Chapter 8

Disability, guardianship and aged-care detention

Introduction

8.1 As outlined in earlier chapters, indefinite detention for the purpose of involuntary treatment for people with a cognitive or psychiatric impairment can occur not just under forensic and civil mental health frameworks, but also under various state and territory disability and guardianship frameworks, particularly for those with a cognitive impairment. It can also occur in aged-care settings.

8.2 Detention that occurs from provisions within mental health legislation, as covered by Chapter 8, generally occurs within large therapeutic medical facilities. This brings an inherent level of protection from the oversight mechanisms that exist within such facilities. However, detention that occurs from provisions within disability or guardianship legislation can occur in a range of locations from large hospitals or disability-specific therapeutic facilities, through to smaller disability accommodation units, aged care facilities or even in private homes.[1]

8.3 The Office of the Public Advocate Victoria (Public Advocate Victoria) identified a form of informal detention in disability and aged care settings as 'compliant detention', which refers to 'those people with disability who are detained, by their apparent compliance with the restrictive environment in which they live.' The Public Advocate Victoria said the 'the definition of indefinite detention could apply to people in an aged-care facility or a secure section of a group home, that are locked or from which they are not free to leave.'[2]

8.4 Although not a key focus of this inquiry, the use of involuntary treatments and restrictive practices, which can be viewed as indefinite detention in the disability and aged care context, is also discussed in this chapter.

The disability or guardianship pathway to indefinite detention

8.5 In addition to mental health-specific legislation which allows for the detention of people for the purpose of providing mental health treatment, various disability and guardianship acts also provide for indefinite detention of people with a cognitive or psychiatric impairment, who pose a risk to themselves or others. Similar to the complexity of mental health frameworks outlined in Chapter 8, evidence presented to the committee was that both within and across the jurisdictions, the detention of people within the disability and guardianship context is a web of complex legislation and practise.

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1 For a lengthy discussion of the wide range of detention types and locations in the disability, guardianship and aged-care context, see Victoria Legal Aid, *Submission 71*. See also Office of the Public Guardian (Queensland), *Submission 56*, p. 4.

2 Office of the Public Advocate (Victoria), *Submission 58*, p. 31.

8.6 The Royal Australian New Zealand College of Psychiatrists (RANZCP) outlined just how many pieces of legislation contain provisions for involuntary detention:

> For example, in Victoria, in addition to the Mental Health Act 2014, involuntary treatment can also be mandated under the Disability Act 2006, the Guardianship and Administration Act 1986, the Powers of Attorney Act 2014, the Crimes (Mental Impairment and Unfitness to be Tried) Act 1997, the Sex Offenders Registration Amendment Act 2014 and the Severe Substance Dependence Treatment Act 2010. Similar legislative provisions exist in other states and jurisdictions.[3]

8.7 The Office of the Public Advocate QLD (Public Advocate QLD) cited a similar environment in QLD, stating 'In Queensland, the regime for the indefinite detention of, involuntary treatment of, and use of restrictive practices with people with impaired decision-making capacity is essentially fragmented across multiple pieces of legislation, systems and service responses.'[4]

8.8 The complexity of the various legislative systems was cited as in and of itself being a key contributor to conditions of detention. Victoria Legal Aid put forward the view that 'the absence of a really consistent and clear framework quite often in relation to people who are indefinitely detained can create an environment for abuse.'[5]

8.9 As there are many different pieces of legislation or practises which result in detention, this report has focused on presenting an overview of concerns, as well as reforms being undertaken in certain jurisdictions which could be replicated across Australia.

Disability detention

8.10 Across all jurisdictions in Australia, disability frameworks allow for the detention of people with a cognitive impairment, through various formal and informal means. The committee received detailed evidence on the frameworks in Victoria, as many submitters and witnesses across Australia focused on providing a critical evaluation of the Victorian framework, with a view to identifying positive changes that could be replicated in other jurisdictions. The next section will focus on key elements of the Victorian model, which were highlighted by submitters as 'best-practice' examples, acknowledging that even this framework still requires improvement.

Victoria: a best practice framework

8.11 Victoria Legal Aid put forward in their submission that any framework that authorises detention for people with cognitive or psychiatric impairment must include the following elements:

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3 Royal Australian New Zealand College of Psychiatrists, *Submission 17*, p. 7.

4 Office of the Public Advocate (Queensland), *Submission 36*, p. 9.

5 Mr Chris Povey, Program Manager, Mental Health and Disability Law Sub-program, Victoria Legal Aid, *Committee Hansard*, 29 April 2016, p. 4.

- There must be clear statutory authority for any detention;
- The person detained has a right of legal representation, and access to state-funded legal services;
- Any decisions authorising detention beyond a short, emergency period must be made by an independent court or specialist tribunal;
- Orders authorising detention must be subject to a right to review or appeal against the initial order;
- Any decision to detain must be demonstrably justified on the basis of cogent evidence;
- Detention may only be authorised if there is no less restrictive means of achieving the objective of the detention;
- Orders authorising detention must be time-limited and subject to periodic review by the independent court or specialist tribunal; and
- The person detained must have a statutory right to apply for revocation of the detention order at regular intervals.[6]

8.12 Victoria Legal Aid further submitted that, in their view, the *Disability Act 2006* (Vic) (Disability Act) contains the best practice example of putting these principles into legislation and practice.[7]

8.13 The Disability Act sets out the framework for detention and involuntary treatment for people with an intellectual disability who pose a risk of harm to others. A supervised treatment order (STO) can be made by the Victorian Civil and Administrative Tribunal (VCAT) only if satisfied the person has previously displayed violent or dangerous behaviour, there is a significant risk of harm that cannot be mitigated in a less restrictive environment, and that detention is necessary to ensure compliance with the treatment plan. Some important safeguards have been built into the framework:

> The legislation requires that the person with an intellectual disability derives a 'benefit' from being placed on a supervised treatment order (STO), and that the levels of restrictions on the person's life are reduced over time. The person must be in receipt of state funded 'residential services'.
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> The STO regime was introduced in order to regulate what was happening in residential facilities. The STO regime brought a greater fairness and scrutiny to decisions affecting the personal liberty of people with intellectual disabilities. The legislation makes it clear that disability service providers must not detain a person with an intellectual disability unless the person is under a STO.[8]

6 Victoria Legal Aid, *Submission 71*, pp 2–3.

7 Victoria Legal Aid, *Submission 71*, p. 3.

8 Office of the Public Advocate (Victoria), *Submission 58*, p. 14.

8.14 Mr Pappos,of disability service provider Australian Community Services Organisation, outlined the difficulties in the regime which require the service provider, in some cases, to be the applicant for an STO:

> It is important to articulate that we do not practice detention. We have participants who might be subject to high levels of supervision in the community because of their assessed risk to others. What is important there is that we balance our obligations to their human rights with the risks that they are assessed as posing to either themselves or others in the community. The tension for us, I suppose, is we are the applicant of these orders in Victoria—because that is what it requires, that the authorised program office under the Disability Act is required to apply for an order—but we are also the service provider. For us, that is a constant tension.[9]

8.15 The Public Advocate Victoria submitted that VCAT plays an 'important monitoring and safeguard role' in that duration of an STO can be no longer than 12 months, and at each renewal must be again tested against the legislative requirements for detention. According to Public Advocate Victoria, since the commencement of the Disability Act, there have been 65 persons detained on an STO.[10]

8.16 The Public Advocate Victoria further submitted that the effectiveness of the STO regime was not just in the legislative framework, but also due to:

- The process that leads to the development of a treatment plan[44] which includes the engagement of skilled professionals, the scrutiny of the Senior Practitioner who must approve the plan, and VCAT who must make the STO having regard to the plan.
- The external bodies involved in regulating and scrutinising the use of STOs (VCAT, the Senior Practitioner, and OPA) are obliged to ensure that the rights, dignity and best interests of the person with the intellectual disability are protected. The Public Advocate also has the power to apply to VCAT for an order directing the authorised program officer to make an application for a STO. This would occur where the Public Advocate believes that a person is being detained to prevent a significant risk of serious harm to others and an application for a STO has not been made.
- Victoria Legal Aid's specialist advocacy for persons proposed for or subject to detention.[11]

8.17 However, the Public Advocate Victoria pointed out in its submission that the Disability Act may produce uneven benefits, as people who are not on STOs are denied access to the same state-funded high quality treatments, services and clinical oversight from the Senior Practitioner that people on STOs have. The Public Advocate Victoria said that this effectively means 'a person's access to the benefits associated

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9 Mr Stan Pappos, Senior Manager, Forensic Housing Services, Australian Community Services Organisation, *Committee Hansard*, 29 April 2016, p. 43.

10 Office of the Public Advocate (Victoria), *Submission 58*, p. 14.

11 Office of the Public Advocate (Victoria), *Submission 58*, p. 15.

with supervised treatment is made conditional upon detention.' Public Advocate Victoria also submitted that as STOs can be renewed, this could lead to a form of de facto indefinite detention.[12]

8.18 Victoria Legal Aid summed up their views on the reforms undertaken in Victoria to the committee:

> If you think about what has happened in Victoria, I think it is important to acknowledge, as it has been acknowledged, it is not perfect…The updated Mental Health Act is an interesting example because it does talk quite strongly about human rights, about recovery and about supported decision-making. All of these sorts of things are not the answer absolutely but this idea about changing culture, about moving away from punitive responses, lead the way.[13]

Committee view

8.19 The committee heard from a range of submitters and witnesses on the positive aspects of the detention provisions of the Disability Act. In some cases, this was from other jurisdictions, citing the reforms as the way forward within their own states and territories. While there are still some concerns with the framework in Victoria, the requirement that the detained person must experience a therapeutic benefit from that detention is clearly a necessary embedding of rights within the legislation. The committee is of the view that this would be an important first step for other jurisdictions.

8.20 The committee received evidence that state-funded treatments are triggered by an STO. The committee is concerned that this may create an incentive for service delivery organisations to seek STOs for clients, in order to receive funding for those services. The committee is further concerned that this creates a link between treatment and indefinite detention.

Guardianship

8.21 Across all jurisdictions, people with a cognitive or psychiatric impairment can be subject to guardianship orders to protect their health and welfare. These orders are administered by tribunals and courts within each jurisdiction, and the guardian can be an individual such as a family member, and organisation such as a disability accommodation services, or can be a public official such as a state or territory Public Advocate or Public Guardian. Guardianship provisions generally allow for orders to

12 Office of the Public Advocate (Victoria), *Submission 58*, p. 15. This issue was also raised by Ms Karly Warner, Executive Officer, National Aboriginal and Torres Strait Islander Legal Services, *Committee Hansard*, Melbourne, 29 April 2016, pp 22–23 and Professor. Rosalind Croucher, President, Australian Law Reform Commission, *Committee Hansard*, Melbourne, 29 April 2016, pp 35–36.

13 Mr Povey, Victoria Legal Aid, *Committee Hansard*, 29 April 2016, p. 17.

include involuntary health treatments as well as specifying where a person must reside.[14]

> Some guardianship orders include functions permitting the guardian to authorise a service provider to contain or seclude an adult. Others have functions permitting retrieval of a person (usually by police) in order to return them to their place of accommodation.[15]

8.22 Evidence presented to this inquiry showed that across Australia, indefinite detention operates under guardianship frameworks in a much more informal way that under forensic or civil mental health regimes. The Office of the Public Advocate Queensland (Public Advocate QLD) submitted that while the *Guardianship and Administration Act 2000* (Qld) does not specifically provide for indefinite detention, the health care and restrictive practices provisions of that legislation, allows for substitute decision-making with regards treatment and behaviour support matters.[16]

8.23 The Office of the Public Guardian Queensland (Public Guardian QLD) submitted similar evidence on the use of the QLD guardianship framework to underpin indefinite detention:

> Another means of 'indefinite detention' under the civil system, is through the use of restrictive practices which are unmonitored in the community in private homes. In certain cases, if an adult displays challenging behaviours that could cause harm to themselves, or others, a guardian may be appointed by the Queensland Civil and Administrative Tribunal (QCAT), with special responsibilities to help manage these behaviours. The appointed guardian is required to consider the use of a Positive Behaviour Support Plan which could include a range of 'restrictive practices' including: containment and seclusion; chemical, physical or mechanical restraint; or restrictive access.[17]

8.24 Victoria Legal Aid submitted that while the *Guardianship and Administration Act* 1986 (VIC) does not specifically authorise detention, it allows a guardian to issue an accommodation order that a person reside in a locked facility and provides no process for oversight of a person's detention. Furthermore:

> People subject to guardianship orders have no legal avenue to challenge a guardian's decision on its merits and there is no regular review of such a decision. Further, once an accommodation decision is made, a guardianship order will often be revoked, meaning that the person will remain detained in the accommodation.[18]

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14 See: Intellectual Disability Rights Service, Guardianship and administration laws across Australia, http://www.idrs.org.au/pdf/Guardianship_and_administration_laws_across_Australia_by_Ben_Fogarty.pdf (accessed 22 November 2016)

15 Intellectual Disability Rights Service, Guardianship and administration laws across Australia, p. 17.

16 Office of the Public Advocate (Queensland), *Submission 36*, p. 10.

17 Office of the Public Guardian (Queensland), *Submission 56*, p. 4.

18 Victoria Legal Aid, *Submission 71*, p. 5.

8.25 The New South Wales (NSW) Government presented evidence that in that jurisdiction, the Guardianship Tribunal can issue a guardianship order with a 'restrictive practices' function, which can include the power to restrict a person's movements or freedom.[19]

8.26 The issue of guardianship being used to authorise detention or involuntary health treatment of people with a cognitive or psychiatric impairment is not new to this committee. This issue was investigated in great detail in the committee's 2015 inquiry report into violence, abuse and neglect against people with disability (abuse inquiry). Beyond benign uses of guardianship orders to undertake a protective function, the abuse inquiry heard from submitters that disability service providers would sometimes apply for guardianship orders in order to streamline or create efficiencies in service delivery, sometimes resulting in involuntary and indefinite detention.[20]

8.27 The abuse inquiry report concluded:

> It is clear that the guardianship arrangements in all jurisdictions require some reform, including improved guidelines on appropriate decision-making through to oversight of the guardians themselves.[21]

Legal capacity

8.28 Underpinning the various regimes of guardianship, is the notion that a person with a cognitive or psychiatric impairment may have a legal incapacity for decision-making. This issue was investigated in detail in the 2015 abuse inquiry, which found:

> In some circumstances, a person is deemed to have a legal incapacity to make their own decisions. Disability-related legal incapacity refers to:
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> > [T]he level of cognitive ability that is required before a person can lawfully do various things. Because lack of capacity can prevent people from participating in many of the activities that form part of daily life, alternative decision-making arrangements are necessary.
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> Although legislation varies slightly in each state and territory, the principles that underpin a determination of legal incapacity are similar. Generally, there is a distinctly binary approach to the determination of legal incapacity—that is, a person is deemed to be either capable or not.[22]

8.29 This view was also put forward by Dr Joanne Bradbury in her submission to this inquiry:

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19 NSW Government, *Submission 66*, p. 19.

20 Community Affairs Committee, *Violence, abuse and neglect against people with disability in institutional and residential settings, including the gender and age related dimensions, and the particular situation of Aboriginal and Torres Strait Islander people with disability, and culturally and linguistically diverse people with disability*, (*Abuse inquiry*) November 2015, pp 79–84.

21 Community Affairs Committee, *Abuse inquiry*, November 2015, p. 87.

22 Community Affairs Committee, *Abuse inquiry*, November 2015, p. 72.

> It is important to note that decisional capacity is not an all-or-none phenomena. People are competent to a greater or lesser degree across a range of skills and tasks. In a legal and health care context, competence is regarded as a *threshold* concept. If, at a certain point along the degree of competence continuum, the capacity to make binding decisions about one's own health is reduced beyond a certain threshold point, the power to make legally binding decisions can be legally be transferred from the person to a surrogate. While the transfer of legal powers is all-or-nothing, the decisional capacity itself is not categorical.[23]

8.30 Dr Bradbury recommended supported decision-making be used to 'help fill the apparent gap in service provision for people with mental health challenges between loss of capacity and risk of harm.'[24]

8.31 The Australian Cross Disability Alliance (Disability Alliance) submitted that designating a person as lacking legal capacity can have far-reaching consequences:

> The deprivation of legal capacity for people with disability is not only a breach of that particular right. It leads to further actual and potential breaches of rights such as the right to live in the community, the right to access justice, the right to be free from violence and abuse, torture, inhuman and degrading treatment, the right to physical and mental integrity, and the right to liberty.[25]

8.32 The Alliance recommended reforms to legal frameworks to change the onus from limiting people with disability to exercise legal capacity, to supporting people with disability to have control over decisions that affect their lives.[26]

Supported decision-making

8.33 Supported decision-making is a mechanism to assist people with a cognitive or psychiatric impairment to effectively participate in decisions that impact their lives:

> [T]he human rights-based model of disability implies a shift from the substitute decision-making paradigm to one that is based on supported decision-making.[27]

8.34 The Australian Medical Association submitted evidence on the changeable nature of legal capacity, and the role that supported decision-making can have to address this in a health care context:

> For many, a loss of decision-making capacity may not be permanent – it may be temporary or may be progressive rather than immediate, and the

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23 Dr Joanne Bradbury, *Submission 63*, p. 6.

24 Dr Bradbury, *Submission 63*, p. 6.

25 Australian Cross Disability Alliance, *Submission 61*, p. 21.

26 Australian Cross Disability Alliance, *Submission 61*, p. 21

27 United Nations Convention on the Rights of Persons with Disabilities, Declarations and Reservations: Australia, https://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV15&chapter=4&lang=en#EndDec (accessed 22 November 2016).

> condition may fluctuate over time. In health care, patients with limited or impaired capacity are encouraged to participate in decision-making consistent with their level of capacity at the time a decision needs to be made.[28]

8.35 The 2015 abuse inquiry considered the practise of supported decision-making, and reviewed the findings of the Australian Law Reform Commission (Law Reform Commission) 2014 discussion paper *Equality, Capacity and Disability in Commonwealth Laws*. In this paper, the Law Reform Commission recommended reform of Commonwealth, state and territory laws, to be consistent with the following national decision-making principles to 'recognise people with disabilities as persons before the law and their right to make choices for themselves':

- The equal right to make decisions—all adults have an equal right to make decisions that affect their lives and to have those decisions respected;
- Support—persons who require support in decision-making must be provided with access to the support necessary for them to make, communicate and participate in decisions that affect their lives;
- Will, preferences and rights—the will, preferences and rights of persons who may require decision-making support must direct decisions that affect their lives; and
- Safeguards—laws and legal frameworks must contain appropriate and effective safeguards in relation to interventions for persons who may require decision-making support, including to prevent abuse and undue influence.[29]

8.36 The Australian Cross Disability Alliance made a series of strong recommendations on employing supported decision-making to the 2015 abuse inquiry,[30] and repeated its key recommendation to this inquiry:

> Australia should establish a nationally consistent supported decision-making framework that strongly and positively promotes and supports people to effectively assert and exercise their legal capacity and enshrines the primacy of supported decision-making mechanisms.[31]

8.37 In the context of this inquiry into indefinite detention, Queensland Advocacy Inc. noted that supported decision-making practices 'decreases the incidence of communicative behaviours that may lead to the application of a Restrictive Practice.'[32]

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28 Australian Medical Association, *Submission 12*, p. 3.

29 Law Reform Commission, Equality, Capacity and Disability in Commonwealth Laws, p. 24, https://www.alrc.gov.au/publications/equality-capacity-disability-report-124 (accessed 22 November 2016)

30 Australian Cross Disability Alliance, *Submission 147 to the 'Abuse inquiry'*, pp 13–15, http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/Violence_abuse_neglect/Submissions, (accessed 22 November 2016).

31 Australian Cross Disability Alliance, *Submission 61*, p. 8.

32 Queensland Advocacy Inc., *Submission 7*, p. 39.

Committee view

8.38 In considering the issue of supported decision-making, the committee concurs with the view expressed during the 2015 abuse inquiry:

> The committee agrees with the Law Reform Commission report and its recommendations about supported decision-making. It is the committee's view that while legislative reform is clearly a necessary step to effect these reforms, more work needs to be done to investigate supported decision-making models in Australia and oversee jurisdictions to ensure that the most sustainable form of supported decision-making is implemented in Australia.[33]

8.39 Indeed, more evidence has now been presented to the committee on the need for such reforms, as a mechanism to address come of the causes of the indefinite detention of people with cognitive and psychiatric impairment.

Restrictive practice

8.40 Restrictive practice refers to seclusion and restraint interventions in mental health and other settings, to control or manage a person's behaviour. Restraint can refer to physical, chemical (pharmacological), mechanical or psychological forms of restraint.[34]

8.41 The Disability Alliance described restrictive practice in its submission:

> People with disability in Australia are routinely subjected to unregulated and under-regulated behaviour management or treatment programs, known as restrictive practices that include chemical, mechanical, social and physical restraint, detention, seclusion and exclusionary time out. These practices can cause physical pain and discomfort, deprivation of liberty, prevent freedom of movement, and alter thought and thought processes.[35]

8.42 As outlined in Chapter 2, in 2015 the National Seclusion and Restraint Project (restraint project) looked at the operation of restrictive practice and made a number of recommendations to be implemented at a Council of Australian Governments level. However, the restraint project is limited to reviewing restrictive practice in the mental health sector. This inquiry has received a range of evidence that clearly shows restrictive practices are used across a variety of settings.

8.43 The Law Reform Commission submitted:

> The term ‘restrictive practices’ refers to the use of interventions that have the effect of restricting the rights or freedom of movement of a person in order to protect them. Serious concerns have been expressed about

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33 Community Affairs Committee, *Abuse inquiry*, November 2015, p. 77. A summary of all relevant legislation and policies relating to the use of restrictive practice can be found at p. 94 of that report.

34 National Mental Health Commission, *A case for change: Position Paper on seclusion, restraint and restrictive practices in mental health services*, May 2015.

35 Australian Cross Disability Alliance, *Submission 61*, pp 15–16.

> inappropriate and under-regulated use of restrictive practices in a range of settings in Australia. [36]

8.44 The Public Advocate Victoria submitted restrictive practices occur in:

> aged-care accommodation; day programs and activities; employment and training services; hospital emergency departments and wards; institutions; schools; shared and supported accommodation services; and supported services—and not just those being applied in prisons or to those who are at risk of or who are indefinitely detained in various accommodations.[37]

8.45 The Public Guardian QLD also discussed the prevalence of restrictive practice occurring outside formal disability accommodation service settings:

> While most of the persons subject to the use of restrictive practices live 'in the community', there is anecdotal evidence to suggest that many experience containment and seclusion on an ongoing basis for long periods of time, effectively detained in their own homes. While effectively 'detained' in their own homes, these persons may also be subject to the use of unmonitored physical and/or mechanical restraint. While QCAT may make an appointment regarding the use of restrictive practices, under the current regime, these people may face effective detention for a period of up to 12 months without a review.[38]

8.46 The committee's 2015 abuse inquiry considered the issue of restrictive practice. In her submission to the abuse inquiry, Dr Linda Steele used the term disability specific lawful violence' to describe interventions such as restrictive practice.[39]

8.47 The abuse inquiry heard from the Disability Alliance that restrictive practice, while considered by the health, legal and disability service sectors to be lawful therapeutic practice, if used in any other context would likely be a form of assault:

> Many of the practices would be considered crimes if committed against people without disability, or outside of institutional and residential settings. However, when "perpetrated against persons with disabilities", restrictive practices "remain invisible or are being justified" as legitimate treatment, behaviour modification or management instead of recognised as "torture or other cruel, inhuman or degrading treatment or punishment".[40]

8.48 Queensland Advocacy Inc. put forward a similar view on restrictive practice to this inquiry:

> In plain language, they are tantamount to assault, drugging and false imprisonment. They would not be tolerated and would be considered in

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36 ALRC, *Submission 4*, p. 3.

37 Office of the Public Advocate (Victoria), *Submission 58*, p. 31.

38 Office of the Public Guardian (Queensland), *Submission 56*, p. 4.

39 Community Affairs Committee, *Abuse inquiry*, November 2015, p. 77.

40 Australian Cross Disability Alliance in Community Affairs Committee, *Abuse inquiry*, November 2015, p. 77.

> contravention of the criminal law if they were done on people who did not have a disability. They are also never a solution. Even aside from all the human rights violations, they never solve the problem. When a person is exhibiting behaviours of concern, we know that the application of restrictive practices usually escalates, rather than calms, their behaviour.[41]

Chemical restraint

8.49 The committee heard evidence on the use of chemical (pharmacological) restraint during the Melbourne inquiry hearing:

> A lot of people with intellectual disability are treated with psychotropic medication, and they are not consenting to it. If they were treated under the Mental Health Act, that would be reviewed by a panel of a layperson, a psychiatrist and a lawyer. Under the Guardianship Act, they are not. It is either a family member or someone appointed by VCAT.[42]

8.50 The Australian Community Services Organisation told the committee that in Victoria, the Disability Act requires that any use of psychotropic medication without a specific diagnosis, administered to a person with an intellectual disability within a residential service, must be reported to the Office of Professional Practice as to why that chemical restraint is being used.[43]

8.51 However, Dr Chad Bennett of RANZCP responded that the Senior Practitioner does not have jurisdiction over the prescriber, so any comments are not enforceable. Dr Bennett went further to say:

> I think the other interesting thing about the idea of chemical restraint is that, for example, in mental health acts the idea of chemical restraint does not exist. It is purely something that exists within a disability kind of framework, although it is not usually a disability you are treating.[44]

8.52 The issue of chemical restraint in aged care settings is discussed later in this chapter.

Safeguards

8.53 As discussed above, the NMHC restraint project made a number of recommendations on safeguards for restrictive practice to be discussed at a Council of Australian Governments level.

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41 Dr Emma Phillips, Systems Advocate, Queensland Advocacy Inc. *Committee Hansard*, Brisbane, 23 March 2016, p. 11.

42 Dr Chad Bennett, Chair, Section for the Psychiatry of Intellectual and Developmental Disabilities, Royal Australian and New Zealand College of Psychiatrists, *Committee Hansard*, Melbourne, 29 April 2016, p. 43.

43 Mr Stan Pappos, Senior Manager, Forensic Housing Services, Australian Community Services Organisation, *Committee Hansard*, 29 April 2016, p. 43.

44 Dr Chad Bennett, Chair, Section for the Psychiatry of Intellectual and Developmental Disabilities, Royal Australian and New Zealand College of Psychiatrists, *Committee Hansard*, Melbourne, 29 April 2016, p. 43.

8.54 The Law Reform Commission noted that the establishment of a nationally consistent approach to safeguards on restrictive practice was endorsed by the Commonwealth:

> Current regulation of restrictive practices occurs mainly at a state and territory level. However, the Commonwealth, state and territory disability ministers endorsed the *National Framework for Reducing and Eliminating the Use of Restrictive Practices in the Disability Service Sector* (National Framework) in March 2014 to forge a consistent national approach.[45]

8.55 Four jurisdictions, Victoria, Queensland, Tasmania and the Northern Territory, have enacted legislation to regulate the use of restrictive practice. However, as noted by the Public Advocate QLD, that regulation is limited to state-funded disability services and 'restrictive interventions used in privately funded services or in hospitals, aged care and other health facilities remain unregulated.'[46]

8.56 The Public Advocate Victoria, while expressing some concerns about the use of restrictive practice in general, noted the safeguards incorporated into the regime in Victoria:

> In Victoria, Part 7 of the Disability Act allows the use of restrictive practices by disability service providers only in specific circumstances, namely when there are no less restrictive options available and only to prevent harm to the person and/or harm to others. Restrictive practices are most often applied to address or manage 'behaviours of concern' of people with a disability or mental ill health.
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> The Disability Act provides a model for consideration by other jurisdictions, where there is not otherwise a legislative framework for the regulation and monitoring of the use of restrictive interventions.[47]

8.57 Victoria Legal Aid similarly recommended the Disability Act as a model which could be replicated in other jurisdictions to improve the regulation of restrictive practice:

> Essential to the operation of the Disability Act are two elements otherwise absent in Victorian legislation: the need for intervention to benefit a person, and the requirement for planning with a view to reducing restrictions over time. In combination they assist to ensure the potency of interventions, increase the speed of a person's trajectory through those interventions and ensure regular scrutiny of the efficacy of supports.[48]

8.58 However, Victoria Legal Aid expressed similar concerns to the Public Advocate Victoria, that the regulation of restrictive practice did not extend to all sectors where such restrictions are being used:

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45 Australian Law Reform Commission, *Submission 4*, p. 3.

46 Office of the Public Advocate (Queensland), *Submission 36*, p. 16.

47 Office of the Public Advocate (Victoria), *Submission 58*, p. 32.

48 Victoria Legal Aid, *Submission 71*, p. 3.

> Aged care facilities, disability residential services and mental health services regularly restrict the freedom of movement of residents without any clear legal authority to do so. For example, services may prevent residents from leaving their rooms or the premises (whether or not the doors are locked). People who are informally detained are not subject to any legal oversight or, generally, any independent clinical oversight as to the necessity and appropriateness of the restrictions on their freedom. Further, the informal nature of the restrictions and lack of legal oversight, also mean there is no mechanism to prompt the involvement of a lawyer to provide independent advice and no real means to end detention.[49]

Committee view

8.59 The committee has heard additional evidence in a similar vein to the extensive evidence presented to the 2015 abuse inquiry and concurs with the views expressed by the committee in its report of that inquiry:

> The committee considers that the right to liberty is a fundamental human right. The committee is concerned with the extent to which restrictive practice is used, and is deeply concerned with the system which allows service providers to arbitrarily deprive people of their liberty.
>
> The Committee acknowledges the development of the National Framework for Reducing and Eliminating the use of Restrictive Practices in the Disability Service Sector. However, the committee is concerned that this implementation of this framework has stalled, and has not been consistently implemented across Australian jurisdictions, with many states and territories still relying on a voluntary code of conduct from disability service providers.
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> The committee notes that the implementation of the framework has stalled, and in some jurisdictions has never really begun. The committee sees a place for commonwealth legislation, should the framework not be vigorously taken up across all jurisdictions as a priority.[50]

Aged care

8.60 The committee has received evidence that the indefinite detention of people with a cognitive or psychiatric impairment is also an issue in the aged care context.

8.61 More than 50 per cent of residents in Australian Government-subsidised aged care facilities have dementia[51] and almost half (44 per cent) of permanent residents with dementia also had a diagnosis of a mental illness.[52] These conditions are often managed with the use of detention:

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49 Victoria Legal Aid, *Submission 71*, p. 4.

50 Community Affairs Committee, *Abuse inquiry report*, p. 99.

51 Alzheimer's Australia defines dementia as ' a complex chronic condition caused by one or more of a large number of illnesses affecting the brain. It is a terminal and devastating condition that affects people's abilities and memories.' See Alzheimer's Australia, *Submission 42*, p. 4.

52 Professor Richard Fleming, Kate Swaffer, Dr. Lyn Phillipson and Dr. Linda Steele, University of Wollongong, *Submission 19*, p. 2

> The confusion which accompanies dementia determines the need for a variety of safety features to be built into the environment. Among other things, they often include the provision of a secure perimeter [3] and/or the establishment of locked dementia specific units which effectively confine the residents to one area.[53]

8.62 Alzheimer's Australia estimates the 'presence of physical restraint in aged care facilities varies, and the evidence suggests prevalence rates from 12 per cent to 49 per cent' and submitted:

> There is extensive evidence that both physical and chemical restraint is often used to respond to the behavioural and psychological symptoms of dementia, despite clinical evidence suggesting that psychosocial responses should be the first line approach. Often behavioural and psychological symptoms are an indication of unmet needs, such as untreated pain, hunger or thirst, or boredom.[54]

8.63 Evidence has been presented which indicates that detention in aged care settings often occurs 'informally' in that it is not specifically authorised under any legislation and is therefore unlawful. In their submission, Global Action for Personhood cites policy prepared by the Office of the Public Advocate South Australia:

> In the 'Guardian Consent for Restrictive Practices in Residential Aged Care Settings' (2015) policy document1 from the Office of the Public Advocate (OPA, South Australia), detention in the aged care setting is defined as:
>
> **….** a situation where a person is unable to physically leave the place where he or she receives aged care services. The means of detention may include locked doors, windows or gates, and the constant supervision and escorting of a person to prevent the person from exercising freedom of movement.
>
> Of particular relevance is their comments on detention and keypad operated doors, a common feature of 'dementia specific' or 'memory' units in residential aged care. The policy notes that:
>
> If a person lives in a locked area, and is able to operate the keypad that person is not detained. If a person lives in a locked area, and cannot operate the keypad, or alternatively cannot ask to have the doors opened on request, and have this request granted, then the person is detained (OPA, 2015: 4).
>
> There is no doubt then, that people with dementia, who reside in units where access is restricted in this way, are detained unlawfully.[55]

8.64 The Public Advocate Victoria submitted similar evidence, that in aged care and disability settings 'restrictive interventions are applied without external authorisation of a court or tribunal.'[56]

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53 Professor Fleming et al, *Submission 19*, p. 2

54 Alzheimer's Australia, *Submission 42*, pp 3 & 7.

55 Global Action on Personhood, *Submission 26*, pp 1–2.

56 Office of the Public Advocate (Victoria), *Submission 58*, p. 31.

8.65 The President of the Guardianship and Administration Board of Tasmania has observed:

> Residential Aged Care Facilities continue to systematically detain people with dementia without clear authority to do so and in circumstances where the establishment of a requirement to do so under their duty of care might be questionable, or in other words, in circumstances where the defence of necessity to a charge or claim of unlawful detention might not exist or, at best, be limited. It seems that most facilities are prepared to 'risk it' that no-one will bring criminal or civil proceedings in relation to unlawful detention.[57]

8.66 Alzheimer's Australia highlighted that of chemical (pharmacological) restraint is also prevalent in aged care:

> It is estimated that about half of people in aged care and about 80% of those with dementia are receiving psychotropic medications, although this varies between facilities. There is evidence to suggest that in some cases these medications have been prescribed inappropriately. The evidence supporting the use of antipsychotic medications is modest at best, with international data suggesting that only 20% of people with dementia derive any benefit from antipsychotic medications.[58]

8.67 Prof Flemming et al recommended:

> The capacity of the aged care system to provide appropriate care to people with dementia could be increased by the delivery of education to managers and staff on human rights and the care of people with dementia and by increasing the emphasis placed by the Department of Health on the provision of suitably designed environments to accommodate those people with dementia who have a real need for secure accommodation. Both of these activities could be undertaken by the Department of Health funded Dementia Training Study Centres.[59]

8.68 Alzheimer's Australia made a range of recommendations for addressing indefinite detention in the aged care sector which included, staff training, improved information for consumers and carers, quality standards and assessment process to include benchmarks on reducing physical and chemical restraint and improved complaints mechanisms. Alzheimer's Australia stressed the importance of addressing this issue:

> Dementia is one of the major chronic diseases of this century. With the continued ageing of the population and the growing numbers of people with dementia, human rights issues in relation to people with dementia who are

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57 Anita Smith, *Detention of People with Dementia in Secure Facilities in State Care in Tasmania,* http://www.guardianship.tas.gov.au/__data/assets/pdf_file/0009/203967/Detention_of_people_with_dementia_in_secure_facilities.doc_31.7.12.pdf , (accessed 31 March 2016).

58 Alzheimer's Australia, *Submission 42*, p. 8.

59 Professor Fleming et al, *Submission 19*, p. 4

> imprisoned, and those who are restrained within the aged care system, need to be considered and addressed.[60]

Committee view

8.69 It is clear from the evidence provided that indefinite detention of people with cognitive or psychiatric impairment is a significant problem within the aged care context, occurring both within external facilities and private homes. It is also clear this detention is often informal, unregulated and unlawful.

8.70 The evidence presented to this inquiry further supports the views formed by the committee during its 2015 abuse inquiry that action needs to be taken in the aged care setting to protect vulnerable people from abuse.

Concluding committee view

8.71 It is clear there is a prevalence of indefinite detention of Australians with cognitive or psychiatric impairment within the mental health, disability, guardianship and aged-care contexts. This detention takes place in a number of location types and comes in many forms. It can stem from formal orders under mental health, disability or guardianship legislation. It can stem from restrictive practice or seclusion that creates a de facto form of indefinite detention. It can also be informal and unregulated, as a result of practices within the disability or aged-care, and in some cases in private homes.

8.72 It is also clear to the committee that evidence for this problem has been well-known to states and territories, and the Commonwealth, for some time. Although there have been some moves to address this form of indefinite detention, they have been patchy at best, and significantly underfunded.

8.73 As with the forensic mental health regimes, changes to these sectors will require effort from the states and territories, as well as coordination and leadership from the Commonwealth.

60 Alzheimer's Australia, *Submission 42*, pp 11–12.