awaiting trials for offences for which they have been charged.

4.26 If a person is to receive compulsory care because he or she is at risk of harming others:

- Should it be necessary to show that the person has been convicted of offences involving harm to others in the past, or has been held unfit to be tried for such offences?
- Alternatively, should risk of harm be determined on a case-by-case basis, by the body with jurisdiction to authorise the compulsory care and treatment, by reference to guiding principles that reflect the need for restrictions of liberties to be consistent with the seriousness of risk?

4.27 The MHA permits involuntary detention in circumstances where the person has not committed an offence. It may be difficult to justify a different approach in dealing with people with intellectual disabilities or cognitive disorders. An obvious difficulty in making it necessary that the person come to the attention of the criminal justice system before they can be compulsorily treated is that it may be necessary for someone to be harmed before any action can be taken to safeguard the community. On the other hand, it may be argued that compulsory care and treatment of people without disabilities is not permitted on the basis of a prediction that they may harm someone in the future.

²¹¹ See however discussion of the provisions relating to indefinite sentences, above n 5.

What Probability of Harm Should be Required?

- 4.28 The probability of risk and whether harm is likely to occur in the near future will be important factors in determining whether or not compulsory care is warranted. At common law, a duty to protect others from harm arises only where the risk of harm is reasonably foreseeable.²¹² Within a culture of institutionalisation and over-protection, the human services system has often adopted quite restrictive practices on the basis of minimal and remote risks. The new system, should be able to determine when risk of harm is sufficiently substantial that the authorisation of compulsory care and treatment becomes reasonable. This suggests that there should be a strong and demonstrable likelihood that the individual or someone else will be harmed, rather than the risk being more remote and impressionistic.
- 4.29 This assessment of risk, as we highlighted before in terms of the concept of ‘dangerousness’, is both complex and controversial.²¹³ These difficulties notwithstanding, the principles of natural justice would suggest, however, that no person’s liberties should be able to be restricted other than on the basis of evidence that is objective and open to scrutiny.

The Seriousness of the Risk

- 4.30 The seriousness of risk relates to the level of harm which might occur as a result of the person’s behaviour. The question then becomes how serious should a risk have to be before compulsory care and treatment can be approved? That is, should the risk be that the person or others will be seriously hurt, or that the risk is either of mere annoyance, or of the person engaging in lifestyle choices that someone else sees as undesirable?

²¹² See above n 45.

²¹³ See above para 4.2.

- 4.31 The probability and seriousness of risk will have to be weighed together. Under the criminal justice system the restriction of people's liberties is normally proportionate to the seriousness of the offence they have committed. If people's liberties are to be restricted on the basis of the harm they *might* cause in the future, this would suggest that compulsory care and treatment should only be authorised where there is a risk of reasonably serious harm.
- 4.32 In the past, significant restrictions have been placed on the liberties of people with intellectual disabilities even where the risk to others is merely one of irritation and annoyance. These restrictions of people's liberties would be unlawful if a new framework were to allow for compulsory care and treatment only where there is a risk of serious harm. This would place a greater onus on society to become more accommodating of behaviours and personalities that might currently tend to be seen as annoying, but that do not in fact cause any real harm.

Causal Link Between the Person's Disability and the Risk

- 4.33 To justify compulsory care and treatment, it is not necessarily enough that the person has a disability *and* that they poses a risk to her or himself and others. It can be argued that there should be a clear and demonstrable link between the two, that is, that the risk is somehow a consequence of the person's disability,²¹⁴ for example, because the person is unable to understand the consequences of their actions, or has poor impulse control. The requirement that there be a causal link would ensure that people with disabilities were not treated less favourably than people without disabilities whose behaviour places them and others at risk, except where there is a clear link between the disability and the risk.
- However, an argument against this approach is that there may be practical difficulty in

²¹⁴ See, for example, the *Mental Health Act 1986* s 8(1)(c), which requires that the person's need for admission must be because of her or his mental illness, or the *Guardianship and Administration Act 1986* s 22 (1)(b) which requires that, before a guardian can be appointed, a person must be found to be unable to make reasonable decisions because of the disability.

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differentiating between the situations where there is and is not the link between the disability and the risk. The Commission would welcome comments on whether it is appropriate to make this distinction.

Possible Legislative Approaches

4.34 There are two main approaches which could be taken. The legislation could specify the legislative requirements which must be satisfied before people can receive care without their consent. The approach taken in section 8 of the MHA, for example, sets out a number of criteria for care and treatment that must be satisfied before a person can be admitted as an involuntary patient.²¹⁵ These criteria include the presence of a mental illness that requires treatment and for which there is no other form of adequate treatment available which would be less restrictive of the person's freedom of decision and action.²¹⁶ A similar approach could apply to compulsory treatment of people with intellectual disabilities or cognitive impairments.

4.35 An alternative approach would be to set out a range of factors which should be taken into account, including the risk of harm to the person and others and the probability and seriousness of the risk. Other factors which could be listed include:

- whether the person has been convicted of an offence involving harm to others;
- the need to protect the freedom of decision and action of people with disabilities;
- the need to ensure that the person cannot be prevented from harming him or herself or others by any less restrictive option than that which is proposed; and

²¹⁵ See above, paras 2.16–17, for the full list of the s 8 criteria.

²¹⁶ The *Vincent Report* recommended that admission to the Statewide Forensic Service be limited, in terms of risk, to those who 'currently presents a risk of violence to person or persons or a serious risk of property damage': see above n 7, Recommendation 11. Other jurisdictions also specify that risks of other forms of harm may also be sufficient. For example, the New Brunswick *Mental Health Act 1973* (Canada) includes the standard of 'a substantial risk of imminent physical or psychological harm to a person or others': s 8(4).

- whether or not the proposed measures will result in a reduction of risk to the person and/or others.

4.36 An approach which required the decision-maker to take account of a number of factors would allow risk to be defined flexibly by reference to the circumstances of each case.

However, the lack of clear legislative criteria for compulsory care may increase the chance that the provisions will be applied arbitrarily. Some combination of both approaches may be appropriate.

Questions

7. How should risk be assessed?
 - Where compulsory care is based on risk to others, should it be necessary to show that the person has committed offences involving harm to others in the past, or has been held unfit to be tried for such offences? Alternatively, should it be sufficient that the relevant body has found there is a risk of harm to others?
 - Where compulsory care is based on risk to self or others, how probable, how serious and how imminent should the risk of harm have to be? That is, should it be necessary to show a risk of serious harm, or any harm? Should there be a difference in the level of harm necessary in the case of risk to self and risk to others?
 - Where compulsory care is based on risk to self or others, should it be necessary to demonstrate a link between the disability and the risk?
 - Should factors other than seriousness, probability and imminence of harm be taken into account in assessing whether compulsory care is justified?
8. Should any proposed system of regulation list the criteria which must be satisfied before compulsory care is authorised, or should it simply list a number of criteria to be taken into account by the decision makers?

WHAT TYPE OF CARE AND TREATMENT PRACTICES SHOULD THE LAW REGULATE?

4.37 In this section we discuss two key questions:

- When should care be regarded as 'compulsory' such that the legal framework for compulsory care must be satisfied; and
- What do we mean by 'care and treatment'?

What is Meant by ‘Compulsory’?

- 4.38 The notion of ‘compulsory’ implies an interference with the body or freedom of movement of a person regardless of whether or not the person consents. The legal system has recognised the importance of the right to personal security for centuries.²¹⁷ Touching a person without her or his consent is an assault, except where it occurs as part of a normal social transaction (such as brushing past someone in a crowd). Detaining someone against his or her will is a civil wrong, known as false imprisonment. Justice Brennan of the High Court has commented that the ‘law will protect equally the dignity of the hale and the hearty and the dignity of the weak and the lame; ... of the intellectually able and of the intellectually disabled’.²¹⁸ This dignity is based on subjective recognition of a person’s ‘own identity and personality’. His Honour went on to say that a person with an intellectual disability still has the capacity of such ‘self-estimate’, even if the outside world only has ‘limited access’ to it.²¹⁹ This ‘self-estimate’ should be respected as much as possible. In other words, informed consent should be the goal, despite any difficulties that may be perceived in terms of the communication necessary to gain the consent.²²⁰ Where a person is unable to consent to treatment, the consent of a guardian or a court order is required, except where treatment is provided in an emergency or otherwise authorised by law.
- 4.39 There are a number of ways in which care and treatment might be provided to a person who refuses or is incapable to consenting to it.²²¹ Some of these may be more intrusive, and more restricting of personal liberties, than others. Some examples that illustrate these differences include:

²¹⁷ See, for example, William Blackstone, *Commentaries on the Laws of England*, Vol 3 (1st ed, 1769) 120.

²¹⁸ *Secretary, Department of Health and Community Services v J. W. B. and S. M. B* (Marion's Case) (1992) 175 CLR 218, 266, Brennan J.

²¹⁹ *Secretary, Department of Health and Community Services v J. W. B. and S. M. B* (Marion's Case) (1992) 175 CLR 218, 268, Brennan J.

²²⁰ The requirement of informed consent applies to treatments under Part 5 of the MHA, in particular, s 53B. Note that it is not required for the application of restraint and seclusion measures (s 81(1A); the application of mechanical restraint; and s 82(2B); seclusion measures) and in certain situation for the application of electro-convulsive therapy (s 73(3) and (4)).

²²¹ Another option, in terms of consent, is to have a procedure for those people who refuse to consent that is different to the procedure for those people who are unable to consent. This is the situation under the *Psychiatric Hospitals (Compulsory Admissions) Act 1994* (Netherlands) ss 3, 60.

- administering non-controversial medical treatment, such as an inoculation, to a person with an intellectual disability who is unable to consent to the procedure;
- administering a non-controversial procedure, such as routine dental work, where the person is actively refusing;
- locking the doors of a nursing home for people with dementia who might inadvertently wander out and get lost;
- administering medication that reduces the sex drive of a person with an intellectual disability who is a frequent sex offender but who is unable to understand the risks and benefits of the medication;
- requiring people to participate in behaviour management programs;
- placing people who pose no risk to other people's safety in a residential facility where the doors are locked in order to prevent other residents, identified as dangerous, from leaving;
- telling people with intellectual disabilities that they are not allowed to come and go as they please, knowing that they will comply because they are unaware of their right to do otherwise;
- locking people in their rooms in residential facilities; and
- putting people in locked residential facilities, against their will, to prevent them from harming members of the public.

4.40 Any of these interventions might be undertaken to help reduce significant risk of serious harm to self or others. Not all of them, however, seem to require regulation by law, or at least, they do not require regulation in the same sorts of ways. Currently, the law is somewhat unclear on just what sorts of processes or regulation should be observed in

relation to many of these practices. As we have seen, the restraint and seclusion provisions of the *Intellectually Disabled Persons' Services Act 1986* (IDPSA) do not clearly define the sorts of practices to which they apply.²²²

4.41 In framing legislation to regulate compulsory care and treatment, it will be necessary to determine the extent to which regulation may be required for different forms of care and treatment without consent. For example, there may be the following interventions:

- Interventions that do not require any regulation. These could include interventions where the consent of the person can be assumed, such as feeding a person who cannot feed him or herself.
- Interventions that can occur with the consent of the person or her or his guardian. These could include interventions that are in the best interests of the person, such as the prescription of an anti-depressant, in a situation where the person is at risk of committing suicide as a result of depression.
- Interventions that can occur only if they are consistent with an order that is already in place. These could include interventions that relate to the day-to-day implementation of an overall treatment plan that has been appropriately approved, such as decisions about daily administration of medication that modifies behaviour or about when to lock the doors of a residential facility in which a person has been placed.
- Interventions that require approval in advance if the person is incapable of consenting. These could include interventions that have significant consequences for the person's rights and liberties and interventions where the person's interests may be in conflict with the interests of others, such as placing a person in a locked residential facility to prevent them from getting out and harming others.

²²² Section 44. See the discussion of these provisions above paras 2.8–11. The Vincent Report made a specific recommendation that 'all instances where a client of the SFS is confined alone in an internal or external area such as a courtyard where there is no means of exit, that this be defined as seclusion': above n 7, Recommendation 12.

- 4.42 Although new legislation could provide different safeguards for different types of intervention it may also be necessary to consider the specific circumstances of a case. This is because some interventions which may appear routine to a caregiver may have a substantial effect on a person's freedom of choice. For example, a person with a phobia about injections would feel that their liberties are compromised if they were forced to have an injection that for others might be routine and uncontroversial. Conversely, a person may appear to agree to a procedure that is nevertheless likely to have major and irreversible restrictive consequences for them. For example, a woman with an intellectual disability might comply with a decision to have a hysterectomy, because she is unable to understand the consequences of the procedure.
- 4.43 This suggests that in addition to specifying procedures that require approval before they can be carried out, decision makers should also be required to consider a number of other factors including:
- the need to properly explain the care or treatment to the person and to obtain his or her informed consent wherever this is possible;
 - whether the treatment will have lasting effects on the individual; and
 - the amount of coercion required to put a care and treatment decision into effect.
- 4.44 Chapter 5 will focus primarily on the issues that arise in relation to the this last issue, that is, to those care and treatment practices which should require an approval process to be gone through before they can be lawfully carried out.

Questions

9. What forms of compulsory care and treatment should be regulated?
- Should regulation of compulsory care differentiate between the types of treatment which can be given without authorisation, the types of treatment which can be administered if included in advance in a care plan and the types of treatment which require authorisation in advance?
 - If so, into what category should restraint and seclusion fall and what other treatments should be included in these three categories?
- Should any other criteria be applied in deciding whether compulsory care is appropriate?

What is Meant by ‘Care and Treatment’?

- 4.45 The notion of ‘care and treatment’ implies that the person is somehow being helped or supported.²²³ This concept is expressed in the involuntary treatment provisions of the MHA, which require that a person cannot be involuntarily admitted to a mental health facility unless ‘the person’s mental illness requires immediate treatment and that treatment can be obtained by admission to and detention in an approved mental health service’.²²⁴ This requirement reflects the view that it is unjustifiable to compulsorily detain a person who has not been convicted of any offence, unless this is of some benefit to that person. Similar conditions can be found in provisions for compulsory care and treatment in some other jurisdictions.²²⁵
- 4.46 To include similar provisions in a new legislative framework for Victoria would mean that a person could not be made to comply with a care and treatment regime, without consent, unless that regime was of some benefit to him or her. The concept of ‘benefit’ could be defined narrowly to require clear proof that the person’s condition will be improved by the treatment. If this approach were taken it would be necessary to decide whether providing a person with accommodation or prescribing medication to suppress violent impulses was to be regarded as beneficial. It would also be necessary to decide what should be done where a person is unable to derive benefit from any proposed care and treatment regime. For example, should a person be released in these circumstances, even if there are strong indicators that he or she will harm others, perhaps seriously?

²²³ In the United States, the courts avoid this implication by using the term ‘habilitation’ instead: see, eg, *Youngberg v Romeo* 457 US 307, 309 (1982).

²²⁴ *Mental Health Act 1986* s 8(1)(b). In practice this means that when the courts are asked to adjudicate mental health issues they leave the question of ‘treatability’ to the psychiatrists, ie, psychiatrists assess the person in question and deliver their assessment to the court. The court then acts on that assessment: see, eg, *R v Jolly* [1994] 1 VR 446. For a discussion of psychiatric testimony see Australian Law Reform Commission, *Opinion Evidence*, Research Paper 13 (1983) 14–16. The issue in that case was the sentencing of an offender to a hospital security order (under s 93 of the *Sentencing Act 1991*). The court accepted the assessments of the psychiatrists that the person’s condition was treatable.

²²⁵ See, for example, the *Mental Health (Treatment and Care) Act 1994* (ACT). The Act provides that, with respect to people with mental illnesses, the Mental Health Tribunal has to be satisfied that the psychiatric treatment is likely to reduce the possibility of harm to themselves or others and that the treatment is likely to result in an improvement of the person’s psychiatric condition (s 26(1)(c)). The Act also provides, with respect to a person with a ‘mental dysfunction’, that the Tribunal is satisfied that the care and support that can be provided is likely to reduce the risk of harm to the person or to others: s 26(2)(c).

4.47 An alternative would be to define ‘treatability’ broadly. Under the MHA, ‘treatment’ means ‘things done in the course of the exercise of professional skills to remedy the mental disorder or lessen its ill effects or the pain and suffering which it causes’.²²⁶ This interpretation essentially leaves the definition of treatment to those with the expertise in the field. If this approach were followed, treatment would in effect be defined on a case-by-case basis. It would also be possible to discuss ‘treatment’ in broader terms. Such broader terms could include that the treatment be aimed at the prevention of the deterioration of a person’s health or condition,²²⁷ or treatment could be ‘aimed at enhancing the mental health status’²²⁸ of the person. It may, however, be desirable for any process of assessing compulsory care to require that the person delivering treatment provide evidence that the measures assist in the rehabilitation of the individual, or offer some other benefit.

Questions

10. Should any proposed system of regulation allow authorisation of compulsory care where the treatment will not directly benefit the person receiving the care? How widely should the term ‘benefit’ be read?

THE POSSIBILITY OF A ‘CARE PLAN’

4.48 In the United Kingdom and New Zealand, proposals have been put forward which recommend that a complete care plan be established for the person in need of care before any compulsory care is approved.²²⁹ That is, the qualified people who assess the person who may be in need of care must also draw up a program which reflects the needs and limitations of the person in need of care. A care plan could include either measures which are directly therapeutic, such as the prescription of drugs, or the preparation of education programs that are tailored to the circumstances of the individual, or, indeed, both.

²²⁶ Section 3.

²²⁷ As has been discussed by the Mental Health Review Board with respect to treatment under the MHA. See, eg, *The Review of RJK* (Unreported, Hearing No 190288:Z25:49428).

²²⁸ Mental Health Care Bill 2001 (South Africa) s 1, definition of ‘mental health care user’.

²²⁹ United Kingdom Home Office, above n 197, Part 1: The New Legal Framework, para 3.18; New Zealand Intellectual Disability (Compulsory Care and Rehabilitation) Bill 1999 s 24.

- 4.49 Requiring the preparation of a care plan could help ensure that services provided to the person in need of care have a clear and articulated rehabilitative focus. We have noted that this focus is sometimes lacking in the present system.²³⁰ This would, in essence, be similar to current justice plan provisions. The limitations of that system,²³¹ however, would need to be addressed in implementing this approach. There is a danger that the preparation of care plans will be largely a symbolic exercise which does not improve the care of people with intellectual disabilities. This approach would need to take account of the possible inadequacies of the current service system in planning and delivering services to achieve the goals of the plan,²³² as well as the potential conflict of roles for a service provider who is expected to provide a supportive service to the person in need of care while also monitoring compliance with the plan. The latter issue, however, arises only in relation to people who are receiving compulsory care as an alternative to another court sentence.
- 4.50 A possible advantage of a care plan would be that it would be written in the language of the people who are to apply it. There is a distinction between the discourses of the medical profession and those who work within social sciences and in the social work field. The former is based on a scientific model and therefore privileges precision of language and diagnosis. This is possible because the discipline focuses on careful observation and description of symptoms.
- 4.51 The language used by other health care professionals may be less precise. It is arguable that the focus of the non-medically trained is on the outcome of any intervention rather than on a detailed description and analysis of the possible causes of the problem.²³³ A

²³⁰ See above para 2.12.

²³¹ See above paras 2.6–7 and more generally paras 2.8–15 for limitations with respect to the IDPSA.

²³² The Victorian Auditor-General noted similar concerns in relation to general service plans, drawing attention to the Department of Human Service's limited capacity to support people with intellectual disabilities and their carers in planning for their future needs: see Auditor General's Report, above n 9, para 4.25.

²³³ The distinction between input and outcome perspectives is discussed below in the context of the regulation of care facilities: see below n 319.

care plan, therefore, could focus on proposed outcomes rather than providing a detailed description of the symptoms, diagnosis and medical treatment.²³⁴

Questions

11. Should a care plan be required as part of the approval process for compulsory care? If so, how should the person's compliance with the plan be monitored?

PLACE OF CARE

4.52 An authorisation of compulsory care and treatment could include directions as to the place of residence of the person who is to receive the care and treatment. The person might be required to live in a residential care facility, or at a particular place outside a facility, for example, in the family home. Instead of being required to live in a particular place, they could be required to participate in care or educational programs at a particular facility. These requirements would be decided on a case-by-case basis, depending on the individual circumstances and needs of the person with a cognitive impairment.

4.53 The terms of reference ask us to examine the need, if any, for community-based compulsory treatment and care. We cannot, in this Discussion Paper, outline all the circumstances and capacities of the individuals who may be subject to the framework. There may be a *need* for community-based compulsory care. The Commission would welcome submissions on this matter. Our discussion throughout this Paper assumes neither facility-based nor community-based care but rather will be potentially applicable to both.²³⁵

²³⁴ An example of the difficulties with respect to conflict of discourses is the concept of dangerousness: see above para 4.2. Applying an imprecise notion of dangerousness to a scientific assessment of risk results in an inaccurate prediction of risk. An exception to this statement is where the predictions of risk relate to recidivism, where the success rates are higher (up to 75% success rate): 'Critical Perspectives on Megan's Law: Protection vs Privacy', (1996) 13 *New York Law School Journal of Human Rights* 1, 127. This exception could be based on the much more accurate 'clinical' assessment of offenders that is available when they are imprisoned than the more 'impressionistic' assessment of the general population used in other studies of risk prediction.

²³⁵ In the *Mental Health (Treatment and Care Act 1994 (ACT)*, the Mental Health Tribunal can make 'community care orders' with respect to people with a mental dysfunction which is not a mental illness: s 26(2). Under the proposed framework contained in the United Kingdom White Paper, the Mental Health Tribunal will be able to make flexible orders covering compulsory care in the treatment in the community as well as the hospital: United Kingdom Home Office, above n 197, Part 1: The New Legal Framework, para 3.51.

4.54 By way of comparison, the MHA contains provisions for ‘community treatment orders’.²³⁶ These orders are available if the person has a mental illness, is refusing or unable to consent to the necessary treatment and there is no less restrictive manner in which the person can receive the treatment.²³⁷ The order must specify the psychiatrist who is to monitor the treatment, the medical practitioner who is to supervise the treatment, the place where the patient is to receive the treatment, the duration of the order and the intervals at which the medical practitioner must submit written reports to the psychiatrist.²³⁸

Questions

12. Should there be provisions authorising compulsory care and treatment outside residential facilities? If so, how should the regulatory framework be modified to deal with the provision of compulsory care and treatment outside residential facilities?

PEOPLE CARED FOR BY THEIR FAMILIES

4.55 A large number of families care for family members who have intellectual disabilities within the family setting.²³⁹ The Commission recognises the difficulties involved in caring for people with severe disabilities in the family home. The Commission is concerned that greater burdens should not be imposed on family members. However, in terms of the protection of the rights of people with intellectual disabilities and cognitive impairments, if people are to live in the family home, there may be less supervision of their care and treatment.²⁴⁰ It will be necessary for the Commission to consider whether different

²³⁶ Section 14. The MHA also contains provisions for restricted community treatment orders, s 15A.

²³⁷ MHA s 14(1A).

²³⁸ *Mental Health Act 1986* s 14(2). The Act also include provisions for the variation, revocation and extension of the orders: s 14(4)–14(8). The section does not, however, require the nature of treatment to be included in the order.

²³⁹ Over the past 20 years, ‘there has been a large increase in the numbers and proportions of people with severe or profound handicap aged under 65 years living with their relatives’, Australian Institute of Health and Welfare, *Disability and Ageing—Australian Population Patterns and Implications* (2000) 29.

²⁴⁰ Wherever a person in need of care is required to live, there is, unfortunately, the potential for exploitation or ill-treatment. There is perhaps a greater risk of harm from others if a person is to live in a facility, given the greater number of people who would live and work there: ‘Research of abuse of people with disabilities highlights that most people with disabilities are abused by other residents [of residential facilities] or by service providers’, Community Services Commission (NSW) and Intellectual Disability Rights Service (NSW), *Crime Prevention in Residential Services for People with Disabilities*, Discussion Paper (2001) 10.

regulatory requirements should apply to compulsory care of people living in facilities and those who remain in the family home.

Questions

13. Should any proposed compulsory care framework apply to care provided by family members?

Chapter 5

Options for Decision Making and Review

5.1 In Chapter 4 we discussed the criteria for compulsory care and treatment. This chapter discusses some procedural issues which will need to be dealt with by legislation regulating compulsory care. These include the following questions.

- How should compulsory care decisions be initiated?
- What assessment process should apply prior to the making of the decision?
- Who should be able to authorise compulsory care and treatment?
- Who should be involved in the assessment?
- Who should manage care and treatment on a day-to-day basis?
- What should the review and appeal process be?

HOW SHOULD COMPULSORY CARE DECISIONS BE INITIATED?

5.2 The need to seek authorisation for compulsory care of a person with an intellectual disability may become apparent to a relative, carer, guardian, social worker, member of the police, a clinical professional or other person. The issue may arise when a person with an intellectual disability or cognitive impairment is living in a residential facility or involved in a service program, while living at home, or when he or she becomes involved in the criminal justice system. The process for initiating an authorisation for the person to be detained or treated without consent must be sufficiently flexible to deal with a wide range of situations. In addition, there are some situations where a full initiation and application will not be feasible. Some of the issues arising from these situations will be

discussed later with respect to interim and emergency authorisations for compulsory care and treatment.²⁴¹

5.3 Under the *Mental Health Act 1986* (MHA), a person may be admitted to and detained in a mental health facility on request by a medical practitioner who has examined the patient within the previous three days. Where a medical practitioner is not available, a person can be taken to a mental health facility on the authorisation of a mental health practitioner.²⁴² After an initial assessment period, continued detention must be confirmed by an authorised psychiatrist.²⁴³

5.4 Although involuntary treatment processes under the MHA are formally initiated by a medical practitioner, this approach may be ill-suited for decisions about compulsory care of people with intellectual disabilities or cognitive impairments. Two possible approaches could be taken to the initiation of compulsory care and treatment processes: allowing a relatively broad range of people to initiate the process or allowing only specified people to initiate the process. We discuss each of these options below.

Option 1: Allow a Broad Range of People to Initiate the Process

5.5 The legislation could allow a broad range of people (for example carers, relatives, social workers²⁴⁴ or any person with a reasonable belief that compulsory care and treatment is necessary)²⁴⁵ to initiate the compulsory care process. This approach would recognise that the fact that a person's behaviour is placing them or others at risk may become apparent to a range of people.²⁴⁶ However, a possible disadvantage of this approach is that it could

²⁴¹ See below paras 6.2–10.

²⁴² *Mental Health Act 1986* s 9(7A). See also s 10 allowing a police officer to apprehend a person who appears to be mentally ill if they are likely to attempt suicide or cause serious bodily harm to themselves or others and s 11 allowing a police officer or any other person to apply to a magistrate for an order allowing entry of premises by police and the examination, by a registered medical practitioner, of a mentally ill person believed to be incapable of caring for her or himself.

²⁴³ *Mental Health Act 1986* s 12A.

²⁴⁴ See, for example, the *Mental Health Act (Northern Ireland) 1961* s 43.

²⁴⁵ See, for example, the *Mental Health (Care and Treatment) Act 1994* (ACT) s 14.

²⁴⁶ It may also be appropriate for police officers, members of the staff of the Office of the Director of Public Prosecutions, magistrates and judges to be able to initiate proceedings under any proposed framework. The issues arising from the integration of the human services system and the criminal justice system will be discussed below: see paras 6.19–33.

lead to a substantial number of applications to authorise compulsory care. Depending on what interim arrangements were made for care during the period before compulsory care was authorised, it could increase the number of people detained until a final decision is made. Arguably, it may also be undesirable to allow people who are involved in the immediate care of the person to apply for authorisation of compulsory care and treatment, because of the conflicts of interest that might apply in such situations. Another possible disadvantage is that applications to authorise compulsory care may be made strategically to give people access to facilities or programs, where their needs would not otherwise justify their admission ahead of others with higher or more urgent need for care.

Option 2: Allow Only Specified People to Initiate the Process

- 5.6 Under this option, only people with particular skills or positions which were specified in the legislation could initiate the process. For example, these could include Department of Human Services (DHS) officers and prescribed clinical practitioners, who might be required to undertake training for the specific purpose of making applications for compulsory care and treatment.²⁴⁷ The legislation could also provide for referrals from the criminal justice system.²⁴⁸
- 5.7 This option could streamline and simplify the process for authorising compulsory care and might prevent inappropriate applications being made. However, it would rely on the availability of appropriate clinical practitioners and/or DHS officers. There may be an insufficient number of people who can undertake this task in rural and regional areas.²⁴⁹

²⁴⁷ It was recommended in the Millan Committee Report that general practitioners should continue to have a role in initiating emergency detention and supporting applications for long-term compulsion. There should be a requirement for general practitioners to receive greater training in mental health issues: see above n 189, Recommendations 7.3–5.

²⁴⁸ See, eg, *Mental Health Act 1986*, Part 3, Divisions 3 and 4.

²⁴⁹ There may be other options available that would cater for the needs of those in regional and rural Victoria. One of these might be a variation of the model of the 'Regional Intake and Response Teams' that the DHS uses for people with a mental illness who live in rural and regional Victoria.

This may be a reason for allowing a broader range of people to initiate the compulsory care process.

Questions

14. Who should be able to initiate the compulsory care process?

WHAT ASSESSMENT PROCESS SHOULD APPLY ?

5.8 We discuss who should be responsible for authorising compulsory care below.²⁵⁰

Whatever process is put in place to authorise compulsory care, the legislation will need to provide for a preliminary assessment of the situation of the person with an intellectual disability or cognitive impairment, to determine whether compulsory care may be justified. The preliminary assessment would examine:

- whether or not the person has an intellectual disability or a cognitive impairment;
- the degree, seriousness and imminence of risk, that is, the likelihood of the person causing harm to self or others, and how serious that harm is likely to be;
- the degree to which the person is able to understand those risks and the consequences;
- the sorts of care and treatment that will minimise the likelihood of harm;
- the impact of the care and treatment on the person; and
- the degree to which the person is able to make decisions relating to his or her care and treatment.

5.9 There are three broad options for considering these matters: that the assessment be carried out by a specified type of practitioner, that the assessment be carried out by a specified team of professionals or that the body overseeing the compulsory care and

²⁵⁰ See below paras 5.16–28.

treatment be responsible for overseeing the process. We discuss each of these options below.

Option 1: Assessment Should be Made by a Specified Type of Practitioner

5.10 Under this approach, the legislation would specify the type of practitioner who would make an initial assessment of the person's need for compulsory care and treatment.²⁵¹ It would specify the assessor's required area of expertise. It would also specify the relationship between the assessor and the body with responsibility for authorising care. For example, if all decisions about compulsory care were required to be made by a tribunal, the legislation could require the assessor's report to be provided as evidence to the tribunal.

5.11 A problem with placing this task in the hands of a single assessor is that it may be necessary to obtain the expert opinions of people from a range of disciplines. Even within the psychology profession, there is considerable difference of opinion about some of the critical aspects of the assessment process, for example, with respect to the tools for accurately assessing risk. Another disadvantage of this approach is that different assessors may make inconsistent decisions. If the assessor's role were to report to a tribunal, it would be the tribunal's responsibility to ensure consistency in decision-making.

Option 2: Assessment Should be Made by a Specified Team of Professionals

5.12 Under this option, the legislation would require appointment of an assessment team drawing on expertise from various relevant disciplines. For example, the legislation could require that an initial assessment be carried out by a psychologist, social worker and psychiatrist. This option could provide a broader, more multi-disciplinary approach to the assessment, and help to ensure better decision-making by the body authorising

²⁵¹ For example, section 9(1) of the *Mental Health Act 1986* specifies that a registered medical practitioner must examine a person, and be satisfied that he or she meets the Act's requirements for involuntary treatment, no more than three days before admission to hospital as an involuntary patient.

compulsory care. One difficulty with this approach is that it may be difficult to assemble a team of assessors with appropriate qualifications in rural and regional areas. This could mean that people would have to be brought to a metropolitan centre in order to be assessed, thus slowing down the authorisation process.²⁵²

Option 3: The Assessment Process Overseen by a Body with Responsibility for Authorising Compulsory Care and Treatment

5.13 This option would leave the details of the assessment process in the hands of the body authorising the treatment. This would be decided on a case-by-case basis depending on the particular circumstances of the case.²⁵³ This option is more flexible than either of the other two options. It places an onus on the decision-making body to look at the circumstances of the particular case and to determine the appropriate sources for gaining information relevant to the assessment. It allows for different professionals to be called in as necessary and relevant. However, it could slow down the authorisation of compulsory care, particularly if the person with an intellectual disability or cognitive impairment is not living in a metropolitan area and must be brought to the city.

5.14 In determining the appropriate assessment process, it will be necessary to balance the need to ensure accurate assessment against the aim of creating a speedy and convenient assessment process. Whichever of these approaches is adopted for authorising on-going compulsory care, provision will also have to be made for use of assessors to authorise compulsory care on an interim basis. This is discussed in Chapter 6.

²⁵² Under the *Mental Health Act 1986*, involuntary admissions can be made on the recommendation of a medical practitioner: s 9. There is a greater availability of medical practitioners in regional Victoria than there is of psychologists who specialise in intellectual disability. However, if a model like that used by the DHS for the Regional Intake and Response Teams is possible then this would reduce the problem.

²⁵³ This is the process adopted in the *Mental Health (Care and Treatment) Act 1994* (ACT) s 16.

Other Issues Relating to Assessors

5.15 In the discussion above, it has been assumed that the assessor or assessment team would provide an expert report to the body responsible for authorising compulsory care. An alternative approach would be for the decision-making body to comprise people with the appropriate expertise.²⁵⁴ The model proposed in the United Kingdom allows for a 28 day detention for compulsory care and treatment on the recommendation of a panel of assessors comprising two doctors and a social worker or other approved mental health professional.²⁵⁵ This model might be appropriate for interim authorisations²⁵⁶ or it could provide the basis for long-term compulsory care assessment. One disadvantage to the model as a basis for the approval of long-term compulsory care is that there may be a perception of a lack of transparency in the decision-making process. If the assessors are members of the decision-making body, there may be no opportunity for an independent assessment of the evidence of the nature of the person's impairment or the seriousness of the risk that he or she poses.²⁵⁷

Questions

15. Who should be involved in the assessment of the person?
 - Should assessors be prescribed in the proposed system of regulation or should the body authorising care decide who should undertake the assessment on a case-by-case basis?
 - If the assessors are prescribed in the proposed system of regulation, what level, and type, of expertise is necessary?

WHO SHOULD BE ABLE TO AUTHORISE COMPULSORY CARE AND TREATMENT?

5.16 There are several possible options for stipulating who should authorise compulsory care and treatment. Compulsory care could be authorised by a suitably qualified person or

²⁵⁴ Under the Tasmanian *Mental Health Act 1963* (s 14(4)) and the Newfoundland *Mental Health Act 1990* (s 5(2)) (Canada) people can be subject to compulsory care on the recommendation of two medical practitioners. There is no need for any other approval.

²⁵⁵ United Kingdom Home Office, above n 197, Part 1: The New Legal Framework, para 3.31.

²⁵⁶ The authorisation of interim compulsory care is discussed in more detail below paras 6.2–9.

²⁵⁷ This disadvantage would be of lesser importance if the body had to make a unanimous decision and had to publish its reasons, as well as the evidence upon which it made the decision.

persons. Alternatively, a tribunal could authorise compulsory care. Such a tribunal could be a new tribunal or the powers of an existing tribunal could be extended. It is also possible that a court, whether an established court or a new court, could perform this function. A combination of these options could form part of the authorisation process.

Option 1: A Single, Suitably Qualified Person

5.17 Compulsory care could be authorised by specified individuals. This could include a guardian,²⁵⁸ one or more relevant clinical practitioners,²⁵⁹ or some other person or persons. This approach is relatively informal and flexible. If a guardian were able to authorise compulsory care, he or she would often have detailed knowledge of the person, which may result in more accurate decision-making. In regional areas, the use of a guardian or a clinical practitioner to authorise compulsory care could make the decision-making process quick and simple. However, as we have seen, there has been criticism of the use of guardians to make compulsory care decisions.²⁶⁰

5.18 The disadvantage of this approach is that it may provide insufficient safeguards against misuse of compulsory care powers. Arguably, authorisation by a single decision maker will not ensure adequate scrutiny of evidence and could result in people being deprived of their rights without receiving an opportunity to participate in the process. If a wide range of people can authorise compulsory care, it may be difficult to ensure high quality and consistent decision-making. If compulsory care is to be authorised by a person with professional expertise alone, there may be little practical opportunity to test the evidence on which the decision is to be based.

5.19 Some of these problems could be addressed by providing a right to appeal against the decision. However, in the case of people with intellectual disabilities, a right to appeal

²⁵⁸ Whether or not that guardian was appointed specifically for that purpose.

²⁵⁹ As noted above n 254, in Tasmania, compulsory care can be provided on the recommendation of two medical practitioners.

²⁶⁰ See above paras 2.57–60.

may only rarely be exercised.²⁶¹ It may be preferable to design an authorisation process which is likely to deliver accurate decisions than to rely on the appeal process to correct mistakes.

Option 2: A Guardianship Tribunal

5.20 This option of a guardianship tribunal would involve the appointment of a guardian who would require the approval of the tribunal before being able to consent to compulsory care and treatment on behalf of the represented person.²⁶² This option would add safeguards where guardians are called upon to make decisions about health care and accommodation. It would ensure that guardians do not make those decisions without some scrutiny. It would also retain the advantages of the current guardianship system where decision makers are appointed on the basis of what is best for the particular individuals and their circumstances. The potential conflicts for guardians in consenting to compulsory care and treatment²⁶³ would, however, not be resolved. Guardianship could still be used to make decisions based on the need to protect others, rather than on the best interests of the represented person.

Option 3: A Tribunal

5.21 The powers of the Mental Health Review Board (MHRB) or the Victorian Civil and Administrative Tribunal (VCAT) could be extended or a new tribunal could be established to undertake the task of authorising compulsory care.²⁶⁴ The legislation could

²⁶¹ This possibility is supported by the Vincent Report's findings that few residents of Statewide Forensic Service exercise their right of review to the Intellectual Disability Review Panel; see above n 7, 22.

²⁶² This is the current situation in Victoria in relation to some medical procedures where the consent of both the guardian and the guardianship tribunal is required: see the *Guardianship and Administration Act 1986* s 42B, see also the *Guardianship and Administration Act 1993* (SA) s 32 which allows the South Australian Guardianship Tribunal to order the detention, upon application of the guardian, of persons who are a risk to the health and safety of themselves or others.

²⁶³ As discussed above paras 2.57–60.

²⁶⁴ In the ACT, the decision is made by the Mental Health Tribunal (*Mental Health (Treatment and Care) Act 1994* s 26). Sue Tait, the President of the Intellectual Disability Review Panel, and John Lesser have also proposed that as a significant step on the road to reform would be that a new tribunal be set up to consider applications for compulsory care. The final stage of the reform process put forward by Sue Tait is the creation of a Victorian Human Rights Commission and Tribunal which would amalgamate compatible jurisdictions along the line of Victorian Civil and Administrative Tribunal (VCAT). The Human Rights Tribunal

require the tribunal to include people with specialist expertise and experience in the area of care and treatment of people with a cognitive impairment. The tribunal could also be required to include people with legal qualifications. This multi-disciplinary approach would help to ensure that decisions are made in a balanced manner, and that a range of disciplinary perspectives are considered.

- 5.22 Tribunals are usually less formal than courts and can design processes suitable to the cases that come before them. A tribunal process is likely to be more transparent than authorisation by a single decision maker and may help to ensure greater adherence to the principles of natural justice.

Option 4: A Court

- 5.23 The decision to authorise compulsory care may substantially restrict a person's freedom. It is arguable that only a court²⁶⁵ should have the power to make a decision of this kind. At present, courts can order compulsory care where the person has been convicted of an offence, or is found unfit to plead or not guilty because of mental impairment. An existing court²⁶⁶ could be given the power to make all compulsory care decisions.
- 5.24 A possible disadvantage of this option is that a judge or magistrates may not have the necessary expertise to make decisions about compulsory care.²⁶⁷ Expert evidence,²⁶⁸ or a requirement that the judge sit with expert assessors,²⁶⁹ could perhaps overcome this problem. Another disadvantage is that court approval may be a costly and slow process,

would incorporate the guardianship list of VCAT, the Mental Health Review Board, the Psychosurgery Review Board and the above new Involuntary Care Tribunal: Tait and Lesser, above n 135.

²⁶⁵ For example, in Alberta, Canada, it is the Court of Queen's Bench that can make the order (*Dependent Adults Act 2000* s 11(3)) and, in New Zealand, many decisions in this area of law are made by the Family Court (eg, under the guardianship provisions in the *Protection of Personal and Property Rights Act 1988*).

²⁶⁶ In theory a new court could be created for this purpose. We do not explore this option here.

²⁶⁷ It is arguable that a court is expert at balancing the facts produced for two competing arguments. As was noted above paras 4.50–1, the language of non-medical health care professionals does not lend itself to the provision of hard facts for judicial consideration. With respect to this possibility, a qualified tribunal or other body may be preferable to a court as the authorising body for compulsory care and treatment.

²⁶⁸ In the case of hospital orders made under s 93 of the *Sentencing Act 1991*, the court must receive information in the prescribed form from a psychiatrist. A similar approach could apply here.

²⁶⁹ As is the case for appeals under the *Guardianship and Administration Act 1993* (SA) s 66(1).

which may dissuade people seeking authorisation for compulsory care. In addition, the formality of court processes would mean that they do not provide an accessible forum for many people with a cognitive impairment.

Option 5: A Combination

5.25 In Chapter 4 we suggested that different authorisation processes may be required for different types of compulsory care. A different process might apply, for example, in situations where people are a risk only to themselves, from the process that applies when they are a risk to others. It also seems appropriate that courts should continue to have power to make decisions about care of people who have committed criminal offences.

5.26 Having a combination of options increases the flexibility of the system. The disadvantage of this approach is that it may create a complex system that is difficult to understand. For example, if a different process were to be followed for people who are a risk to themselves from the process that is followed where they are a risk to others, considerable confusion could arise where the distinction between harm to self and harm to others is unclear, or where a person seems to fit in both camps.

5.27 Comparisons with other jurisdictions where decisions are made regarding compulsory care and treatment, or that lead to the restriction of liberties in other ways, might help in determining this issue.²⁷⁰

5.28 Some relevant observations that arise from this comparison include that:

- in most Australian jurisdictions, decisions relating to compulsory care and treatment are made by either a quasi-judicial tribunal or a court;

²⁷⁰ See Appendix 3 for a comparison of how compulsory care decisions are made in other jurisdictions.

- Victoria follows the practice of other Australian jurisdictions in its use of a tribunal (the Mental Health Review Board) as the body which reviews decisions relating to detention²⁷¹ of people with a mental illness,²⁷²
- decisions that restrict liberties for those who do not have intellectual disabilities are usually made by courts; and
- compulsory care and treatment decisions, made on the basis of perceived *future* risk, arguably represent an even more significant restriction of liberties than those made by courts in relation to people who have already committed offences.²⁷³

Questions

16. Who should have responsibility for authorising compulsory care and treatment?

HOW SHOULD COMPULSORY CARE AND TREATMENT MANAGED?

5.29 The body which authorises compulsory care will not be in a position to make daily treatment decisions. Some clinical decisions will need to be made within the overall parameters of a plan for compulsory care. These could include changes to medication in response to a crisis, or the locking of a door of a secure residential facility to deal with a situation in which a resident's behaviour unexpectedly becomes difficult to control. Such decisions will need to be made on the advice and recommendation of a range of professionals who may be involved in the care and treatment of the person. In this section we consider a number of options for handling that process.

²⁷¹ The Board also hears appeals against various decisions, for example, appeals against the refusal of the Chief Psychiatrist to grant leave to security patients: see *Mental Health Act 1986* s 22.

²⁷² A possible argument for making the approval requirements under any framework proposed here more stringent than under the mental health legislation is that a mental illness is more likely to be either transient or at least more treatable than other cognitive impairments. It has also been suggested that when 'mental health services do become involved, they tend to be focused on dealing with crises rather than ongoing assistance', Intellectual Disability Rights Service (NSW), *The Framework Report* (2001) s 4.9. People with intellectual disabilities or other cognitive impairments, however, may be subject to compulsory care and treatment for extremely long periods of time.

²⁷³ Protection of the community is, however, one of a number of purposes for imposing a sentence on a person who has been convicted of an offence: see *Sentencing Act 1991* s 5 (1)(e).

Option 1: A Specified Senior Government Clinician,

5.30 Under this option a designated person (for example, the Chief Psychologist) would have responsibility for ensuring that the compulsory care and treatment is properly managed. Under the MHA, the Chief Psychiatrist has overall responsibility for the medical care and treatment of people with mental illnesses. Day-to-day management decisions are undertaken by the person's authorised psychiatrist.²⁷⁴ In relation to people with intellectual disabilities, the Vincent Report recommended that the position of Senior Clinician be formally recognised and be empowered to authorise treatment plans and to authorise seclusion and restraint.²⁷⁵ This option places responsibility on the government to monitor the services it delivers, and aims to ensure that monitoring is managed by someone with appropriate clinical expertise. A possible disadvantage of this approach is that the Senior Clinician will be required to make decisions about the management of a large number of people. Because it may be impractical for these decisions to be made by a single person, the power to make day-to-day management decisions will have to be delegated. This may provide insufficient safeguards for individuals, whose interests could be given a lower priority than the smooth running of the service.

Option 2: The Public Advocate

5.31 Under this option, the Public Advocate would receive regular reports on the care and treatment that the person is receiving, and would oversee treatment decisions. Under this option, the person with overall responsibility for monitoring a person's care and treatment would be doing so from a rights-based, advocacy-oriented perspective.

5.32 However, this option may create a conflict of interest for the Public Advocate who may be required to play an advocacy role for the person, while at the same time commenting on the effectiveness of the care and treatment regime in meeting the needs of the person

²⁷⁴ Section 105.

²⁷⁵ See above n 7, Recommendations 5, 7.

receiving the care. The Public Advocate is also unlikely to have the clinical expertise necessary to monitor care and treatment regimes appropriately. The Public Advocate would, furthermore, only have the power to approve a particular service regime, or *request* that it be varied, rather than to order that a service be provided in a particular way. The Public Advocate does not manage these services and has no control over how they are delivered.

Option 3: An Independent Person

5.33 This option would allow a person to be appointed at the time the care is authorised. This could be a guardian appointed specifically for that purpose, or it could be an independent clinician. It could include the option of appointing a senior government clinician or the Public Advocate if that was the most appropriate choice in the particular case. This option would allow greater flexibility than either of the two previous options and could help to ensure that an appropriate balance is found between the need to involve a person with relevant clinical expertise as well as a close enough knowledge of the needs and interests of the particular person.

5.34 All three of the above options are relevant both to care that is provided in a residential facility and to care provided in a person's family home. Issues around the day-to-day management of the order will arise regardless of where the care and treatment is to be provided.

Questions

17. Who should have responsibility for overseeing compulsory care?
18. How should compulsory care be managed on a day-to-day basis?

THE REVIEW PROCESS

5.35 Review processes provide an important means of monitoring, and ensuring accountability for decisions. Two types of review need to be considered:

- periodic review; and
- review on the basis of application.

Periodic Review

5.36 The purpose of periodic review is to ensure that the original decision continues to be appropriate. The review body could consider:

- whether or not the person's circumstances have changed to a degree that the original authorisation is no longer appropriate and needs to be altered or dismissed altogether;
- whether or not the care and treatment being provided under the authorisation is achieving what it was intended to achieve; and
- whether or not there may be a better way of achieving what the compulsory care and treatment is intended to achieve.

5.37 Some of these issues, of course, should be examined on a day-to-day basis as part of the ongoing delivery of care and treatment. Issues around responsibility for daily management of the care and treatment are discussed in the previous section. Here, however, we are looking at how these issues could be examined in a more formal way through regular review.

5.38 The main issues to be determined in relation to periodic review are:

- who should do it? and
- how often should it be done?

REVIEW BODY

5.39 Issues around who should carry out the review are essentially similar to those that we discussed in relation to who should have the power to authorise the care and treatment in the first place. The options are:

- a single, suitably qualified person or persons (including a properly appointed guardian);²⁷⁶
- a guardianship tribunal;
- a quasi-judicial tribunal; or
- a court.

5.40 Obviously, choosing which of these is the most appropriate body for undertaking a periodic review of a compulsory care authorisation will depend on what sort of body authorised the care and treatment in the first place. It is not uncommon for a periodic review to be undertaken by the same body that first authorised the care.²⁷⁷ It is arguable, however, that the more informal and unregulated the original decision-making body, the more important it is that the review body is more formal and regulated.²⁷⁸ This added formality increases the level of accountability in the overall process.²⁷⁹

FREQUENCY OF REVIEW

5.41 Determining how often reviews should be undertaken is largely a matter of finding a balance between the need to ensure that:

- a person's liberties are not unnecessarily restricted;

²⁷⁶ The Vincent Report recommended that, with respect to the residents of the SFS, the Senior Clinician, through the Clinical Assessment and Review Committee, formally undertake the review of residents' treatment and care at least every three months: above n 5, Recommendation 13.

²⁷⁷ This is currently the case in relation to decisions made by the MHRB and by the guardianship list of VCAT. Both bodies review their own decisions on an ongoing and regular basis. For the situation in other jurisdictions, see Appendix 3.

²⁷⁸ For example, it would probably not be appropriate that if a single person, such as a guardian, initially authorised the compulsory care, that the same person has the responsibility for ongoing review of care and treatment.

²⁷⁹ A further option is that after the initial authorisation of compulsory care, a different body than the authorising body review the decision. After that initial review, later periodic reviews are undertaken by the initial authorising body. This is similar to the procedure under the New Zealand Intellectual Disability (Compulsory Care and Rehabilitation) Bill 1999 ss 72, 77.

- the care and treatment is being implemented effectively; and
- the review process is manageable and efficient.

5.42 Because compulsory care decisions may place severe restrictions on a person's liberty, it may be necessary to ensure that reviews are conducted relatively frequently.²⁸⁰

Questions

19. Should there be periodic reviews of compulsory care decisions?
- If so, who should carry them out?
 - How often should the periodic reviews be carried out?

Review on the Basis of Application

5.43 The right to review on the basis of application is a matter of natural justice.²⁸¹ Any person who has had their liberty restricted through compulsory care and treatment must be entitled to apply to have that decision reviewed.²⁸² If the person is unable to apply for a review him or herself, then an advocate or guardian acting on their behalf should be able to apply as well.

WHO SHOULD BE ABLE TO APPLY?

5.44 This raises questions about who should be entitled to apply for a review. There are several options for this.

OPTION 1: THE AFFECTED PERSON OR GUARDIAN

5.45 This option is consistent with the Tasmanian *Mental Health Act 1963*.²⁸³ The disadvantage is that it relies on the person her or himself being able to initiate the review or a guardian being prepared to do this on their behalf. Often this will not be the case.

²⁸⁰ Reviews of involuntary treatment orders under the *Mental Health Act 1986* must be undertaken by the MHRB at least once every twelve months: s 30 (1)(b).

²⁸¹ Some of the legislation in other jurisdictions makes specific provision for the application of natural justice in the procedures for the review of the provision of compulsory care. See, eg, the *Mental Health (Treatment and Care) Act 1994* (ACT) s 96.

²⁸² See the discussion of natural justice, above para 3.13.

²⁸³ Section 21(4).

OPTION 2: PEOPLE SPECIFIED IN THE LEGISLATION

5.46 This option has the advantage of recognising a broader range of people who might appropriately want to initiate a review, but it places some limits on applications.²⁸⁴ The legislation could set out this list in terms of a relationship between the applicant and the person receiving the care. It could limit applications to people who are aggrieved and affected by the detention of the person.²⁸⁵ It could even allow advocacy bodies, such as the Mental Health Legal Centre or the Disability Discrimination Legal Centre to apply for a review on behalf of a person with an intellectual disability or cognitive impairment.

OPTION 3: NO LIMITATIONS

5.47 Under this option, anyone who saw the need for a review could apply for one.²⁸⁶ It is an option that, in effect, might turn out to be quite similar to Option 2, as it is unlikely that people other than those with some sort of connection to the person, and with some sort of interest in their care and treatment, would apply for a review.²⁸⁷

OPTION 4: THE BODY THAT FIRST AUTHORISED THE CARE AND TREATMENT

5.48 The legislation could allow the decision-making body to initiate a review itself, in addition to a provision allowing others to apply.²⁸⁸ The decision-making body could become aware of changed circumstances, or of more information, that might be relevant to the need for the compulsory provision of care and treatment. It therefore increases the likelihood that inappropriate reviews will be identified and responded to quickly.

²⁸⁴ Under the *Mental Health Act 1986*, the patient, a community visitor or any other person who satisfies the Mental Health Review Board that they have a genuine concern for the patient may apply to the Board for a review of the detention of the patient: s 29.

²⁸⁵ This is the requirement in the Newfoundland *Mental Health Act 1990* (Canada) s 16.

²⁸⁶ In s 36 of the *Mental Health (Treatment and Care) Act 1994* (ACT) there is no qualifications listed for those who can make an application for review.

²⁸⁷ Depending on the procedures of the reviewing body, privacy issues may be raised by the possibility of too wide a range of people having the option of applying for a review.

²⁸⁸ See *Mental Health (Treatment and Care) Act 1994* (ACT) s 36 (1).

Review Body

- 5.49 The question as to who should carry out the review appears to be more straightforward. The question has already been discussed above with respect to periodic reviews.²⁸⁹ It is worth repeating, however, that in many jurisdictions, an application for a review is made to the body that first authorised the compulsory care. If the original authorisation was made by an individual such as a guardian, rather than by a tribunal or court, then an application for review, for the purposes of accountability, could be heard by the tribunal that appointed the guardian.²⁹⁰
- 5.50 A further issue with respect to reviews undertaken after an application relates to the nature of the review. If the review process requires a complete rehearing of the facts, the review body could be overwhelmed by applications without merit.²⁹¹ On the other hand, limiting the grounds for review may mean that the review procedure provides inadequate protection to individuals and/or that the review body's time is unnecessarily taken up by considering whether it has jurisdiction to review the decision. One way of reducing the chance of the review body being overwhelmed is to limit the number of applications that can be made with respect to a person receiving compulsory care. The proposed framework in the United Kingdom limits applications to one per care order.²⁹² If this option were followed, an authorisation for compulsory care and treatment would have to be limited to a reasonable period of time. In the United Kingdom, the maximum length proposed is 12 months.²⁹³ Another approach would be to require the applicant to show that a change in circumstances had occurred since the authorisation was made or the care and treatment last reviewed.

²⁸⁹ See above paras 5.39–40.

²⁹⁰ See, for example, *Guardianship and Administration Act 1993* (SA) s 30. The decisions that can be reviewed under this provision are not the decisions which authorise compulsory care (such decisions are made by the Board itself), however, the model could still be used in any proposed framework here.

²⁹¹ It should be noted, however, that not all legislation in the other jurisdictions specifies grounds for applications for review. See, eg, *Mental Health (Treatment and Care) Act 1994* (ACT) s 36 (1). Other legislation just stipulates that the applications should contain the grounds of review on which the application is based. See, for example, the South African Mental Health Care Bill s 35.

²⁹² United Kingdom Home Office, above n 197, Part 1: The New Legal Framework, para 3.61.

²⁹³ Ibid para 3.52.

Question

20. Should there be provision for applications to review compulsory care decisions?

- If so, who should be entitled to apply for a review?
- On what grounds should they be entitled to apply for a review?
- Who should undertake the review?

What, if any, limits should be placed on the review process?

THE APPEAL PROCESS

5.51 Should there be a process for appealing against the original decision and what should that process be?²⁹⁴ The argument in favour of an appeal process is that this provides the opportunity to correct a decision. The argument against providing for appeal is that it is an unnecessarily legalistic approach, which may be ill-suited to the management of people with intellectual disabilities. If the legislation allows an appeal process, three questions arise:

- Who should be able to appeal?
- Under what conditions should an appeal be able to be made?
- To whom should the appeal be made?

Who Should be Able to Appeal?

5.52 The question of who should be able to appeal raises the same sorts of options and issues as does the question of who should be able to apply for a review of compulsory care and treatment.

Under what Conditions Should an Appeal be Made?

5.53 The question of the conditions under which an appeal should be allowed raises a number of possibilities.

²⁹⁴ Some jurisdictions also leave open the possibility of using the relevant Minister as an avenue of appeal. See, for example, the *Mental Health Act (Northern Ireland) 1961* s 54.

OPTION 1: THE PERSON AFFECTED IS DISSATISFIED WITH THE ORIGINAL DECISION

5.54 This is the broadest option. It recognises the significance of compulsory care decisions on the individual affected. A disadvantage of this approach may be that an appellate body such as a court may have a lower level of expertise in the area than the original decision maker. If there are unrestricted opportunities to appeal, especially to a jurisdiction without the specialist expertise, the end result may be that more, rather than less, bad decisions are made.

OPTION 2: APPEALS ON POINTS OF LAW

5.55 Appeals on points of law are appeals which argue that the original decision maker made an error in interpretation or application of the law.²⁹⁵ This is a much more limited grounds for appeal than in Option 1. The advantage of this option is that it recognises that the original decision maker is the one most likely to have the specialist expertise to enable him or her to make the right decision on the basis of the facts. However it also allows scope for correction of mistakes of law.

OPTION 3: REQUIREMENT FOR LEAVE TO APPEAL

5.56 This option allows the merit of a person's appeal to be determined on a case-by-case basis. The advantage of this is that it can help minimise resources being spent on matters that have no reasonable chance of success, while still ensuring that people who are dissatisfied with decisions made by the original decision maker have some real opportunity for redress.

Appeal Body

5.57 The question of to whom the appeal should be made will depend largely on who makes the original decision:

²⁹⁵ Currently in Victoria, decisions of, for example, the guardianship list of VCAT, can be appealed only on points of law: *Victorian Civil and Administrative Tribunal Act 1998* s 148.

- If the original decision is made by an individual, such as a guardian, then appeal would most logically be made to the body that regulates that person's decision-making role,²⁹⁶ such as the VCAT.
- If the original decision maker is a member of a tribunal, provision could be made for an appeal to a higher level within the tribunal. For example, a decision made by a single member of the VCAT could be appealed to three VCAT members.
- If the original decision maker is a tribunal, such as the VCAT or a new specialist tribunal, then appeal could be to either a different tribunal²⁹⁷ or to a court.
- If the original decision maker is a judge, then the normal process of appeal from the judge's decision would apply.

Question

21. Should there be a right of appeal from a compulsory care decision?

- If so, who should be able to appeal?
- On what grounds should they be able to appeal?

Should appeals be heard by a different body to the reviewing body? If so, who should hear the appeal?

²⁹⁶ For example, in the Vincent Report, it was recommended that the IDRP hears all matters relating to the SFS: above n 5, Recommendation 14. Decisions within the SFS were recommended to be taken by the Senior Clinician, therefore, the report was recommending that the decisions of a single person be subject to appeals heard by a Tribunal.

²⁹⁷ For example, under the *Mental Health Act 1986*, appeals from the MHRB are heard by the VCAT: s 120.

Chapter 6

Other Issues

6.1 Other issues which will need to be determined in establishing a framework for regulating compulsory care decisions. These include the following questions:

- How should interim care be authorised while a person is being assessed?
- What provisions should be made for emergencies?
- What should be the relationship between the process for authorising compulsory care and decisions made within the criminal justice system?
- How should providers of compulsory care and treatment services be approved?

INTERIM CARE

6.2 Interim care issues arise during the time between an application for compulsory care and treatment and the actual decision on whether or not compulsory care should be authorised. There may be some instances where the risk of harm to self or others is substantial enough to warrant detention, or some other form of care and treatment, while the process for determining the need for compulsory care and treatment is being undertaken.

6.3 Factors which need to be weighed up in determining how best to deal with the issue of interim care include:

- the need to avoid detaining a person, or restricting his or her liberties, before a full assessment has occurred;
- the need to protect the person's safety and the safety of others before compulsory care is authorised;

- the need to allow time to observe a person in order to make an appropriate assessment of the need for compulsory care and treatment;
- the need to recognise that the process of obtaining appropriate assessments, and of hearing and determining an application for compulsory care and treatment, could take a long time, particularly in more remote parts of the State; and
- whether or not the person is consenting to interim care and treatment.

6.4 There are a number of options for dealing with interim care and treatment provisions, which we detail below.

Option 1: Interim Care to be Authorised by the Same Body that Authorises Long-term Care

6.5 This option would recognise that interim care measures can limit a person's liberties in exactly the same way as an ordinary authorisation for care and treatment. It therefore requires that the process for approving interim care should be as accountable and rigorous as possible, and that any interim authorisation should only operate for a limited period.

6.6 This option may have some practical disadvantages. At times, an interim decision may need to be made very quickly, and there may not be enough time to involve the decision-making body, particularly if it is a specialist tribunal or court.²⁹⁸ Another relevant concern is the potential for delay under this option if the person who is to be subject to an interim authorisation lives in a remote area.

²⁹⁸ The issue of time may be of less importance if there is a separate procedure in place for emergency situations. Emergency procedures are discussed below. The authorisation of interim and emergency compulsory care should not be considered separately as there is a possibility the procedures could be inappropriately applied to minimise the inconvenience of those applying for such authorisations. Any minimising of inconvenience may mean reducing the accountability of the framework and the protection of the interests of the person who is to be subject to the compulsory care.

Option 2: Authorisation for Interim Care to be Made by Designated People

6.7 If this option were adopted, the legislation could provide that the authorisation should operate only for a limited period. The decision-making body should be required to authorise extension of any interim care if it is necessary to extend it beyond that period. This option allows decisions to be made quickly, for example, to deal with people who are unable to care for themselves. However, a more rigorous process of authorisation applies if a person is to be detained, or forced to comply with a care and treatment regime beyond that period.²⁹⁹

Option 3: Interim Care to be Authorised Only by a Magistrate

6.8 This option recognises the potential seriousness of the authorisation of interim care involving, as it does, the possibility of detention of people who might not be a risk to the safety of themselves or others at all. It is an option that would make the process for the authorisation of interim care more or less consistent with current processes for detention on remand of people charged, but not convicted of, criminal offences.³⁰⁰

6.9 The disadvantage of this approach is that magistrates may not be well-equipped to assess the need for interim detention. This is particularly the case where the decision may need to be made on the basis of specialised expertise which is not yet available for consideration by the magistrate.³⁰¹ In Options 1 and 2, by contrast, the people involved in the process of determining the need for interim compulsory care are likely to have some of this specialised expertise themselves.

²⁹⁹ See, for example, *Mental Health (Care and Treatment) Act 1994* (ACT) s 41, where a doctor may authorise involuntary detention for no more than three days, and the Tribunal may then authorise it for no more than a further seven days.

³⁰⁰ See, eg, the provisions in the *Bail Act 1977*.

³⁰¹ A variation on this model would have interim compulsory care approved by Justices of the Peace. If this option were followed, it may be possible to require the Justices of the Peace to undergo specific training in the area before they could approve interim care.

Question

22. Should there be provisions for interim authorisation to take effect while the person is being assessed?

- If so, who should be able to authorise interim care?
- What should be the grounds for the authorisation?

EMERGENCIES

6.10 Provisions for emergencies will involve some similar considerations to those that arise in relation to interim care. There will also need to be provisions conferring powers to apprehend people in emergencies and to take them somewhere where they will be detained or receive compulsory care and treatment. The current situation, with respect to people with cognitive impairments, does not provide any agency with clear authorisation for the detention of people at risk to themselves or others in emergency situations.³⁰² To remedy this, the police and/or designated clinical professionals, such as doctors, psychiatrists or psychologists, for example, could be given power to authorise the detention or treatment of a person in an emergency.³⁰³ There should be time limits within which an interim or final authorisation for compulsory care and treatment would need to be properly approved.

Questions

23. Should there be provisions for emergencies, specifically:

- Should there be any difference, in either process or effect, between an interim and an emergency authorisation?
- If so, under what circumstances should emergency care be authorised, by whom, and how long should it last?

24. Should the powers of police, or other emergency personnel, be extended to cover the apprehension and detention of a person prior to the authorisation of emergency or interim care?

³⁰² As it stands now, emergency service personnel have to rely on the common law doctrine of necessity to protect them from civil suits. The doctrine protects a person who has, in an emergency, done what is reasonable in the circumstances to avoid harm (whether to a person, to property or the general public). For a discussion of the doctrine see *In the matter of F (Mental Patient: Sterilisation)* [1990] 2 AC 1 (HL), in particular the judgment of Lord Goff.

³⁰³ See, eg, *Mental Health (Care and Treatment) Act 1994* (ACT) s 37.

LEAVE OF ABSENCE

6.11 Arrangements for leave of absence (otherwise known as community access) allow a person undergoing compulsory care and treatment to leave the facility at which they are living for specified periods.³⁰⁴ Considerations about granting leave of absence need to be made by balancing:

- the right of the person to have opportunities to learn independence and to experience greater responsibility;
- the role that leave of absence can play in the person's rehabilitation and eventual return to the community; and
- the need to ensure that the safety of anyone at risk, including the person her or himself, is maintained to the degree that is reasonable in the circumstances.

6.12 This gives rise to questions about who should have the power to authorise leave of absence. Some options are listed below.

Option 1: The Body that Initially Authorised the Care and Treatment

6.13 Under this option, leave of absence should be treated as a departure from the original authorisation and should only be able to be approved by the body that initially authorised the compulsory care.³⁰⁵ The advantage of this option is that it would ensure a high level of scrutiny of leave of absence. It would give the person the opportunity to apply for leave from someone who is not involved in her or his daily care. This may provide a greater likelihood that the request will be assessed objectively, rather than on the basis of

³⁰⁴ There are already provisions for leave of absence for forensic residents under the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* Part 7 and under the *Mental Health Act 1986* with respect to involuntary patients (s 40) and security patients (ss 51–3). These sections have been amended under the *Forensic Health Legislation (Amendment) Act 2001*, however, the amending provisions, as of 1 May 2002, have not come into operation but must do so by 1 July 2002: *Forensic Health Legislation (Amendment) Act 2001* s 2.

³⁰⁵ A variation of this option is to have the body that undertakes the reviews of the authorisation and treatment as the body that approves any leave of absence. This is the option recommended by the Vincent Report, above n 7, Recommendation 19.

more subjective considerations which might influence someone closer to day-to-day provision of their care and treatment.

6.14 The disadvantage, however, is that it could be a cumbersome option and could discourage people from applying for leave of absence.

Option 2: The Person Responsible for the Overall Management of Compulsory Care

6.15 Under this option, leave of absence would be treated as an aspect of the day-to-day management of the compulsory care and could be determined within that context.

Option 3: The Manager of the Residential Service

6.16 This option would have the advantage of being quicker and easier to manage than either of the two previous options. It would also mean that decisions about leave of absence are being made by someone who has detailed knowledge of the circumstances of the particular person. The disadvantage of this option, however, is that it might mean that leave of absence decisions are not made independently enough of the service that is providing the care and treatment.

Option 4: Whoever is Specified in the Original Authorisation

6.17 This option would be more flexible than any of the other three options. It also has the advantage that the body authorising compulsory care could require a higher level of scrutiny for leave of absence in cases where the person's previous behaviour suggests there is a very serious risk that she or he could harm others.³⁰⁶

6.18 While the flexibility of this option is its obvious advantage, it brings with it a degree of uncertainty and possible inconsistency, with different levels of scrutiny and rigour

³⁰⁶ This is comparable with the situation under the *Mental Health Act 1986* where an authorised psychiatrist can approve leave for an involuntary patient (s 40) but the approval of the Secretary of the Department of Justice is required before leave of absence can be granted to a security patient, the Chief Psychiatrist must be consulted and the Chief Commissioner of Police must be consulted in relation to people who were held in a police gaol before they became a security patient: s 51.

required to approve leave of absence for different people. This may result in an inequitable arrangement.

Question

25. What arrangements should be in place to allow leaves of absence?

THE RELATIONSHIP BETWEEN COMPULSORY CARE AND THE CRIMINAL JUSTICE SYSTEM

6.19 The *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (CMIA) provides for a process for assessment, based on evidence, of the person's mental capacity.³⁰⁷ There is provision for periodic review, and reviews on application, both to be heard by a court and provision for appeal to a higher body. There are also provisions for the regulation of ongoing detention of the person in terms of leave of absence. As this framework complies with all the principles that we discussed in Chapter 3 there may be little reason to change it, except for the possibility of inconsistency with authorisations for compulsory care under the human services system. The Commission welcomes comments on whether the CMIA provides an appropriate framework for the compulsory care of people with intellectual disabilities or cognitive impairments. It will also be necessary to consider whether changes are necessary to integrate the CMIA more effectively with the compulsory care provisions of with the human services system.

Question

26. Is the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* working in practice? Have the amendments to the Act under the *Forensic Health Legislation (Amendment) Act 2001* remedied any deficiencies?

6.20 There are two broad areas where the human services system and the criminal justice system could be integrated. The first area relates to the transfer of people from the criminal justice system to the human service system before they appear in court. The

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³⁰⁷ See above paras 2.32–6 for a discussion of the *Crimes (Mental Impairment Unfitness to be Tried) Act 1997*. Note that the Act has recently been amended by the *Forensic Health Legislation Amendment Act 2001*. All amendments that were made under the have been included in this Discussion Paper.

second area relates to the care of people with cognitive impairments after they have been found guilty of offences.

Transfers of People with Cognitive Impairments to the Human Service System Prior to Court

6.21 There may be circumstances where it will be clear to either the police officers involved or to members of staff of the Office of Public Prosecutions (OPP) that there is no possibility that a particular person with a cognitive impairment will be found guilty of an offence because of her or his mental state. It may be appropriate in those circumstances for the police officer or OPP staff member to be able to initiate proceedings for compulsory care and treatment for the person with the cognitive impairment.³⁰⁸ This option would prevent courts having to deal with matters unnecessarily, particularly in cases where a conviction is unlikely because of the disability of the alleged offender. This option would, most likely, be suitable for less serious offences.³⁰⁹ Whatever framework is adopted to more effectively co-ordinate the human services and the criminal justice systems, the distinct aims of the two systems should not be compromised.

Question

27. Should either the police or the Office of Public Prosecutions (OPP) be given the power to initiate an application for compulsory care and treatment if they feel that there is little chance that the person would be convicted of the offence for which they have come to the attention of the police or OPP?

6.22 As noted above, under the CMIA, the Supreme Court and the County Court may release a person unconditionally or subject him or her to a supervision order where the person is either unfit to be tried or found not guilty because of mental impairment. Under the

³⁰⁸ Under the ACT legislation, referrals can be made by a police officer or a member of staff of the Office of the Director of Public Prosecutions: *Mental Health (Treatment and Care) Act 1994* s 15. Under this Act, referrals can be made by police officers without charges being laid. That is, as long as the officer is satisfied that there are sufficient grounds on which to charge the person in connection with an offence, or the person has been arrested in connection with an offence, the person can be referred to the Mental Health Tribunal: s 15(4).

³⁰⁹ Under the ACT legislation, the referring officer must have regard to the nature and circumstances of the offence when considering the appropriateness of the referral: *Mental Health (Treatment and Care) Act 1994* s 15(1)(b)(i).

recent amendment to the CMIA, it is now clear that if the Magistrates' Court finds a person not guilty because of mental impairment, the court must discharge the person.³¹⁰ However, there is no integration of the Magistrates' Court and the human services system.

6.23 There are two possible options. First, in circumstances where the magistrate considers the person charged with an offence to be in need of care, he or she, at the time of discharging the person, would be able to initiate an application process for the authorisation of compulsory care.³¹¹ This would mean that the person is not neglected and may be given the care that she or he needs. However, a power of this kind would be of little practical assistance for people with intellectual disabilities unless there are appropriate and accessible facilities available to care for those who are at risk to themselves and others.

6.24 The second option would be for magistrates to have the detention options which are currently available to the higher courts under the CMIA. That is, where a person has committed a summary offence or an indictable offence triable summarily, but has been found not guilty because of mental impairment, it would be open to the magistrate to make a supervision order. Where the offence is minor, a non-custodial supervision order may be appropriate instead of community-based orders with attendant justice plans. Where the offence is more serious, a custodial supervision order would be more appropriate than a prison term. This option would mean that in the case of summary offences or indictable offences triable summarily those people who may be suited to a custodial supervision order could be dealt with in the Magistrates' Court rather than transferred to the County Court or the Supreme Court.

³¹⁰ *Forensic Health Legislation (Amendment) Act 2001* s 4. There is no capacity, therefore, for someone to be found 'unfit to be tried' for summary offences. More specifically, magistrates do not have the power to order a dismissal of a charge because the person is unfit to be tried: Richard Fox, *Victorian Criminal Procedure 2002*, para 6.2.31. The findings available to a magistrate are either guilty or not guilty. In practical terms, however, there may be little difference at the Magistrate's Court level between discharging a person after a verdict of not guilty because of mental impairment and an unconditional release after a finding of not being fit to be tried.

³¹¹ This could include, where necessary, the approval by the magistrate of an interim authorisation for compulsory care.

Questions

28. Should magistrates be given the power to initiate applications for the authorisation of compulsory care where they have found a person who does not have a mental illness not guilty because of mental impairment? If so, should magistrates have the power to authorise interim compulsory care for the purpose of assessment?

29. Should the supervision orders under the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* be available to magistrates where a person is found not guilty because of mental impairment?

Alternatives for People with Cognitive Impairments who Have Been Found Guilty

6.25 There are two areas where the human services system and the criminal justice system could be better integrated. These relate to:

- sentencing of offenders with intellectual disabilities or cognitive impairments; and
- transfer of offenders with intellectual disabilities or cognitive impairments from prison to secure residential facilities.

SENTENCING OPTIONS FOR OFFENDERS WITH COGNITIVE IMPAIRMENTS

6.26 An offender with a cognitive impairment may not have a sufficient level of impairment to be considered unfit to be tried or to have been found not guilty because of mental impairment. However, the person's impairment may mean that he or she would not be suited to a term in prison. Under the *Sentencing Act 1991*, offenders with mental illnesses may be subjected to hospital orders.³¹² There is no similar provision for the detention of offenders with cognitive impairments. Justice plans have been considered to be the 'counterpart of a hospital order for intellectually disabled persons',³¹³ however, as discussed above, justice plans are not custodial orders and cannot operate for longer than two years.³¹⁴ It would be possible to introduce a new sentencing option, equivalent to the hospital orders, for offenders with cognitive impairments who are not suited to detention in prison.

³¹² Section 93. Hospital orders and hospital security orders are discussed above 2.37–40.

³¹³ Fox and Freiberg, above n 113, para 10.209.

³¹⁴ See above para 2.28.

- 6.27 A new sentencing option of this kind could provide for the care of a person within a residential facility, instead of a prison. A provision of this kind would have to retain the offender's primary status as a person convicted of an offence. The purpose of a custodial sentence is to remove the offender from the community for a specified period.³¹⁵ This would have to be reflected in provisions relating to leave of absence and any other conditions applicable to the person's detention in a residential facility.
- 6.28 It may also be desirable to consider whether other non-custodial sentencing options should be available, for example, the requirement that a person attend a particular program for a specified period, instead of serving a period in prison. Again, this sentencing option would need to take account of the fact of the person's status as someone convicted of an offence.

Question

30. Should new custodial sentencing options be available for the compulsory care of offenders with a cognitive impairment? If so, under what circumstances should they be available?

REFERRALS FROM PRISON

- 6.29 The issue of referrals from prison arises in relation to people who have already been convicted of offences and who have received prison sentences, for whom it later becomes apparent that an environment other than prison is needed in order to meet their needs. This could, for example, happen where a prisoner sustains a head injury to the extent that they have an Acquired Brain Injury. Currently, section 21 of the *Intellectually Disabled Persons' Services Act 1986* allows for the transfer of a person, who is eligible for services under that Act, from prison to the care of the Department of Human Services

³¹⁵ In the *Report of the Review Panel Appointed to Consider leave Arrangements for Patients at the Victorian Institute of Forensic Mental Health* (2001) a number of principles were considered to be important to the 'interface between Victoria's Mental Health and Correctional systems'. These included 'that security patients are either under sentence or on remand, that a transfer from the prison system to the Victorian Institute of Forensic Mental Health should not, of itself, lead to a diminution of security and that there must be a continuity of security between services [and] that any leave must also be considered in terms of the potential impact on public safety, security of the individual and impact on any individual involved in the offence'; *ibid* 1–2.

(DHS), as a security resident. This transfer happens through an application made by the Minister administering the Office of Corrections to the Secretary of the Department.

6.30 It would be possible, however, to utilise a different body to hear applications for transfer of prisoners to the care of DHS. This option would require new legislation³¹⁶ providing that the responsibility for determining whether a prisoner should be transferred to DHS rested with the same body that makes all other compulsory care and treatment decisions. This option would take the issue of transfer out of the hands of the departments responsible for the actual service provision, and confer it on a body that had no role other than to determine appropriate care and treatment.

6.31 The option may have the disadvantage of creating a significant demand for services that are not available. If the consent of the Secretary of DHS was not required for a transfer, DHS could be forced to provide services that it does not have the resources to provide. This disadvantage could be overcome by requiring the consent of DHS, after the request for transfer has been approved by the new body.

Question

31. Under what circumstances should prisoners with a cognitive impairment be able to be transferred to a secure residential facility?

COMPULSORY CARE AFTER THE END OF A SENTENCE

6.32 As noted above,³¹⁷ there is no provision for the compulsory care of a person with a cognitive impairment who has completed a sentence. This is the case regardless of whether the sentence was a custodial sentence or a community-based order with an associated justice plan. It may be appropriate to retain the status quo, as changing it would be treating people with intellectual disabilities differently to people without disabilities.

³¹⁶ The current transfer provisions are in the *Intellectually Disabled Persons' Services Act 1986* s 21.

³¹⁷ See above para 2.42.

6.33 However, it is arguable that, in the interests of an offender with a cognitive impairment, there should be a provision for a transfer from the criminal justice system to the health services system at the end of their sentence or justice plan. This does not mean that offenders should go straight from the prison to a residential facility, but that their needs could be assessed at the end of their sentences or plans, to see if the services offered by the human services system can meet their needs.

Question

32. Are justice plans working in practice? How could they be improved, if at all?

33. Should there be provision for the continuation of the compulsory care of offenders with a cognitive impairment who have completed their custodial sentences or justice plans? If so, what should be the procedure for the continuation of the care?

APPROVAL OF CARE PROVIDERS

6.34 The Vincent Report noted the ‘standards under which a facility may operate for the compulsory care of a person is not regulated’.³¹⁸ It is important, therefore, that the framework includes provisions for such regulations. There are, however, two aspects to the notion of regulation. There is regulation that predominantly functions to punish those who do not perform to the required standard. There is also a more positive form of regulation which would seek to encourage and enable good practices, rather than just seeking to punish bad practices. Given the purpose of the residential facilities, it may be more appropriate to propose a more positive form of regulation of facilities.³¹⁹

6.35 A further issue with respect to care facilities concerns the disabilities and conditions of the people who may reside there. As was highlighted in Chapter 2, there are a number of

³¹⁸ Above n 7, 12.

³¹⁹ The distinction between the two aspects of regulation has been discussed in the context of the regulation of nursing homes in John Braithwaite, Toni Makkai, Valerie Braithwaite and Diane Gibson, *Raising the Standard—Resident Centred Nursing Home Regulation in Australia*, Aged and Community Care Service Development and Evaluation Report Number 10 (1993). In the Report the distinction was discussed in terms of the move from the regulation of inputs (ie, the minimum standards necessary to comply with the regulations) to an outcome orientation. One of the examples provided was ‘if a nursing home can deliver superior social services to residents by employing two unqualified people instead of one social work graduate’, and the required input standard was for there to be at least one social work graduate is need to supply care, then despite the fact that a better outcome is delivered to the resident, the nursing home would fail the input standard: *ibid* 9.

other statutes that allow for the involuntary committal of people. It would be possible that any care facility that is available for people who are to be subject to compulsory care and treatment under the framework we propose may be appropriate for people subject to other committal orders.³²⁰

6.36 In determining the appropriateness of care and treatment provider it will be necessary to ensure that:

- services conform to relevant service delivery principles, particularly those discussed in Chapter 3, including maximising social participation, ensuring quality of life, recognising and safeguarding rights and liberties, and protecting against exploitation and abuse; and
- services work as effectively as possible to help minimise harmful behaviours, and to rehabilitation of offenders.

6.37 There are two main ways in which this issue could be addressed, which are discussed below.

Option 1: A Formal System

6.38 Under this option, the body authorising compulsory care and treatment with respect to where people will live, or the program in which they must participate, would have a list of services and facilities to choose between.³²¹ That is, services could be approved through an accreditation process that may involve a professionally constituted board, or other registration process.³²² It is likely that a system such as this would need to be reinforced through regular inspections of services to ensure that they continue to meet the relevant

³²⁰ As was highlighted above para 2.23, one reason for the lack of use of the committal proceedings under the *Alcoholics and Drug-dependent Persons Act 1968* is the lack of a secure facility in which people could be housed.

³²¹ Under the *Mental Health Act 1986* s 8, a person with a mental illness may be involuntarily detained only in an approved Mental Health Service. Services are proclaimed under s 94 of the Act.

³²² In the ACT, the owners or managers of private psychiatric institutions have to have licensed: *Mental Health (Treatment and Care) Act 1994* s 124. These licences are issued by the relevant Minister: s 125.

standards and to operate according to the relevant principles. This could be achieved through the current community visitor³²³ scheme, or something similar to it.³²⁴

6.39 This option has the advantage of rigour. It could allow for quite stringent criteria for approving a service and could thereby help to guarantee effective service delivery, consistent with the necessary principles. It is, however, an option that would limit the choices available at the time of authorising compulsory care and treatment. This may mean that some service options that might be best for the particular person might not be able to be used because the particular service has not been through the formal registration or approval process.

Option 2: A Less Formal System

6.40 This option would give the body authorising compulsory care and treatment more or less unlimited discretion in choosing service providers, including what facility the person will live at and if the care is to be provided in a facility.³²⁵ This option has the advantage of greater flexibility. It allows the body to choose whatever option is best for the person and his or her particular circumstances.

6.41 However, it is an option that may result in a certain degree of ‘arbitrariness’ in the provision of compulsory care and treatment. It would be an option that would largely rely on the disability service providers to develop and deliver quality services, rather than being able to facilitate this through a regulation or approval process.

Some combination of these two broad options may be best. For example, a more rigorous approval and regulation system might be required for facility-based providers, but a more flexible system for community-based orders.

Questions

34. How should residential and other care providers be regulated?
 - What type of regulatory framework is most likely to encourage high quality care practices?
 - Should there be regular inspections of the facilities?
35. What other mechanisms should be put in place to ensure that people receiving compulsory care obtain appropriate treatment?

Opportunities for Complaints and Redress

- 6.42 Regardless of which, or which combination, of these options seems best, there will still be the need to ensure that there are opportunities for complaints and redress if a person is dissatisfied with the service that is being provided.
- 6.43 This issue is not limited to the provision of compulsory care and treatment. It is relevant to the provision of any services to people with disabilities. At the moment, there is no body with specialist expertise in this area that can order redress where a service is failing to meet its obligations or to deliver what is expected of it.³²⁶ It is particularly important to provide redress where services are provided on a compulsory basis and potentially involve major restrictions on rights and liberties. One possibility would be to have an independent person take on the role, such as an ombudsman.
- 6.44 While this issue lies beyond our terms of reference, we nevertheless note the importance of addressing it, and its crucial place in any framework for compulsory care and treatment.

Question

36. What other avenues of complaint and redress should be available for people under a compulsory care order who are not being treated in accordance with their needs?

³²⁶ There are three independent bodies that already perform a review function in the health services/disability area. The three bodies are the Ombudsman, the Health Services Commissioner and the Public Advocate. The Ombudsman has the power to investigate any administrative action of government departments and public statutory bodies (*Ombudsman Act 1973* s 13), which would include DHS and the IDRP but not care providers that are not statutory bodies. The Health Services Commissioner has the power to investigate complaints relating to health services (*Health Services (Conciliation and Review) Act 1987* s 9). The Public Advocate can seek assistance in the best interests of any person with a disability from any government department, institution, welfare organisation or service provider (*Guardianship and Administration Act 1986* s16) but does not have any investigative powers outside those with respect to guardians. It should also be noted that under the *Mental Health Act 1986* there is specific provision for involuntary and security patients to appeal in writing against their detention to either the Ombudsman or the Health Services Commissioner: s 29. It has been noted that 'there are a number of bodies able to respond to complaints by people who use health or disability services, yet none of the existing mechanisms have the ability to compel a service provider to act to remedy a complaint or provide redress to a complainant': Tait and Lesser, above n 135.

Appendix 1

Relevant Victorian Legislation³²⁷

HUMAN SERVICES SYSTEM	Compulsory Care Provisions	Criteria	Safeguards
<i>Intellectually Disabled Persons' Services Act 1986</i>	Restraint and seclusion	<ul style="list-style-type: none"> • Intellectual disability • Measures are part of a person's program plan 	Instances of use must be reported to the Intellectual Disability Review Panel
<i>Intellectually Disabled Persons' Services Act 1986</i>	Security order—transfer from prison to residential facility	<ul style="list-style-type: none"> • Person eligible for services under the Act • Person convicted of an offence and sentenced to prison 	Review by the Intellectual Disability Review Panel, which can only make recommendations; its findings are not determinative.
<i>Mental Health Act 1986</i>	Community treatment orders	<ul style="list-style-type: none"> • Mental illness that can be treated • Person should be detained for her or his own safety or the protection of others 	<ul style="list-style-type: none"> • Review by the Mental Health Review Board • Review of Board decisions by the Victorian Civil and Administrative Tribunal
<i>Mental Health Act 1986</i>	Involuntary patient	<ul style="list-style-type: none"> • Mental illness that can be treated • Person should be subject to the order for his or her own health and safety or for the protection of the public 	<ul style="list-style-type: none"> • Review by the Mental Health Review Board • Review of Board decisions by the Victorian Civil and Administrative Tribunal
<i>Health Act 1958</i>	Examining, testing, counselling, restriction and isolation orders	<ul style="list-style-type: none"> • A person who has, or is reasonably likely to have, an infection • A person is likely to transmit the disease • Serious risk to public health 	<ul style="list-style-type: none"> • Review by Secretary of the Department of Human Services • Appeal to Supreme Court
<i>Alcoholics and Drug-dependent Persons Act 1968</i>	Committal to treatment order	<ul style="list-style-type: none"> • Alcoholic or drug-dependent person • Person assessed to be in need of treatment 	Appeal to court

³²⁷ The provisions included here are not comprehensive and are intended as a guide only. For a more complete discussion of the legislation, see Chapter 2.

CRIMINAL JUSTICE SYSTEM	Options	Criteria	Safeguards
<i>Sentencing Act 1991</i>	Justice plans	<ul style="list-style-type: none"> • Intellectual disability • Conviction for an offence • Suitability for a community-based order 	<ul style="list-style-type: none"> • Review by Secretary of the Department of Human Services • Report of Secretary considered by court
<i>Sentencing Act 1991</i>	Hospital orders	<ul style="list-style-type: none"> • Mental illness • Conviction for an offence • Illness is treatable 	<ul style="list-style-type: none"> • Care of offender is transferred to the health services system • Safeguards under the <i>Mental Health Act 1986</i> apply
<i>Sentencing Act 1991</i>	Hospital security orders	<ul style="list-style-type: none"> • Mental illness • Conviction for an offence • But for the illness, the person would have been sentenced to imprisonment • Illness is treatable 	<ul style="list-style-type: none"> • Sentence can be appealed to a court • Illness is reviewed by the Mental Health Review Board or the Chief Psychiatrist
<i>Crimes (Mental Impairment and Unfitness to be Tried) Act 1997</i>	Supervision orders	<ul style="list-style-type: none"> • Unfit to be tried, or • Not guilty because of mental impairment 	Application to court
SUBSTITUTED DECISION-MAKING	Options	Criterion	Safeguards
<i>Guardianship Act 1986</i>	Guardianship orders	People who, because of their disabilities, are unable to make decisions that are in their own best interests.	Guardianship list of the Victorian Civil and Administrative Tribunal

Appendix 2

Categories of Intellectual Disability in Other Jurisdictions³²⁸

Legislation & Jurisdiction	Category	Definition
<i>Mental Health (Treatment and Care) Act 1994</i> (Australian Capital Territory)	'mental dysfunction'	A disturbance or defect, to a substantially disabling degree, of perceptual interpretation, comprehension, reasoning, learning, judgment, memory, motivation or emotion.
<i>Guardianship and Administration Act 1993</i> (South Australia) ³²⁹	'mental incapacity'	An inability of a person to look after his or her own health safety or welfare as a result of any damage to, or any illness, disorder, imperfect or delayed development, impairment or deterioration of the brain or mind.
<i>Mental Health Act 1963</i> (Tasmania)	'mental disorder'	Mental illness, arrested or incomplete development of mind, psychopathic disorder, ³³⁰ and any other disorder or disability of mind.
<i>Mental Health Act 1963</i> (Tasmania) ³³¹	'severe subnormality'	A state of arrested or incomplete development of mind that includes subnormality of intelligence and is of such a nature or degree that the patient is incapable of living an independent life or of guarding him or herself against serious exploitation.
Intellectual Disability (Compulsory Care and Rehabilitation) Bill 1999 (New Zealand)	'intellectual disability'	An impairment that results in significantly sub-average intelligence ³³² as measured by standard psychometric tests generally used by clinicians and results in significant deficits, as measured by tests generally used by clinicians, in at least two listed skills ³³³ and that became apparent during the developmental period of the person.
<i>Dependent Adults Act 2000</i> (Alberta, Canada)	'dependent adults'	An adult who is repeatedly or continuously unable to care for him_ or herself and unable to make reasonable judgments in respect of matters relating to his or her person. ³³⁴

³²⁸ This table does not include reference to legislation relating to people with a cognitive impairment who have been charged with criminal offences. The exception to this is the New Zealand Bill. We have included this Bill because of its comprehensive definition and its currency. With the difficulties associated with accessing up-to-date international legislation, the overseas legislation referred to in these Appendices may not be fully current. However, the legislation included here is intended as a guide only for possible changes here in Victoria.

³²⁹ The Act does provide for the involuntary detention of people.

³³⁰ Defined as a persistent disorder or disability of mind (whether or not including subnormality of intelligence) that results in abnormally aggressive or seriously irresponsible conduct on the part of the patient, and requires or is susceptible to medical treatment.

³³¹ For people over 21 years, compulsory admission to hospitals are only available for people with a mental illness or a 'severe subnormality of mind'. For people under 21 years, applications can be made on the basis of subnormality or psychopathic disorder.

³³² Significantly sub-average intelligence is defined as an IQ of approximately 70 or less, expressed within an accuracy of plus or minus 5 points with a possible IQ of 75 as the effective maximum at which a person's intelligence can be considered to be significantly sub-average.

³³³ The listed skills are communication; self-care; home living; social skills; use of community services; self-direction; health and safety; reading, writing and arithmetic; and leisure and work.

³³⁴ Only those dependent adults who have been assessed as being a danger to themselves or others can be subject to a compulsory care.

<i>Mental Health Act 1990</i> (Newfoundland, Canada)	'mental disorder'	A disease or disability of the mind.
<i>Mental Health Ordinance</i> (Hong Kong)	'mental disorder'	<ul style="list-style-type: none"> • Mental illness. • A state of arrested or incomplete development of mind which amounts to a significant impairment of intelligence and social functioning which is associated with abnormally aggressive or seriously irresponsible conduct. • Psychopathic disorder. • Any other disorder or disability of mind that does not amount to mental handicap.³³⁵
Mental Health Care Bill 2001 (South Africa) ³³⁶	'mental health care user' ³³⁷	A person receiving care, treatment and rehabilitation services or using a health service aimed at enhancing the mental health status of a user. ³³⁸
Reforms under the <i>Reforming the Mental Health Act White Paper</i> (England) ³³⁹ .	'mental disorder'	Any disability or disorder of mind or brain, whether permanent or temporary, which results in an impairment or disturbance of mental functioning. ³⁴⁰
<i>Mental Health (Scotland) Act 1984</i>	'mental disorder'	Includes mental illness, mental handicap, however caused or manifested, and personality disorder
Reforms proposed in the Millan Committee Report ³⁴¹ on the <i>Mental Health (Scotland) Act 1984</i>	'mental disorder'	<p>Covers three categories:</p> <ul style="list-style-type: none"> • mental illness;³⁴² • learning disability; and³⁴³ • personality disorder. <p>None of these should be defined, but guidance should be provided as to their application.</p>

³³⁵ Mental handicap is defined as sub-average general intellectual functioning with deficiencies in adaptive behaviour.

³³⁶ The Bill does include provisions for care, treatment and rehabilitation of mental health care users without consent where the user is likely to inflict serious harm to him or herself or others.

³³⁷ This category is comprised of the two subcategories of people with a 'mental illness' and people with a 'severe and profound disability'. The latter subcategory is defined as a 'range of intellectual functioning extending from partial self-maintenance under close supervision, together with limited self-protection skills in a controlled environment through limited self care and requiring constant aid and supervision, to severely restricted sensory and motor functioning and requiring nursing care'.

³³⁸ Mental health status is defined as the level of mental well-being of an individual as affected by physical, social and psychological factors and which may result in a psychiatric diagnosis.

³³⁹ See above n 197.

³⁴⁰ This definition is intended to include severe personality disorders.

³⁴¹ More formally known as *New Directions—Report on the Review of the Mental Health (Scotland) Act 1984* (2001).

³⁴² Mental illness is intended to include psychotic disorders such as schizophrenia, but also non-psychotic conditions such as disorders of mood, severe obsessive compulsive disorder and anorexia nervosa.

³⁴³ Learning disability is intended to include autistic spectrum disorders.

Appendix 3

Decision-making Bodies in Other Jurisdictions³⁴⁴

Name of Act & Jurisdiction	Assessors ³⁴⁵	Decision-makers ³⁴⁶	Reviewing Body	Appeal Body
<i>Mental Health (Treatment and Care) Act 1994</i> (ACT)		Mental Health Tribunal	Mental Health Tribunal	Supreme Court
<i>Guardianship and Administration Act 1993</i> (South Australia)		Guardianship Board	Guardianship Board	Administrative and Disciplinary Division of the District Court
<i>Mental Health Act 1963</i> (Tasmania)	Two medical practitioners	Decided by the assessors	Mental Health Review Tribunal	Supreme Court
Intellectual Disability (Compulsory Care and Rehabilitation) Bill 1999 (New Zealand)		Decided by the assessors ³⁴⁷	Initial review by Family Court, periodic reviews by specialist assessors	Appeal from Family Court decisions to the High Court.
<i>Dependent Adults Act 2000</i> (Alberta, Canada)		Court of Queen's Bench	Court of Appeal	
<i>Mental Health Act 1990</i> (Ontario, Canada)	One physician ³⁴⁸	Decided by the assessor	Consent and Capacity Board	Superior Court of Justice
Mental Health Ordinance c. 136 (Hong Kong)	Two medical practitioners	District Judge	Mental Health Review Tribunal	Court of First Instance (on points of law)
Mental Health Care Bill 2001 (South Africa) ³⁴⁹	Two mental health care practitioners	Head of the health establishment concerned	Mental Health Review Board ³⁵⁰	High Court ³⁵¹
Reforms under the <i>Reforming the Mental Health Act</i> White	Two medical Practitioners and a social	Mental Health Tribunal	Mental Health Tribunal	High Court

Deleted:

³⁴⁴ This table does not include reference to legislation relating to people with a cognitive impairment who have been charged with criminal offences. The exception is the New Zealand Bill. This is included for its currency and its profile.

³⁴⁵ Not all statutes specify the number or qualifications of the assessors.

³⁴⁶ The decisions that are made are in relation to a standard application for compulsory care and treatment. The decision makers may be different with respect to either interim or emergency care.

³⁴⁷ The qualifications of the assessors are not listed in the Bill. The Bill does set out that an assessor can include a 'health assessor' under the *Criminal Justice Act 1985* and in certain circumstances the assessors are to be designated by the appointed compulsory care co-ordinator.

³⁴⁸ After an application for admission has been filed by a different physician.

³⁴⁹ The provisions listed here relate only to people with a cognitive impairment rather than a mental illness or to State patients. It is worth noting that there is an avenue of appeal beyond the Review Board for people with a mental illness who are subject to involuntary care decisions. That appeal is to the High Court.

³⁵⁰ The first review must be done within 37 days of the decision of the head of the health establishment. Periodic reviews are then to be conducted regularly by the head of the health establishment with the Review Board monitoring the periodic review reports.

³⁵¹ The High Court can provide judicial review of decisions relating to involuntary care of patients.

Paper (England).	worker			
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Appendix 4

Questions

The Victorian Law Reform Commission welcomes your response to these questions. We hope that this publication has been useful in the formulation of your answer. The Commission recognises that not all people will have an interest in all parts of this Paper, and therefore, we encourage you to answer as many, or as few, of the questions as you like.

Chapter 3

Broad Policy Issues

1. Are the principles of:
 - maximising social participation and ensuring quality of life;
 - recognising and safeguarding rights and liberties;
 - protection against exploitation and abuse; and
 - protecting the security of the community.appropriate for the regulation of compulsory care?
2. The Discussion Paper suggests the following practical issues need to be taken into account in any new regulatory system:
 - flexibility and responsiveness;
 - reducing inconsistencies;
 - ensuring appropriate interaction between disability services and the criminal justice system; and
 - quality practices.

Are there any issues we have not identified that need to be considered in designing a system of regulation for compulsory care for people with cognitive impairments?

Chapter 4

Limits of the Legislation

3. Are the current provisions of the *Children and Young Person Act 1989* adequate to deal with children and young people with intellectual disabilities or cognitive impairments?
4. Should the provisions regulating compulsory care apply to children as well as adults with intellectual disabilities or should children with intellectual disabilities continue to be dealt with under the *Children and Young Person Act 1989*?
5. Should legislation authorising compulsory care apply to:
 - people with a broad range of mental disorders?
 - people with intellectual disabilities and specified forms of cognitive impairment, including dual disability? If so, which forms of cognitive impairment should be covered?Whichever criteria is chosen, how should the relevant conditions be defined?
6. Should there be a single process for authorising compulsory care, regardless of who is at risk, or should there be one process when a person is a risk to others and another process when a person is a risk only to him or herself?
7. How should risk be assessed?

- Where compulsory care is based on risk to others, should it be necessary to show that the person has committed offences involving harm to others in the past, or has been held unfit to be tried for such offences? Alternatively, should it be sufficient that the relevant body has found there is a risk of harm to others?
 - Where compulsory care is based on risk to self or others how probable, how serious and how imminent should the risk of harm have to be? That is, should it be necessary to show a risk of serious harm, or any harm? Should there be a difference in the level of harm necessary in the case of risk to self and risk to others?
 - Where compulsory care is based on risk to self or others, should it be necessary to demonstrate a link between the disability and the risk?
 - Should factors other than seriousness, probability and imminence of harm be taken into account in assessing whether compulsory care is justified?
8. Should any proposed system of regulation list the criteria which must be satisfied before compulsory care is authorised, or should it simply list a number of criteria to be taken into account by the decision makers?
9. What forms of compulsory care and treatment should be regulated?
- Should regulation of compulsory care differentiate between the types of treatment which can be given without authorisation, the types of treatment which can be administered if included in advance in a care plan and the types of treatment which require authorisation in advance?
 - If so, into what category should restraint and seclusion fall and what other treatments should be included in these three categories?
 - Should any other criteria be applied in deciding whether compulsory care is appropriate?
10. Should any proposed system of regulation allow authorisation of compulsory care where the treatment will not directly benefit the person receiving the care? How widely should the term 'benefit' be read?
11. Should a care plan be required as part of the approval process for compulsory care? If so, how should the person's compliance with the plan be monitored?
12. Should there be provisions authorising compulsory care and treatment outside residential facilities? If so, how should the regulatory framework be modified to deal with the provision of compulsory care and treatment outside residential facilities?
13. Should any proposed compulsory care framework apply to care provided by family members?

Chapter 5

The Legislative Framework

14. Who should be able to initiate the compulsory care process?
15. Who should be involved in the assessment of the person?
- Should assessors be prescribed in the proposed system of regulation or should the body authorising care decide who should undertake the assessment on a case-by-case basis?

- If the assessors are prescribed in the proposed system of regulation what level, and type, of expertise is necessary?
16. Who should have responsibility for authorising compulsory care and treatment?
 17. Who should have responsibility for overseeing compulsory care?
 18. How should compulsory care be managed on a day-to-day basis?
 19. Should there be periodic reviews of compulsory care decisions?
 - If so, who should carry them out?
 - How often should the periodic reviews be carried out?
 20. Should there be provision for applications to review compulsory care decisions?
 - If so, who should be entitled to apply for a review?
 - On what grounds should they be entitled to apply for a review?
 - Who should undertake the review?
 - What, if any, limits should be placed on the review process?
 21. Should there be a right of appeal from a compulsory care decision?
 - If so, who should be able to appeal?
 - On what grounds should they be able to appeal?
 - Should appeals be heard by a different body to the reviewing body? If so, who should hear the appeal?

Chapter 6

Interim Care

22. Should there be provisions for interim authorisation to take effect while the person is being assessed?
 - If so, who should be able to authorise interim care?
 - What should be the grounds for the authorisation?
 - How long should an interim authorisation last?
23. Should there be provisions for emergencies, specifically:
 - Should there be any difference, in either process or effect, between an interim and an emergency authorisation?
 - If so, under what circumstances should emergency care be authorised, by whom, and how long should it last?
24. Should the powers of police, or other emergency personnel, be extended to cover the apprehension and detention of a person prior to the authorisation of emergency or interim care?

Leave of Absence

25. What arrangements should be in place to allow leaves of absence?

Relationship with the Criminal Justice System

26. Is the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* working in practice? Have the amendments to the Act under the *Forensic Health Legislation (Amendment) Act 2001* remedied any deficiencies?

27. Should either the police or the Office of Public Prosecutions (OPP) be given the power to initiate an application for compulsory care and treatment if they feel that there is little chance that the person would be convicted of the offence for which they have come to the attention of the police or OPP?

28. Should magistrates be given the power to initiate an application for the authorisation of compulsory care where they have found a person who does not have a mental illness not guilty because of mental impairment? If so, should magistrates have the power to authorise interim compulsory care for the purpose of assessment?

29. Should the supervision orders under the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* be available to magistrates where a person is found not guilty because of mental impairment?

30. Should new custodial sentencing options be available for the compulsory care of offenders with a cognitive impairment? If so, under what circumstances should they be available?

31. Under what circumstances should prisoners with cognitive impairments be able to be transferred to a secure residential facility?

32. Are justice plans working in practice? How could they be improved, if at all?

33. Should there be provision for the continuation of the compulsory care of offenders with cognitive impairments who have completed their custodial sentence or justice plans? If so, what should be the procedure for the continuation of the care?

Regulation of Services

34. How should residential and other care providers be regulated?

- What type of regulatory framework is most likely to encourage high quality care practices?
- Should there be regular inspections of the facilities?

35. What other mechanisms should be put in place to ensure that people receiving compulsory care obtain appropriate treatment?

36. What other avenues of complaint and redress should be available for people undergoing compulsory care and treatment who are not being treated in accordance with their needs?

Final general question

37. Are there any issues we have failed to identify or existing best-practice models we have not canvassed in our review of current systems or in the possibilities for a new regulatory system for the compulsory care of people with a cognitive impairment who are a risk to themselves or others?