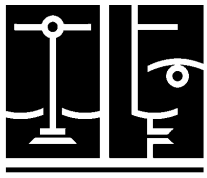

Victorian
Law Reform
Commission

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

FINAL REPORT

Easy English Version

Victorian Law Reform Commission

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Contents

Words Used in this Book

There are many different words used in this book. This part of the book explains the meanings of some of these words.

Assessment Panel

The assessment panel is a group of people whose job it is to decide if a person with an intellectual disability needs to live in a special detention place because they are likely to hurt other people. The people who are on the panel could include psychiatrists, psychologists, direct care staff or others.

Care Plan

This is a written plan, which describes how and when a person with an intellectual disability can be restrained. The plan also says how using restraint will help the person.

Chemical Restraint

This is giving a person with an intellectual disability tablets or medicine to control their behaviour.

Cognitive Impairment

This is used to describe disabilities, which may affect the way people think. If a person has a cognitive impairment, it means that they might have some problems remembering, understanding or learning new things. The different types of disabilities, which may affect the way a person thinks, include acquired brain injury, autism, Alzheimer's, dual disability and others.

Compulsory Care Report or the Report

The Compulsory Care Report is a report written by the Victorian Law Reform Commission. The Report talks about making new laws to say what should happen to people with intellectual disabilities if they are likely to hurt themselves or other people.

Criminal Justice System

When a person commits a crime such as hurting another person they can end up becoming involved with the criminal justice system. The criminal justice system means being involved with the police, courts, judges, and jail.

Department of Human Services or DHS

This is the department in the government responsible for providing services and support to people with disabilities.

Detention, Detained, Detain

These words are all about making a person to live in a place. When a person is detained they cannot come and go as they want to.

Detention Laws

Detention laws are rules about making a person with an intellectual disability live somewhere in order to stop them from hurting other people.

Detention Plan

This is a written plan, which explains the services and programs the person will get when they live in a special detention place.

Laws

Laws are the rules that the government writes down to say what people can and cannot do.

Locked Door Policy

This is a written plan saying when staff are allowed to lock the doors or windows of a house or other place to stop a person with an intellectual disability from hurting themselves or others.

Mechanical Restraint

This is using things such as belts, straps, harnesses or sheets to stop a person with an intellectual disability from moving or to control their movements.

Physical Restraint

This is when a staff member or someone else uses their body to physically stop a person with an intellectual disability who is about to hurt themselves or other people.

Principles

Principles are a list of special rules. The new laws must follow these rules or principles to make sure that people with intellectual disabilities get their rights.

Programs

Programs are written plans, which describe the different ways of teaching new skills to people with intellectual disabilities.

Restraint Laws

Restraint laws are rules about the different ways of controlling what a person with an intellectual disability can do to stop them from hurting themselves or other people.

Restrictive Practices, Restraint, Restraining or Restrained

These words are used to describe some of the things that may be done to stop or change the behaviour of a person with an intellectual disability if they are likely to hurt themselves or other people. The different ways of restraining a person to stop them from hurting themselves or others include chemical restraint, seclusion, mechanical restraint and locking doors.

Seclusion

This is locking or placing a person with an intellectual disability alone in a room, which they cannot get out of. This is done to control a person's behaviour.

Senior Clinician

The Senior Clinician is a special person in charge of making sure people with intellectual disabilities get their rights, especially when they are detained or restrained.

Special Detention Place

This is a place where people with intellectual disabilities or cognitive impairments can be made to live if they have hurt or are likely to hurt other people.

The Office of the Senior Clinician

The Senior Clinician will have a team of workers to help make sure the new laws are fair and people with intellectual disabilities and cognitive impairments have their rights protected. The Senior Clinician and the team of workers are called the Office of the Senior Clinician.

The Victorian Law Reform Commission or the Commission

The Victorian Law Reform Commission is a group of people who wrote the Compulsory Care Report. The Victorian Government asked the Commission to write the report.

Victorian Civil & Administrative Tribunal or the Tribunal

The Tribunal is a group of people whose job it is to decide whether or not a person with an intellectual disability should be detained in a special detention place.

CHAPTER 1: WHAT IS THIS BOOK ABOUT?

This book suggests new laws for people with intellectual disabilities. The new laws are about what should happen to a person with an intellectual disability if they are likely to hurt themselves or other people.

This book uses easy English to explain a report written by the Victorian Law Reform Commission called *People with Intellectual Disabilities at Risk: A Legal Framework for Compulsory Care.*

WHAT IS THE COMPULSORY CARE REPORT ABOUT?

The Compulsory Care Report (th***e Report***) suggests making ***new laws*** to say what should happen to people with intellectual disabilities if they are likely to hurt themselves or other people. The report also talks about:

- why new laws are needed;
- what the new laws should say, and
- what different people and organisations think about having new laws.

WHY ARE NEW LAWS NEEDED?

The Victorian Government asked the Victorian Law Reform Commission to tell them what should happen to people with intellectual disabilities if they are likely to hurt themselves or other people. The government thinks the laws we have now are not strong enough and are not always fair to people with an intellectual disability.

The Victorian Law Reform Commission (the ***Commission***) asked different people and groups to say what they thought about having new

laws. People said many different things. Some people said they agree that there should be laws to help stop those people with intellectual disabilities who may hurt other people or themselves. Other people said they were worried that the laws may discriminate against people with intellectual disabilities.

WHO WILL THE NEW LAWS AFFECT?

The new laws are for people who have an intellectual disability or a cognitive impairment. Cognitive impairment includes disabilities such as brain injury, autism, Alzheimer's, dual disability etc.

The government thinks some people with intellectual disabilities or cognitive impairments hurt themselves or others because they are not able to understand what they are doing, or because they are not getting the services or support they need. The new laws ***only*** apply to people with intellectual disabilities. The new laws ***will not*** apply to people who do not have an intellectual disability.

WHAT ARE THE SUGGESTED NEW LAWS ABOUT?

The ***Commission*** thinks there should be two types of new laws. They are:

1. Detention Laws

Detention laws are about making a person with an intellectual disability or cognitive impairment live somewhere they do not want to live to stop them from hurting other people. Making someone live where they do not want to live is called ***detention.***

2. Restraint Laws

Restraint laws are about controlling the behaviour of a person with an intellectual disability to stop them from hurting themselves or other people. ***Restraint*** includes locking a person in a special room (***seclusion***), giving a person medicine to control their behaviour (***chemical restraint***), stopping a person from hurting themselves by using a belt to control their movements (***mechanical restraint***), or locking the doors where a person lives to restrict their freedom. The report calls all of these things ***restrictive practices***.

CHAPTER 2: PRINCIPLES

The new laws must follow rules or principles to make sure people with intellectual disabilities get their rights.

This chapter will talk about the ***principles*** that the new laws about people with intellectual disabilities must follow. ***Principles*** are a bit like rules. The new laws must follow these ***principles*** or rules to make sure that people with disabilities get their rights.

WHAT SHOULD THE PRINCIPLES FOR THE NEW LAWS BE?

The ***Commission*** thinks that the ***principles*** or rules the new laws should follow are:

- The rights of people with intellectual disabilities or cognitive impairments should be protected.
- People with intellectual disabilities or cognitive impairments should have their rights explained to them.
- If people have to live where they do not want to, or have treatment they do not want, they must still have as much freedom as possible.
- If people have to live where they do not want to, or have treatment they do not want, they should still have the chance to be involved in the community and learn new things.
- The government needs to check that the laws are being followed, and that people are not treated cruelly or hurt.
- People must be able to complain if they feel they are being treated unfairly.

- People can only be made to live where they do not want to, or have treatment they do not want, if it will benefit and help them to stop hurting themselves or other people in the future.

WHAT ARE BENEFITS?

The principles say that a person with an intellectual disability or cognitive impairment should only be ***detained*** or restricted if it will be of benefit to them. ***Benefit*** means that if a person is forced to live somewhere or have treatment, it can only be done if it makes their life better, and helps them learn not to hurt themselves, or other people.

CHAPTER 3: DETENTION

The ***Commission*** has suggested new laws for making people with intellectual disabilities live in a special place if they hurt or may hurt other people. This is called detention.

This chapter talks about the suggested new ***detention laws***.

WHAT IS DETENTION?

Detention means making people stay in a place where they do not want to be.

WHY DO WE NEED DETENTION LAWS?

The ***Commission*** thinks we need ***detention*** laws so a person with an intellectual disability can be made to live in a ***special detention place*** if they have hurt or may hurt other people. At the moment, if a person with an intellectual disability hurts another person, they may go to jail.

The ***Commission*** thinks new laws are needed to ***detain*** a person with an intellectual disability if there is a real chance that they may seriously hurt other people. This means they can be made to live somewhere they may not want to live. The ***Commission*** thinks that for some people with a disability, ***detention*** in a special place is the only way to help them learn not to hurt other people.

WHAT DO PEOPLE THINK ABOUT DETENTION?

The ***Commission*** asked different people and groups to say if they thought it was all right to ***detain*** people with intellectual disabilities. Some people said they were very worried the new laws would discriminate against people with intellectual disabilities. They think having special laws to ***detain*** a person with an intellectual disability ***before*** they commit a crime (hurt someone), means they are treated differently from other people. People ***without*** an intellectual disability can only be ***detained after*** they commit a crime.

Other people said there should be new laws because they think that sometimes a person needs to be made to live in a ***special detention place*** so they can be helped to control their behaviour, and learn to stop hurting other people.

WHO CAN BE DETAINED?

The *Commission* thinks that a person with an intellectual disability can only be ***detained*** if:

- they are over 17 years old, and they have seriously hurt people, or there is a real risk they may seriously hurt other people;
- being in ***detention*** will help the person to have a better life because they will learn not to hurt other people;
- there is no other way for them to get services that will help them learn not to hurt others; and
- there is a plan written down which explains the services and programs the person will get when they live in the special place. This plan is called a ***detention plan.***

The ***Commission*** thinks the new detention laws should ***not*** be for people with intellectual disabilities who hurt themselves. They think the new detention laws should ***only*** be for people with intellectual disabilities who may hurt other people.

WHAT IS A DETENTION PLAN?

The ***Commission*** thinks that before a person with an intellectual disability can be made to live in a ***special detention place*** there must be a written ***detention plan***.

A ***detention plan*** should explain:

- the services and ***programs*** people will get when they live in the ***special detention place***;
- how these services and ***programs*** will be of ***benefit*** and help the person learn not to hurt others;
- what will happen when the person moves out of the ***special detention place*** into the community; and
- how long the person will have to stay in the ***special detention place***. A person cannot be ***detained*** for longer than a total five years.

WHERE WILL PEOPLE BE DETAINED?

The ***Commission*** thinks the government should set up special places where people with intellectual disabilities who may hurt others can be forced to live (***detained***).

THE SENIOR CLINICIAN

The ***Commission*** thinks there should be a special person in charge of making sure people with intellectual disabilities are getting their rights when they have to be detained. This person will be called the ***Senior Clinician***. The ***Commission*** thinks that the ***Senior Clinician*** should have a team of workers to help make sure the new laws are fair, and that people have their rights protected. The ***Senior Clinician*** and the team would be called the ***Office of the Senior Clinician***.

HOW IS THE DECISION MADE TO DETAIN A PERSON?

The ***Commission*** thinks the following things should have to happen before a person with an intellectual disability can be ***detained***:

- ***Step 1***

  The ***Office of the Senior Clinician*** (the ***Office***) is told about a person who needs to be detained to help them learn not to hurt other people. The following people can ask that a person be ***detained***:

  - the Public Advocate
  - the ***Department of Human Services (DHS)***
  - a doctor, a nurse, or other health care staff
  - family or guardians
  - senior police

- ***Step 2***

  Once the ***Office*** has been told that a person with an intellectual disability needs to be detained, it must speak to a special group of people called an ***assessment panel***. The ***Commission*** thinks this group or panel could include psychiatrists, psychologists, or direct care staff. The special group, or ***assessment panel***, will write a report saying:

  - if they think there is a strong chance that if the person is not detained they will seriously hurt other people.
  - why they think making the person live in a special place will help them.

- ***Step 3***

If the ***assessment panel*** decides that a person with an intellectual disability needs to be ***detained***, the next step is to write a ***detention plan***. Before a ***detention plan*** is written down, the ***Office*** must talk about the plan with the person with the intellectual disability, their staff, family, and/or guardian.

A copy of the ***detention plan*** should be given to the person with an intellectual disability.

- ***Step 4***

The ***Office*** gives the detention plan to the ***Victorian Civil and Administrative Tribunal*** (the ***Tribunal)***. The ***Tribunal*** is a group of people whose job it is to decide whether or not a person should be detained.

The ***Commission*** thinks that the people on the ***Tribunal*** should include a judge, and one or more other special people such as direct care staff, psychiatrists, psychologists, and/or disability advocates.

WHAT HAPPENS AT THE TRIBUNAL?

The members of *the* ***Tribunal*** meet to decide if a person with an intellectual disability should be ***detained***. The ***Tribunal*** can only decide to ***detain*** a person if:

- they have hurt people, or there is a real risk that they may seriously hurt other people; and
- there is strong proof that being in detention will help the person to have a better life because they will learn not to hurt other people.

The ***Commission*** thinks that there should be special rules the ***Tribunal*** should follow. Some of the special rules are:

- The person who might be ***detained*** has to be at the meeting (unless the ***Tribunal*** thinks that attending the hearing would be bad for the person's health).
- The person who might be ***detained*** has the right to have their say at the meeting.
- The person who might be ***detained*** has the right to see what has been written about them, except if it may cause danger to them or others.
- The person who might be ***detained*** has the right to a legal advocate such as a lawyer, or disability advocate. An advocate is someone who speaks up for what they think is best for the person.
- If people think the ***Tribunal*** did not follow the rules properly or did not listen to all the information, they have the right to ask for another meeting at the Supreme Court. This is called an appeal.

The ***Commission*** thinks a person with an intellectual disability could be ***detained*** without a tribunal meeting if there is an emergency and people are in serious danger. A person with an intellectual disability should only be detained without a tribunal meeting for up to 14 days.

WHAT HAPPENS ONCE A PERSON WITH AN INTELLECTUAL DISABILITY IS DETAINED?

The ***Commission*** thinks that when a person is made to live in a ***special detention place*** to stop them hurting others, they must receive the services and ***programs*** that are written in their ***detention plan.***

The ***Commission*** thinks that the person should also have the right to go out into the community. This is called ***leave of absence***. The ***Commission*** thinks it is very important that a person be given the chance to go out into the community. Sometimes, the person will go out into the community with staff. This is called ***escorted leave.*** Sometimes, the person will be able to go out alone. This is called ***unescorted leave.*** A description of the sort of leave planned for the person should be written in the ***detention plan.***

If a person with an intellectual disability runs away from the place where they are being ***detained***, the police or a special staff member has the right to bring them back.

The ***Commission*** thinks that every six months, the ***Tribunal*** should check to make sure the person still needs to be ***detained***. This is called a review**.** The person, their family, or guardian also has the right to ask the ***Tribunal*** to review the detention plan.

CHAPTER 4: RESTRICTIVE PRACTICES

The Commission thinks new laws are needed to control the use of physical restraint, mechanical restraint, medicines and seclusion in Government funded services.

This chapter will talk about ***changing*** some of the old laws we have about ***restrictive practices***, or ***restraint***.

WHAT ARE RESTRICTIVE PRACTICES?

Restrictive practices are things that may be done to stop a person with an intellectual disability from hurting themselves or other people. The different ways of ***restraining*** a person to stop them hurting themselves or others includes giving them medicine (***chemical restraint***), locking them in a room (***seclusion***), or stopping them from moving using straps (***mechanical restraint***). All of these things are called ***restrictive practices***, which means ***restraining*** a person to stop them doing things they want.

The government already has some laws about ***restraining*** people to stop them hurting themselves or others.

WHAT ARE THE OLD LAWS ABOUT RESTRAINT?

The old laws about ***restraining*** people are written down in the Intellectually Disabled Person's Services Act (the Act). The Act says that the ways of restraining people with intellectual disabilities include ***chemical restraint***, ***mechanical restraint*,** and ***seclusion***.

The Act says ***restraint*** can be used to change the behaviour of a person with an intellectual disability to stop them from hurting themselves or other people. The ***Commission*** thinks that ***restraining*** a person with an intellectual disability is a very serious thing.

The ***Commission*** thinks we need to change some of the old laws written in the Act.

WHY DO WE NEED TO CHANGE THE OLD LAWS?

The ***Commission*** thinks some of the problems with the old laws are:

- they do not always give people with intellectual disabilities their rights;
- sometimes the wrong decisions are made and sometimes people may be ***restrained*** when they should not be;
- there needs to be more information explaining the different types of restraint, when it can be used and why it is needed; and
- there is not enough checking to make sure that people who are being restrained are getting their rights.

The ***Commission*** thinks that the old laws should be changed to make sure that people are treated more fairly, and to try to make sure people have rights when they are ***restrained***.

WHAT DO PEOPLE THINK ABOUT USING RESTRAINT?

The ***Commission*** asked different people and groups to say if they thought it was all right to ***restrain*** people. Some people said it should only happen if a person is going to hurt other people. Other people said they thought it was important that people can also be ***restrained*** if they are hurting themselves. Some people were worried that this may mean stopping a person with a disability from choosing to smoke or eat too much because it is a risk to their health. They thought using restraint might discriminate against a person with an intellectual disability.

WHAT ARE THE SUGGESTED CHANGES TO THE OLD LAWS?

The ***Commission*** thinks there should be strong new laws about ***restraint***. The ***Commission*** thinks that the new laws should be written into the Intellectually Disabled Person's Services Act. The ***Commission*** thinks that the types of ***restraint*** which should be used to control a person's behaviour are:

- ***mechanical restraint***—this is using things such as belts, straps, harnesses, or sheets to stop a person with an intellectual disability from moving or to control their movements.
- ***chemical restraint***—this is using tablets or medicine to control behaviour.
- ***seclusion***—this is locking or placing a person alone in a room which they cannot get out of. The person can be locked in the room at any time of the day or night.
- ***physical restraint***—this is when a staff member or someone else uses their body to stop a person with an intellectual disability from hurting themselves. This means they may have to grab or hold the person with an intellectual disability to stop them doing things like running in front of a car, or attacking another person. At the moment there are no laws about physical restraint. The ***Commission*** thinks there should be laws made about when ***physical restraint*** can be used.
- ***locked doors***—this means locking the doors or windows of a building to stop a person from hurting himself or herself. An example of this is when staff lock the front door of the house to stop someone who runs onto roads, but does not know that they can be hurt by cars. At the moment, there are no laws about locking doors. The ***Commission*** thinks there should be laws made about when you can lock doors or windows.

WHO CAN BE RESTRAINED?

The ***Commission*** thinks that people with intellectual disabilities should ***only*** be ***restrained*** if they:

- have hurt or may hurt themselves or other people; ***and***
- they are living in or going to a government funded service.

WHEN SHOULD CHEMICAL RESTRAINT, MECHANICAL RESTRAINT OR SECLUSION BE USED?

The ***Commission*** thinks that ***chemical restraint, mechanical restraint*** and ***seclusion*** should only be used when:

- there are no other ways to stop a person with an intellectual disability from hurting themselves or hurting others;
- using restraint will help or benefit the person to learn not to hurt themselves or others;
- the ***Senior Clinician*** says it is all right to use restraint; and
- there is a written plan saying how a person will be restrained and how using ***restraint*** will help or benefit the person. This is called a ***care plan***.

The ***Commission*** also thinks that sometimes, in an emergency, a person can be restrained or secluded without a ***care plan***. If a person is restrained in an emergency, the staff must tell the ***Senior Clinician*** within 48 hours.

WHEN SHOULD PHYSICAL RESTRAINT BE USED?

Physical restraint is when staff or other people use part of their body to physically stop a person with an intellectual disability from moving. The ***Commission*** thinks that ***physical restraint*** should only be used when:

- the person is about to seriously hurt themselves or other people if they are not stopped; or
- it is written in the ***care plan***, because it is needed to control the behaviour of a person with an intellectual disability to stop them hurting themselves or other people. The ***Senior Clinician*** must see the plan, and say it is all right to use physical restraint.

WHEN SHOULD DOORS BE LOCKED?

The ***Commission*** thinks that it should be the job of the ***Senior Clinician*** to write down when staff or other people are allowed to lock doors and windows to stop a person with an intellectual disability from hurting themselves or others. This will be called the ***locked door policy***.

The ***Commission*** thinks that staff should tell the ***Senior Clinician*** if they are locking doors. The ***Senior Clinician*** can tell staff and other people to stop locking doors and windows if it is not needed.

WHO IS THE SENIOR CLINICIAN?

In the last chapter we talked about the ***Senior Clinician***. The ***Commission*** thinks that the ***Senior Clinician*** should be a special person in charge of making sure people with intellectual disabilities are getting their rights when they are detained or restrained. The ***Commission*** thinks that the ***Senior Clinician*** should have a team of workers to help make sure the new laws are fair, and that people with disabilities have their rights protected. The ***Senior Clinician*** and the team will set up the ***Office of the Senior Clinician***.

WHAT IS THE JOB OF THE OFFICE OF THE SENIOR CLINICIAN?

The ***Commission*** thinks that the job of the ***Office of the Senior Clinician*** (the ***Office***) should be to:

- Read each person's ***care plan*** and say if it is all right to use ***restraint*** to control that person's behaviour.
- Check everybody's ***care plans*** once a year, to decide if the plans should be changed, stay the same, or be stopped.
- Make rules about when services can lock their doors to stop someone from hurting themselves or others.
- Make sure that staff tell people with intellectual disabilities exactly what is in their ***care plan*** about being ***restrained***. The staff must also tell their carers or guardians. All of these people must get copies of the ***care plan***.

The ***Commission*** has also suggested that there should be new laws to say that a person with an intellectual disability who receives government-funded services should have a medical report written once a year. The medical report should include information about the person's mental and physical health, and the medicine they are taking.

WHAT SHOULD HAPPEN IF A PERSON IS UNHAPPY ABOUT THE DECISION TO RESTRAIN OR SECLUDE THEM?

The ***Commission*** thinks a person with an intellectual disability should have the right to say they are not happy about the decision to restrain them. If a person is not happy with the decision, they can ask the ***Victorian Civil and Administrative Tribunal*** (the ***Tribunal***) to listen to their complaint, and decide if they really do need to be ***restrained***.

CHAPTER 5: COGNITIVE IMPAIRMENTS

The *Commission* thinks the new laws about making people live in special places, and making people have special treatments should also be for people who have cognitive impairments. Cognitive impairments include acquired brain injury, autism, Alzheimer, and dual disabilities.

This chapter talks about applying the suggested new laws to people with different types of disabilities called ***cognitive impairments***.

WHAT ARE COGNITIVE IMPAIRMENTS?

The term ***cognitive impairment*** is used to describe disabilities which may affect the way people think. ***Cognitive impairments*** are different to intellectual disabilities. If a person has a ***cognitive impairment***, it means they might have problems remembering, understanding or learning new things. The different types of disabilities, which may affect the way a person thinks, include acquired brain injury, autism, Alzheimer's, dual disability, and others.

SHOULD THE NEW LAWS ALSO BE FOR PEOPLE WITH COGNITIVE IMPAIRMENTS?

The ***Commission*** thinks the new laws about ***detention*** and ***restraint*** should also be for people with ***cognitive impairments***.

The ***Commission*** thinks that over the next three years, the ***Office of the Senior Clinician*** should be responsible for writing down the rules about when people with ***cognitive impairments*** can be ***detained*** or ***restrained***.

The ***Commission*** thinks that new laws for people with ***cognitive impairments*** should not include people with personality disorders, or people living in nursing homes.

CHAPTER 6: CRIMINAL JUSTICE SYSTEM

The *Commission* thinks there should be new laws about what happens to people with intellectual disabilities who commit crimes. The *Commission* thinks people who hurt others should be sent to a special detention place instead of jail. They also want new laws to make sure people get good services and supports when they are in jail.

This chapter will talk about how the suggested new ***detention*** and ***restraint*** laws will affect people in the ***criminal justice system***.

WHAT IS THE CRIMINAL JUSTICE SYSTEM?

When a person commits a crime such as hurting someone, they can end up being involved in the ***criminal justice system.*** The ***criminal justice system*** means being involved with the police, courts, judges, and jail.

WHAT ARE THE SUGGESTED NEW LAWS FOR PEOPLE WITH INTELLECTUAL DISABILITIES WHO COMMIT A CRIME?

The ***Commission*** thinks there should be new laws about what happens to some people with an intellectual disability who commit a crime including:

- sending people who have hurt others to live in a ***special detention place*** instead of sending them to jail;
- sending people to live in a ***special detention place*** after they have finished their jail sentence. This would only be done if there is still a strong chance they will hurt other people after they are

released. (This new law is mainly for people who are in jail now) and

- making sure a plan is written down about the services and support provided for people with intellectual disabilities or cognitive impairments, when they are in jail. If the person is found not guilty because they did not understand what they were doing (a person found not guilty cannot be put in jail, the ***Senior Clinician*** must think about whether they need services to help them learn not to commit crimes. The person should receive the services they need to help them to learn not to commit crimes.

JUSTICE PLANS

Sometimes when a person commits a crime, they may be forced to work in the community instead of going to jail. This is called a community-based order. When a person with an intellectual disability receives a community-based order, they may get a special plan called a justice plan. The justice plan describes the work they have to do and how many hours they have to work. The ***Commission*** thinks there should be new laws about justice plans for people with disabilities that include:

- writing justice plans for people with cognitive impairments if they receive a community-based order;
- making sure that people follow their justice plans; and
- giving ***DHS*** the job of helping people to change their justice plan if there is a reason they cannot obey them.

CHAPTER 7: THE OFFICE OF THE SENIOR CLINICIAN

The *Commission* thinks that there should be a special person in charge of making sure people with intellectual disabilities get their rights. This person will be called the Senior Clinician.

In this book, we have already talked about the ***Senior Clinician*** and the ***Office of the Senior Clinician***. This chapter will talk more about what the ***Office of the Senior Clinician*** does.

WHAT IS THE OFFICE OF THE SENIOR CLINICIAN?

The ***Commission*** thinks the ***Senior Clinician*** should be a special person in charge of making sure people with intellectual disabilities get their rights when they are ***detained*** or ***restrained***. The ***Commission*** thinks the ***Senior Clinician*** should have a team of workers to help make sure the new laws are fair, and that people with disabilities have their rights protected. The ***Senior Clinician*** and the team would set up an ***Office of the Senior Clinician.***

WHAT WILL THE OFFICE OF THE SENIOR CLINICIAN DO?

The ***Commission*** thinks it should be the job of the *Office* to try to make sure people with intellectual disabilities or cognitive impairments get their rights when they are ***detained*** or ***restrained*** including:

- making sure they know their rights, and understand what is happening to them;
- deciding when they can be detained or restrained, and how they will be looked after;
- deciding the types of special places they can be detained in;

- having the power to change things if they are not being looked after very well;
- going into government funded houses or day programs to check that people with intellectual disabilities are getting their rights, and good quality services;
- teaching staff about rights, and the different ways of supporting people with intellectual disabilities; and
- deciding what should happen to staff and services if they do not follow all the rules.

WHAT OTHER WAYS CAN PEOPLE'S RIGHTS BE PROTECTED?

The ***Commission*** has suggested other ways of protecting the rights of people with intellectual disabilities or cognitive impairments including:

- Making new laws about the community visitors. Community visitors are people who go into houses to make sure the staff are doing the right things and that people are getting all their rights.
- Giving people the right to tell someone if the are unhappy about the treatment and/or services they are receiving. This is called making a complaint. The ***Commission*** thinks that there should be a group of people whose job it is to hear complaints, and decide what should happen to fix the problem.

Recommendations

The following is the list of all the recommendations written in the full report written by the Victorian Law Reform Commission. ***They are <u>not</u> in easy English.***

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

2. These principles should refer to:

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

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

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

5. A person may be detained if:

- the person has an intellectual disability;
- the person has previously exhibited a pattern of violent or dangerous
  behaviour that has harmed others seriously or exposed another person to significant risk of serious harm;
- it is necessary to detain the person because there is a significant risk that otherwise he or she will seriously harm others;
- the risk that the person may harm others cannot be substantially reduced by using other less restrictive measures;
- a detention plan has been prepared, indicating the services and programs that will be provided during the period that the person is detained and providing for transition between detention and the person being cared for in a less restrictive environment;
- the services that will be provided under the plan will benefit the person by reducing the risk that he or she will harm others; and
- the person is unable or unwilling to consent to living in a prescribed
  facility and to participating in a program to reduce the risk of harming others.

6. A detention plan should include:

- the programs that will be provided to the person during the period of detention and how they will benefit him or her;
- any restrictive practices that it is proposed to apply to the person while involuntary detention;
- a proposed process for the person’s transition between detention and living in the community, including provision for leaves of absence; and
- the proposed duration of the order.

7. Before a detention plan is prepared, the Office of Senior Clinician must consult with the person and the person's primary carer or guardian.

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

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

10. The Annual Report of the Office of Senior Clinician should be tabled in Parliament.

11. The Office of Senior Clinician should be responsible for overseeing detention of people with an intellectual disability who are at significant risk of causing serious harm to others. The Office of Senior Clinician shall:

- receive requests for the assessment and the development of detention plans;
- prepare guidelines as to the other matters which should be included in detention plans;
- arrange for assessments and the development of a detention plan to benefit persons whom it is proposed to detain;
- arrange appropriate facilities to receive persons on detention orders;
- make applications to the relevant body for the approval of detention plans and the making of detention orders.

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

13. The following persons should be able to request the Senior Clinician to apply for a detention order for a person with an intellectual disability:

- the Public Advocate;
- an authorised officer of the Department of Human Services;

- a clinician or other health care professional who has been involved in caring for the person;
- a guardian or family member of the person with a cognitive disability; and
- a senior police officer, who is authorised to do so.

14. The Senior Clinician should be able to initiate an application for a detention order without a request from a third party.

15. The Victorian Civil and Administrative Tribunal (VCAT) should have power to:

- authorise and review decisions for the detention of a person with an intellectual disability whose behaviour creates a significant risk of serious harm to others; and
- approve a detention plan for a person who is subject to a detention order

16. Before making a detention order, VCAT must be satisfied that the criteria set out in Recommendation 5 are satisfied.

17. VCAT should determine whether it is necessary to detain a person because there is a significant risk that if not detained the person will harm others, on the balance of probabilities.

18. The Office of Senior Clinician should be responsible for arranging for a panel of experts to assess a person who is subject to an application for a detention order, and for providing a report to VCAT.

19. The assessment panel should include a person with appropriate professional qualifications, and a person with experience in behaviour modification programs and direct care of people with an intellectual disability.

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

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

implemented.

21. Applications for detention orders should be heard by a panel that includes a Supreme or County Court judge and at least one other member with

- knowledge and experience in one of the following areas:
- psychology (with specialisation in intellectual disability);
- psychiatry;
- neurophysiology;
- direct care of people with an intellectual disability;
- pharmacology; or
- disability advocacy.

22. Section 94 of the Victorian Civil and Administrative Tribunal Act 1998, which allows VCAT to seek the assistance of an expert, should apply to detention proceedings.

23. VCAT should be funded sufficiently to allow it to *Commission* independent expert advice about the need for detention.

24. Section 62 of the Victorian Civil and Administrative Tribunal Act 1998 should be amended to allow a person with an intellectual disability to be represented in detention proceedings by a lawyer, a disability advocate, or any other person approved by the Tribunal.

25. VCAT should have power to order that a person with an intellectual
disability is represented by an advocate.

26. An advocate in detention proceedings should be obliged to act in the best interests of the client.

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

28. Detention orders should be reviewed by VCAT at least every six months.

29. A VCAT order, authorising detention, may contain provisions requiring review of the original decision within a shorter period.

30. An application may be made to VCAT for a reassessment of a decision authorising detention within the six month period, or the shorter period required by VCAT. The application may be made by the person with an intellectual disability, a family member or guardian, or a person providing services or care to the person.

31. VCAT should have the power to reject an application for review.

32. The person affected by the proceedings must be present at the hearing, except where VCAT orders that the person should not appear because appearance would be detrimental to the person's health or wellbeing.

33. VCAT hearings should be open to the public, unless VCAT otherwise directs. An application may be made by a party to the proceedings or the party's representative, to have the hearing closed.

34. If the hearing is closed, VCAT may permit a family member of the person, or any other person with a direct interest in proceedings to be present during the whole or any part of the hearing.

35. The person who will be affected by a detention decision has the right to be heard and to inspect any relevant documents, except where: inspection of documents would cause serious harm to the person's health, safety or wellbeing; this would expose another person to a risk of serious harm; involve the unreasonable disclosure of information relating to the personal affairs of any person; or breach a confidentiality provision imposed by a person who supplied information that is contained in the documents or document.

36. Any other person with a direct interest in a detention decision has the right to be heard.

37. The term of a detention order cannot exceed five years. An order cannot be received beyond the five year period.

38. The Office of Senior Clinician may apply to VCAT for an assessment order or an emergency detention order, either on the initiative of the Office or on the request of an authorised police officer or a clinician.

39. An assessment order should only be able to be made in circumstances where it is necessary to detain the person for the purposes of assessment, because there is a significant risk of serious harm being caused to other members of the community. A judicial member of VCAT can authorise the detention of a person for the purposes of assessment, for a period of up to 14 days.

40. In the case of an emergency, where the person's behaviour has created an extreme risk of harm to others, an ordinary member of VCAT can authorise a detention order for up to 72 hours. The person must be released at the end of that period, unless a judicial member authorises detention for the purposes of assessment, for a period of up to 14 days.

41. Escorted leaves of absence may be authorised by the person in charge of the prescribed detention facility. All escorted leaves of absence must be reported to the Office of Senior Clinician on a quarterly basis.

42. The Office of Senior Clinician shall prepare and publish guidelines indicating when escorted leave should be permitted and the qualifications and skills required for escorts.

43. The detention plan may provide for unescorted leaves of absence from a facility. The criteria for authorising an unescorted leave of absence should be contained within the detention plan.

44. Unescorted leave must by endorsed by the person in charge of the facility after there has been an assessment of the person's current behaviour. If leave allowed for in the plan is not permitted this must be reported to the Office of Senior Clinician.

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

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

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

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

49. Clear criteria regulating use of the following restrictive practices should be set out in the IDPSA or in regulations under that Act.

50. The restrictive practices that should be regulated are:

- mechanical restraint of a person for behavioural control purposes, for example using straps on a person who is behaving aggressively;
- prescribing medication for behavioural control purposes (chemical
- restraint);
- seclusion of the person, for example locking a person in an area apart from others;
- physical restraint of a person for behavioural control purposes, for example holding a person down; and
- locking doors to prevent a person leaving a facility or an area within the facility

51. Mechanical restraint should be defined as use of a mechanical device to prevent, restrict or subdue movement of a person's body for the primary purpose of behavioural control.

52. The definition should exclude mechanical restraint used for therapeutic purposes (such as where leg braces are used on a person

with cerebral palsy to limit muscular contractions), and mechanical restraint used to enable a person to be transported safely.

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

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

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

56. The IDPSA should provide that mechanical or chemical restraint or seclusion (as defined in Recommendations 51–5) may only be used where:

- this is necessary to prevent the person from physically harming himself or herself or any other person; or
- this is necessary to prevent a person persistently destroying property, or
- destroying property in a way that will pose a risk of serious harm to others; and
- the particular form of restraint or seclusion used is the least restrictive means of preventing the person from physically harming himself or herself or any other person or destroying property; and
- use of restraint and seclusion on the particular occasion has been
- authorised by the person in charge of the service.

57. Where it is proposed that provision of services to a person with an intellectual disability may require the use of mechanical or chemical restraint and seclusion:

- a care plan must be prepared that indicates how the proposed form of restraint or seclusion will be used in managing the person's behaviour;
- the care plan must indicate how the use of restraint or seclusion will benefit the person; and
- the care plan proposing use of these measures must be approved by the Office of Senior Clinician, who must be satisfied that the statutory criteria apply.

58. Where restraint or seclusion have not been authorised in a care plan that has been approved by the Senior Clinician, they can be used in an emergency where:

- the measure is necessary to prevent the person from seriously injuring himself or herself or any other person;
- the particular form of restraint or seclusion used is the least restrictive means of preventing the person from doing such serious harm; and
- use of restraint or seclusion has been authorised by the person in charge of the service.

59. Where restraint or seclusion is used in an emergency the Office of Senior Clinician must be notified within 48 hours.

60. In addition to the functions that are recommended to be conferred on the Office of Senior Clinician in Chapter 4, the Office should be responsible for:

- approving care plans, including provision for restraint or seclusion;
- conducting an annual review of care plans that provide for use of restraint and seclusion to determine whether the plans should be changed;
- receiving reports on emergency use of restraint or seclusion; and
- monitoring use of restraint and seclusion.

61. Before a care plan is approved, DHS must consult with the person and the person's primary carer or guardian.

62. A copy of the care plan must be provided to the person, the primary carer and any association or organisation that provides the person with services.

63. Where DHS has prepared a care plan that provides for restraint and
seclusion, the Office of Senior Clinician should have power to request additional information from DHS or to direct a more detailed assessment of the person's needs, before approving the care plan.

64. The Office of Senior Clinician must annually review plans that contain provisions for restraint and seclusion. In situations where the Office declines to authorise a care plan providing for use of restraint and seclusion, the Office shall liaise with the service provider to make arrangements as to how the person should be managed.

65. The Office of Senior Clinician must establish a system for monitoring the use of restraint and seclusion.

66. VCAT should have jurisdiction to review care plans providing for restraint and seclusion for persons with an intellectual disability.

67. The following persons may apply for a review:

- the person to whom the plan applies;
- a family member or guardian of that person; or
- the Office of the Public Advocate.

68. The membership of the VCAT panel and the procedures applied by VCAT in reviewing care plans providing for restraint and seclusion should be the same as those recommended for VCAT reviews of detention plans.

69. Physical restraint should be defined as the use of any part of a person's body to prevent, restrict, or subdue movement of the body or part of a body of an person with an intellectual disability.

70. The IDPSA should provide that physical restraint may only be used;

- in an emergency situation that makes it necessary to restrain a person with an intellectual disability in order to discharge the duty of care that is owed to the individual, to other residents, or to staff members, or to prevent serious harm to another person.
- where provision is made for the routine use of physical restraint in a care plan, because it is necessary to prevent the person from self-harming or causing serious harm to another person, a care plan providing for routine use must be approved by the Office of Senior Clinician.

71. When physical restraint is permitted under Recommendation 70 the person applying it must use the minimum force necessary for the purpose for which it is used.

72. The person applying physical restraint should cease to do so as soon as it is no longer necessary to prevent the person from harming him or herself or causing serious harm to another person.

73. VCAT should have jurisdiction to review a care plan that provides for routine use of physical restraint.

74. A locked door policy should be defined as:

- the regular locking of external doors and windows while clients and staff are inside the building, which restricts the entrance and exit of clients;
- the regular locking of doors and windows, which confines a client to a particular part of a building or premises.

75. The Senior Clinician should develop guidelines indicating the circumstances in which a service provider may adopt a locked door policy.

76. Service providers should be required to provide an annual report to the Office of Senior Clinician about practices affecting access to and exit from premises.

77. The Senior Clinician should monitor service providers' practices relating to the locking of doors and windows and should have power to instruct service providers to change practices relating to client's access to and exit from premises.

78. The IDPSA should require preparation of an annual medical report for all people receiving services under the IDPSA

79. The medical report should be provided to the Office of Senior Clinician.

80. Where the person is being prescribed drugs for the treatment of a mental illness, the Senior Clinician may request the Chief Psychiatrist to assess the person, to determine whether the provisions for involuntary treatment for mental illness should apply to that person.

81. Where the person is being prescribed drugs for the purposes of treatment of a physical condition the Senior Clinician should have power to refer the matter to the Office of the Public Advocate, who may decide that an application should be made to appoint a guardian for the person.

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

83. The proposed framework for regulating detention should not apply to people whose cognitive impairment is solely due to mental illness.

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

85. The legislative criteria and approval process for detention orders should apply to people with a cognitive impairment, as well as to people with an intellectual disability.

86. The VCAT panel constituted to hear a detention application for a person with a cognitive impairment shall include a person with professional expertise or experience in caring for people with cognitive impairments.

87. The Office of Senior Clinician should develop legislative criteria and a process for developing, approving and regularly reviewing care plans that allow people with a cognitive impairment to be restrained or secluded.

88. The process for developing, approving and regularly reviewing care plans that allow people with a cognitive impairment to be restrained or secluded should be phased in over a three year period.

89. In the meantime the Office of Senior Clinician should establish and publicise a system to require quarterly reporting of use of restraint and seclusion.

90. Recommendation 126 which requires service providers to provide the Senior Clinician with an Annual Report about their practices in relation to access to and exit from premises, should apply to service providers which provide facilities for people with cognitive impairments.

91. Aged care facilities should not be required to report on use of restraint and seclusion and practices in relation to locking of doors.

92. The Crimes (Mental Impairment and Unfitness to be Tried) Act 1997 should be amended to allow facilities prescribed for people subject to detention orders to be 'appropriate places' to receive persons subject to custodial supervision orders.

93. Where a magistrate finds a person with an intellectual disability or mental impairment is not guilty because of a mental impairment under s 20 of the Crimes (Mental Impairment and Unfitness to be Tried) Act 1997, the Magistrate may refer the person to the Office of Senior Clinician.

94. The Office of Senior Clinician shall consider whether the person is eligible for services under the Intellectually Disabled Persons' Services Act 1986 or the Disability Services Act 1991 and whether the provision of such services could reduce the likelihood of the person re-offending.

95. Where the Office of Senior Clinician believes that the provision of services would reduce the likelihood of the person re-offending, the Office may recommend to DHS that such services be provided to the person.

96. Where the Office of Senior Clinician is of the view that the person's
behaviour poses a significant risk of serious harm to others, the Senior Clinician shall arrange for the assessment of the person to determine whether an application for detention should be made.

97. If a Magistrate refers a person to the Office of Senior Clinician, the Office must file a report with the Court within 14 days of the referral, indicating any steps which are being taken in relation to the person.

98. The Sentencing Act 1991 should be amended to make justice plans available to offenders with a cognitive impairment.

99. Operation of this provision should be deferred for two years, to allow for development of appropriate services for people with cognitive impairments who commit offences.

100. DHS should ensure that service providers are aware that offenders must comply with justice plans.

101. Where a change in program provision occurs, which would prevent the offender complying with the conditions of a justice plan, DHS should be required to refer the matter to the Secretary to the Department of Justice, or in the case of a justice plan entered into as a condition of an adjourned undertaking, to Victoria Police.

102. Where a change in program provision has prevented the offender from complying with the justice plan, the offender may request the

Secretary to the Department of Human Services to advise the Secretary to the Department of Justice.

103. Where the matter is referred to the Secretary to the Department of Justice, or to the Victoria Police, the Secretary or Victoria Police must consider whether an application should be made to the court under section 82 of the Sentencing Act 1991 for a change to the provisions of the justice plan.

104. The Sentencing Act 1991 should be amended to allow the court to refer a person with an intellectual disability or cognitive impairment, who has been found guilty of an offence, and is to be sentenced to a term of imprisonment, to DHS, for an assessment and the development of a care plan, indicating the services that will be provided to the person during his or her period of imprisonment.

105. Where the court refers a person to DHS, a care plan must be prepared for the person indicating the services that are to be provided to the person during his or her imprisonment, for the purposes of reducing the risk that the person will re-offend.

106. The Court shall not make a care plan order unless the court is satisfied that the proposed care plan will reduce the risk that the person will re-offend.

107. Where a person with an intellectual disability or cognitive impairment has been found guilty of an offence, the court may order that the person serves his or her sentence in a prescribed facility instead of in jail (this is known as a security order).

108. The Court may not make a security order unless:

- a detention plan has been prepared by DHS indicating how the person will be cared for and the services that will be provided to the person in the secure facility;
- the court is satisfied that the services which will be provided to the person in the prescribed facility will reduce the risk that the person will re-offend; and

- but for the person's intellectual disability or cognitive impairment, the court would have sentenced the person to a term of imprisonment.

109. The term of the security cannot exceed the period of imprisonment to which the person would have been sentenced had the care and treatment order not been made.

110. A security order can only be made where the services that the person needs to reduce the possibility that he or she will re-offend cannot be effectively provided within a prison environment.

111. Provision should be made to allow prisoners with a cognitive impairment to be transferred to an appropriate residential institution for the whole or a part of their sentence.

112. Leaves of absence, not exceeding six months, for offenders sentenced to security orders, or for offenders transferred from prison to an appropriate facility, should be approved by the Secretary to the Department of Justice.

113. Before granting leave, the Secretary to the Department of Justice must be satisfied that the safety of members of the public is not endangered by the granting of leave and that the Office of Senior Clinician has been consulted.

114. Special leave, not exceeding 24 hours, for offenders sentenced to security orders should be approved by the Office of Senior Clinician.

115. Before granting leave, the Office of Senior Clinician must be satisfied that there are special circumstances justifying the granting of leave and that the safety of members of the public will not be endangered by the granting of leave.

116. If the Corrections Victoria *Commissione*r or the Adult Parole Board considers that a person's behaviour is likely to pose a significant risk of serious harm to others after the expiry of his or her prison sentence or care and treatment order, they may refer the person to the Office of Senior Clinician.

117. The Office of Senior Clinician shall consider whether the person should be assessed, to determine whether they meet the criteria for the making of a detention order.

118. If an assessment is made, the Office of Senior Clinician must consider whether an application should be made to VCAT for a detention order.

119. The duration of a detention order that is to take effect when a person is released from prison must take into account any period of time that a person has spent on a care and treatment order whilst in prison and the cumulative total of the two orders must not exceed five years.

120. All guidelines prepared by the Office of Senior Clinician should take account of the principles in Chapter 3 of this Report. They should also:

- emphasise the importance of obtaining the consent of people with an intellectual disability or cognitive impairment to treatment and care, wherever possible;
- prescribe standards of treatment and care which take account of cultural factors that affect people who are being cared for; and
- ensure that people receiving treatment and care and their families and guardians receive information about their rights, including information about their opportunity to make complaints and to seek a review of care decisions.

121. Minimum standards for prescribed facilities should be developed jointly by the Office of Senior Clinician and DHS and should be approved by the Minister of Community Services.

122. Stakeholders, including service providers and disability advocacy groups, should be consulted about proposed minimum standards.

123. Facilities prescribed for people subject to detention orders should be proclaimed by the Governor-in-Council.

124. Minimum standards for staff employed by service providers under the IDPSA should be developed jointly by the Office of Senior Clinician and DHS and be approved by the Minister for Community Services.

125. The Office of Senior Clinician should be responsible for monitoring compliance with minimum staffing standards.

126. Where a person with an intellectual disability is subjected to restraint and seclusion in accordance with their care plan, this must be recorded by the service provider. Service providers must forward an annual report to the Office of Senior Clinician on all persons in their care, indicating all instances of use of restraint and seclusion.

127. Where emergency use of restraint and seclusion is reported to the Office of Senior Clinician, the Office of Senior Clinician may direct that use of restraint and seclusion should cease, either immediately or after an alternative method of care is put in place. Before giving such a direction the Office of Senior Clinician must consult with the service provider about alternative means of managing the person's behaviour.

128. Providers of services under the DSA should be required to record all instances of use of restraint and seclusion affecting people with cognitive impairments.

129. Providers of services under the DSA should report quarterly to the Office of Senior Clinician on all instances of use of restraint and seclusion.

130. The Office of Senior Clinician should function as a central records agency for detention plans and care plans.

131. The Office of Senior Clinician should be resourced with the computer infrastructure to enable all reports and records from service providers to be submitted and monitored electronically and to permit systems to be established for monitoring particular care practices.

132. The Office of Senior Clinician should develop mechanisms to monitor the performance of service providers.

133. The Office of Senior Clinician should have power to visit and inspect premises, to obtain access to records of service providers, to inspect documents and to see any person who is receiving care.

134. Service agreements should permit the Secretary of the Department of Human Services to amend the agreement or impose additional conditions on the service provider to ensure compliance with guidelines and appropriate standards of care.

135. The Office of Senior Clinician should have power to report breaches of service agreements, failure to comply with guidelines or directives of the Office of Senior Clinician or inappropriate service practices, to the Secretary of the Department of Human Services.

136. Where the service provider has consistently failed to comply with guidelines or directives of the Office of Senior Clinician or to provide an acceptable level of care, the Secretary should consider whether the service agreement should be amended or rescinded.

137. In the case of persistent breaches with guidelines or failure to comply with directives of the Office of Senior Clinician the Secretary of the Department of Human Services may recommend to the Minister that approval of a prescribed facility should be rescinded.

138. Community visitors must respond to a request to be seen by a resident or her or his representative within 14 days of being advised of the request. The community visitor must respond to the request by visiting the person who made the request or by notifying, in writing, the Office of the Public Advocate of the reasons for not visiting the person who made the request.

139. Where the community visitor notifies the Office of the Public Advocate of the reasons for not visiting the person who made the request, the Office of the Public Advocate should send copies of these reasons to the person, the person's guardian, if any, and to the Office of Senior Clinician.

140. If the Office of the Public Advocate does not consider the community visitor's reasons for not making a requested visit are

sufficient then the Office may request the responsible Minister to direct a community visitor to visit the facility.

141. An independent complaints handling system should be established to receive, investigate, mediate and resolve complaints with respect to detention and use of restrictive practices, and other aspects of service provision for people with an intellectual disability or cognitive impairment.