

**Office of the Public Advocate**

**Submission to the Victorian Law Reform Commission report: People with  
Intellectual Disabilities at Risk: A Legal Framework for Compulsory Care.**

**14 October 2002**

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**Table of contents**

Introduction.....	2
Role of guardianship.....	3
Criteria for application of the legislation.....	3
Issue of disability.....	3
Decision-making capacity.....	3
Issue of risk.....	4
Therapeutic benefit.....	4
Least restrictive option.....	5
Voluntary service system.....	5
Type of care and treatment and location.....	5
Making a decision involving compulsory care.....	6
Review of care plans.....	7
Appeals.....	7
The tribunal.....	7
Investigative role of the Office of the Public Advocate (OPA).....	7
Access to advocacy.....	8
How should compulsory care and treatment be managed?.....	8
Monitoring of care providers.....	8
Care providers complaints mechanism.....	8
Appendix A.....	9
Voluntary or involuntary provision of services.....	9
Recommendations:.....	10
Appendix B.....	11
Complaint mechanism.....	11

## Introduction

The Office of the Public Advocate (OPA) views the rights of the individual as being the starting point for any legislation that has the capacity to affect the liberty of those individuals.

It is important to recognise that at present in Victoria a number of decisions are made that have the effect of imposing compulsory care upon people with a disability. Such decisions can involve significant restrictions upon individual freedom of movement, for example by requiring that someone live within a secure facility. There are, in OPA's view, gross inadequacies in the extent to which under the current practices the rights of individuals are protected. In particular, it is noted that:

- The criteria by which decisions are made are not necessarily transparent;
- There are no guarantees that decisions are made that give effect to the option that is the least restrictive of an individual's freedom; that are designed to achieve therapeutically positive and beneficial outcomes for the individual; that are made in the best interests of the individual rather than for the concern of others or to avoid confronting the lack of service availability;
- The decisions are not subject to independent, external, determinative review by an expert body; and
- The decisions are not made within a legal framework.

OPA has also on many occasions recorded the view that the use of guardianship powers to, in effect, civilly detain someone on the ground that they represent a risk to others is inappropriate.

Given the deficiencies in current practice, OPA supports the development of legislation that will more adequately protect the rights of people who may require compulsory care and treatment.

Any legislation should not discriminate on the basis of disability alone. There is a general acceptance that there is insufficient evidence of any clear relationship between disability and offending behaviour. As a consequence any legislation which primarily focuses on disability would be discriminatory. The legislation being considered should not cover people with intellectual disability alone nor should it cover disabilities in general. It should relate to any member of the community who:

- Has impaired decision-making capacity; and
- Presents a significant risk to the wider community; and
- Requires a therapeutic rather than a punitive response.

In drafting and applying the legislation care needs to be exercised to avoid encouraging community fears that people with disabilities are more likely to be offenders than other members of the community.

The scope of the legislation should also be limited by excluding coverage of persons who pose a risk not to other members of the community but solely to themselves or to property.

## ***Role of guardianship***

OPA considers that guardianship provides the most appropriate legal framework for providing compulsory care and treatment for those who are solely a risk to themselves. The *Guardianship and Administration Act* 1986 provides for the appointment of a guardian as a substitute decision-maker who is required to act in the best interests of the represented person whilst taking their wishes into account and pursuing the least restrictive option. Guardians should be able to place people in the full range of locked facilities where it can be demonstrated that this is appropriate and necessary for the person's protection and care. Currently there is no automatic review of a guardian's decision to place a person in a locked facility, the most common of which are nursing homes. OPA considers that such decisions (i.e. decisions by a guardian to agree to compulsory care because someone presents a risk to themselves) should be reviewed by the Victorian Civil and Administrative Tribunal-Guardianship List within a stated time, say 30 days.

Therefore where the person is a risk to themselves and to others, or just presents as a risk to others, compulsory care and treatment legislation ought to be the mechanism which should be applied. Given the gravity of decisions which have the effect of civil detention, namely their significant intrusion upon the liberty of an individual to protect the community, they should not be made through the use of guardianship. The manner in which they are made should involve a process which is transparent, accountable and subject to appropriate review and appeal mechanisms.

## **Criteria for application of the legislation**

### ***Issue of disability***

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

In relation to specific disabilities such as personality disorder, it needs to be clear as to why compulsory care is warranted given the established view that for most people with a personality disorder this can increase the risk of harm to self or others.

### ***Decision-making capacity***

The current thinking by experts in this area is that disability is not a predictor of offending behaviour. Therefore the capacity to make reasonable judgements is a more appropriate standard for such legislation. Such a criterion would also appropriately capture persons whose cognitive functioning is temporarily impaired through the use of drugs and alcohol but who do not have an acquired brain injury from the use of these substances

Some people with a disability are unable to understand that their actions are unlawful or to understand the nature of the harm they cause to others. It may also be assessed that because of their disability they are unable to form criminal intent, control their

behaviour or learn non-offending behaviour. An assessment of the person's capacity to make decisions would be an important part of any assessment and review process.

### ***Issue of risk***

The use of the compulsory care and treatment of people with disabilities, when their behaviour places others at risk, raises issues central to civil liberties. A key aspect is whether it is appropriate to limit the rights of a person with a disability, when the person may have not done something wrong, but rather because they may do something wrong in the future. The assessment of the dangerousness of the behaviour and assessments of risk need to be a central consideration of this legislation. This legislation should not apply to behaviour where the sole risk is to property.

The limited capacity to accurately assess risk is a significant challenge facing any legislation in this area. However, whilst acknowledging these difficulties, the level of risk is a critical factor in any process that will potentially limit the person's liberties. Consequently the process of decision-making needs to be one which is able to critically make any individual risk assessment. Compulsory care and treatment should only occur if the identified risks are:

- ◆ Serious; and
- ◆ Probable; and
- ◆ Imminent.

In assessing the risk, factors to be taken into account could include:

- ◆ The person has previously harmed others;
- ◆ The seriousness of this previous harm;
- ◆ The behaviour of concern has happened before;
- ◆ The imminence of the behaviour;
- ◆ The person has a previous history of being abused;
- ◆ The behaviour is extremely challenging and sometimes dangerous;
- ◆ There are significant protective concerns for children and young people;
- ◆ There is a history of criminal offending behaviour;
- ◆ There is a history of repeated contact with police and the criminal justice system;
- ◆ The person is socially isolated, transient and/or homeless;
- ◆ There is a history of family dysfunction;
- ◆ The person is repeatedly in crisis situations.

It is unreasonable to only consider people with previous convictions when considering the issue of identified risk. There should be a recognition that behaviour may not have resulted in criminal charges. Moreover this legislation would have the effect of diverting people away from the criminal justice system where appropriate.

### ***Therapeutic benefit***

The principles outlined in the discussion paper reflect a primary concern for safeguarding the rights of the person with a disability and promoting their best

interests. This is of utmost importance. Any compulsory intervention should, as far as practicable, have a benefit for the person with a disability. Another way of conceptualising this is to consider a broad notion of therapeutic benefit for the person as a result of the intervention. This care and/or treatment should occur in the context of a broader care plan for the individual, which should be approved by the tribunal and regularly reviewed externally. (This should be done by the tribunal referred to later in this submission.

### ***Least restrictive option***

This legislation should not be used as an alternative to potentially less restrictive forms of support, which may be inadequately funded. Evidence should be required which demonstrates that less restrictive options have been explored, trialled and/or rejected or failed. Indeed such legislation may provide an important opportunity to promote a more effective response to the needs of this group by the service system.

### ***Voluntary service system***

The voluntary nature of service provision can result in service providers using the requirement of consent to avoid engaging in the provision of a service where it concerns a person with difficult at risk behaviour. This is of particular concern where the nature of the disability affects the person's insight into their capacity to manage and therefore their perception of their need for assistance.

The need for the service system to take on a more assertive outreach approach is seen as important in providing support to people with disabilities at risk. There is a lack of flexibility in the existing service system to be able to respond to individual needs in a variety of ways. A more flexible service system which is able to take a more assertive outreach approach to service delivery may reduce the number of applications seeking compulsory care and treatment.

(Refer appendix A for part of the OPA submission to the review of *Intellectually Disabled Persons' Services Act 1986*)

### ***Type of care and treatment and location***

The Public Advocate does not consider that this legislation should apply to restraint and seclusion. To do so would have the potential to include so many persons as to make the review system unworkable. It is acknowledged, however, that there is a need to review existing legislation relating to the use of restraint and seclusion so that their use is more rigorously controlled.

The type of compulsory care and treatment that should be included in this proposal is that of the most serious kind, namely -

- A requirement to reside in a secure facility; or
- The imposition of significant restrictions upon freedom of movement for someone who has access to the community.

The scope of such legislation should apply to facilities provided or funded by the state government, which can include non-government agencies, but should not include

placement with the family of the person with the disability. It is felt that this would place an unreasonable burden on family, which may prove difficult to monitor.

## **Making a decision involving compulsory care**

The proposed process therefore covers those decisions that involve a person, because they present a risk to others, who is required to live in secure accommodation or who is allowed access to the community but subject to significant restrictions.

Such compulsory care should only be imposed pursuant to a care plan. A care plan should only be made by:

- A Regional Director of the Department of Human Services or their delegate; or
- Where care is being provided by a non-government agency by a person occupying a position within that agency which is gazetted for this purpose.

These persons are referred to below as primary decision-makers.

It is submitted that a care plan should not take effect until reviewed by a tribunal (a similar mechanism exists in relation to restricted community treatment orders under the *Mental Health Act*). This is discussed below.

Where the primary decision-maker believes that the risk to others justifies it they may apply for a temporary detention order giving effect to compulsory care pending the development of a care plan and its review by the tribunal. (This procedure would be analogous to the provision for temporary guardianship orders under the *Guardianship and Administration Act*.)

The standard of proof for the making of a temporary detention order would not be as high as required if the matter were being finally considered. There must be evidence adduced of the need for such an order (that the risk is serious, harm imminent and probable) and an evaluation of the benefits to be achieved by removing the person to a place of detention over their continuing to remain in their current circumstances.

The period of a temporary detention order must be kept to a minimum. The current period relating to temporary guardianship is 21 days with an opportunity to renew this for a further 21 days.

The purpose of the detention period is to develop a care plan for the person detained.

During the period of detention the primary decision-maker is authorised to perform assessments of the person in detention with a view to the development of a care plan. It is likely that there will be significant information relating to this individual and the assessors must have access to such information and previous service providers.

It is envisaged that it would not always be necessary to seek a temporary detention order. Where a service provider considers that a person requires compulsory care they can apply to a primary decision-maker to develop a care plan setting out the care and treatment to be provided.

### ***Review of care plans.***

The tribunal's role is to approve care plans that require compulsory care. If the tribunal is not satisfied with the care plan it can make recommendations. If the applicant is not prepared to accept these recommendations, the tribunal may reject the care plan and the person will not be subject to compulsory care.

Where a temporary detention order applies and the tribunal rejects the care plan, the temporary detention order lapses.

The hearing of a review of a care plan should commence within five weeks of the making of the care plan.

A care plan should be subject to periodic review by the tribunal. The period for review should be not greater than 12 months and may be such lesser period as is determined by the tribunal.

### ***Appeals.***

A person who is the subject of the care plan or a community visitor or any other person who satisfies the tribunal of a genuine concern for the person may appeal to the tribunal at any time.

Any person aggrieved by a decision of the tribunal in relation to the making of a care plan may appeal to the VCAT within 28 days of the decision by the tribunal.

### ***The tribunal.***

The tribunal's constitution should be multi-member and multi-disciplinary. Such composition is justified by the complex nature of cases involving compulsory care and the significance of a decision having the effect of civil detention. The current composition of the Mental Health Review Board is a useful example to draw upon in constructing the tribunal given that it has the benefit of the multi-disciplinary composition that brings together a range of skills, knowledge and expertise by which it can consider the various issues as well as potentially reflect the views of the wider community.

### ***Investigative role of the Office of the Public Advocate (OPA).***

The role of OPA in relation to such matters would be that of independent investigator. The tribunal would have legislative authority to refer the matter to OPA for a report (same as clause 35 (1) of the VCAT Act) with the Public Advocate having authority to 'require a person, government department, institution, welfare organization or service provider to provide information' (amended s 16 (1) (ha) of the *Guardianship and Administration Act*). The functions of OPA could include:

- Ensuring that a critical investigation and exploration of all expert evidence occurs;
- Ensuring the Tribunal has current and relevant evidence of the person's disability (where this a factor) and the effect of that disability on their capacity;

- Identifying and providing advice on alternative or less restrictive options;
- Providing critical analysis of proposed care plans with particular emphasis on the anticipated therapeutic value of a compulsory care and treatment order.
- Making submissions to the Tribunal in relation to the application.

It should be noted that such investigatory functions would involve resourcing requirements for OPA.

### ***Access to advocacy***

As part of the process, the person who is the subject of the application should have access to independent legal advice and advocacy. Where the person is unable or unwilling to engage an advocate of choice and the tribunal believes that the person cannot represent themselves, the tribunal will refer the matter to:

- The Public Advocate who will make available the services of an advocate, and
- Victoria Legal Aid (VLA) which will make available free advice from a VLA lawyer or private practitioner with relevant experience. If the person then seeks legal representation, VLA will consider such application applying its usual means and merits test.

(Note: This is similar to the protocol adopted by the OPA with the Family Court in relation to special medical procedures concerning children with a disability).

### **How should compulsory care and treatment be managed?**

The Office makes a distinction between clinical management and monitoring. The Office does not support the proposal made in 5.31 of the Discussion Paper that it would oversee treatment decisions because of its lack of expertise in this role and the potential to compromise OPA's role in providing independent advocacy. Clinical management should be provided by a senior clinician. OPA would provide advocacy upon request in relation to the care plan.

### ***Monitoring of care providers***

Community visitors are an appropriate mechanism to monitor the standard of care provided to people under this legislation. To assist community visitors perform this function it would be important for them to have access to the care plans developed for individuals detained under this legislation.

### ***Care providers complaints mechanism***

The Office supports the need for an independent complaints mechanism for all services provided to people with disabilities. (Refer appendix B for details)

## Appendix A

### *Voluntary or involuntary provision of services*

#### *Context*

Unlike the *Mental Health Act 1986*, which can be used to compel treatment and the receipt of services where a person has a mental illness, the *Intellectually Disabled Persons' Services Act 1986* (IDPSA) essentially relies on a notion of voluntary service provision for those who are determined to be eligible persons under that legislation. Eligibility for service is based upon criteria of disability that, in all likelihood, will directly affect the decision-making capacity of an individual. Many clients, by virtue of their disability, lack insight into their need for services and supports or the benefits which may accrue to them as a consequence of case management and service provision.

DisAbility Services at the Department of Human Services asserts a 'cultural' position of service provision based on the notion of voluntariness, that is, that an eligible person must be willing to receive services. This position is emphasised by the Department (beyond the provisions in the IDPSA relating to restraint, seclusion, forensic and security residents), from the standpoint that it does not have a clear legislative mandate to compel, direct or coerce eligible clients to accept services.

In practice, this often means that limited effort will be made to encourage clients to accept services or to engage in assertive, crisis prevention case management for clients. Departmental managerial objectives of case closure and efficient throughput may also contribute to this approach. Furthermore, case planning provisions oblige the Department to develop individual plans (General Service Plans and Individual Service Plans) through a collaborative decision-making process that focuses upon clients needs and interests. The presumption is that the Department will implement these plans when the client is not objecting by express wish or action.

This context raises the following issues:

- There is a lack of consistency and clarity in DHS policy and attitude towards voluntary service provision. Considerable differences of interpretation across regions and between workers.
- Principle of voluntary service provision used as a gate-keeping mechanism
- Frequently voluntary nature of service provision is raised where clients are at high risk but are non-compliant with DHS efforts to meet the person's needs, manage behaviour or risk, that is in the situations where people with a disability are most at risk.
- When a person with an ID also has other problems such as drug and alcohol abuse, they are even less likely to see a need for support or assistance. The mainstream assumption is that people with addictions can only be helped when they are prepared to accept it. If a person with an intellectual disability also has a serious addiction, they may be beyond assistance or rehabilitation by the time they are prepared to accept intervention.
- Experience of guardians wishing to access services on behalf of clients being told that DHS can only provide services if the client agrees (accepting the

legal mandate or guardianship but in addition requiring the compliance of the client).

- Voluntary service principle may result in lack of willingness to undertake assertive and persistent case management for clients in difficult circumstances (in contrast to some areas of mental health and ABI service providers) with anticipated outcomes of crisis emerging often recurrently.
- Voluntary provisions are associated with a lack of internal review mechanisms of decisions made for clients (IDRP very limited in coverage).
- DHS may use voluntary service provision to attempt to limit their liability where clients are seen to be difficult.
- Consent should become an issue in respect of persons with an ID only in limited circumstances typically characterised by dispute or their special gravity.

***Recommendations:***

- The legislation ought hold a reference to affirming needs focused and best interests principle that as far as possible respects the wishes of persons with disability.
- The legislation ought in prescribed protective circumstances, include a clear and accountable mandate to compel, direct or coerce eligible clients. This ought encompass the provision of restraint and seclusion. Such decisions ought be subject to an independent review body.
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Legislation ought maintain and reassert an individual needs focused planning responsibility for clients in respect of major life areas that is based upon less restrictive and consultative processes. A rights-based review and complaint mechanisms in respect of this mechanism ought be retained with an emphasis on strengthened Departmental accountability.

**(Note: This is part of a recent OPA submission to the Department of Human Services in relation to the proposed review of the *Intellectually Disabled Persons' Services Act 1986*)**

## **Appendix B**

### ***Complaint mechanism***

#### Introduction

The Public Advocate accepts as a starting point, the need for a complaints mechanism for people with disabilities. The role of the Public Advocate is to promote the rights and dignity of people with disabilities. This can be achieved, in part, through the creation of an independent complaints mechanism, which may lead to improvements in service quality and associated quality of life. A properly resourced and empowered complaints mechanism illustrates a commitment to accountable, transparent and responsive service delivery. This is important generally, and for people with disabilities who may experience particular vulnerabilities.

The need to develop an independent complaints mechanism for people with disabilities, as included in the State Disability Plan 2002-2012 prepared by the Department of Human Services (DHS), is therefore to be commended.

What follows is the Public Advocate's comments in relation to the establishment of the disability complaints mechanism, including access to the mechanism, the types of complaints it should receive and where it should be 'sited'.

#### Principles underpinning the establishment of a complaints mechanism

The following principles should inform the development of a disability complaints mechanism.

- The complaints mechanism should be completely independent from any bodies, which fund disability services, given the obvious and potential conflict of interest, particularly in relation to DHS. The mechanism should also not be attached administratively to DHS.
- The sitting of the complaints mechanism should reflect a separation between the fields of disability and health, given the unacceptable potential for 'disability' to be 'lexicalised' and for health concerns to perhaps dominate a complaints agenda.
- The mechanism should embody a strong justice or rights orientation.
- If the mechanism is to be co-located with another organisation, that organisation should be robust and viable with adequate infrastructure.
- The mechanism should understand the culture of disability and employ staff with relevant skills in terms of this culture.
- The mechanism should encourage complaints to be dealt with, in the first instance, at the local organisational level.

- The mechanism should recognise that agreed quality service standards may preclude most complaints and should therefore encourage, at the local level:
  - The setting and monitoring of standards;
  - The establishment of local complaint resolution mechanisms;
  - The availability of sanctions where standards are not satisfactory;
  - Education and training of agency staff and management; and
  - Advice to people with disabilities on their rights and entitlements.

#### Design of mechanism

- The mechanism should embrace reactive (individual complaint work) and proactive (preventative systemic work) roles in relation to complaints.
- In its reactive role, the mechanism should hear and determine complaints, in an impartial and unbiased manner. In so doing, it should have a mix of determinative and recommendatory powers. Recommendatory powers may be useful in circumstances where a decision has particular political, administrative or resource implications, or impacts on policy and procedures in a manner, which is likely to be complex. A comparative example in this vein is contained in sections 125 & 126 of the *Equal Opportunity Act 1995*, which outlines procedures in relation to "special complaints". These are complaints in which the resolution "may have significant social, economic or financial effects on the community or a section of the community." The mechanism may refer matters requiring attention to the appropriate authority.
- In its proactive role, the mechanism would focus on a range of systemic issues, including the monitoring and reviewing of service quality and the improvement of infrastructure for people with disabilities. Management practices, the allocation of resources, case management issues and compliance with best practice could all potentially be areas of interest and activity for the mechanism in its proactive role. It should also have a power/responsibility to report to a Minister or Parliamentary Committee regularly and on issues that warrant ministerial attention.
- For both the reactive and proactive roles, the mechanism would need wide authority to undertake investigations, require the production of documents, call witnesses, visit work sites and isolate systemic issues.
- The mechanism would have a capacity to initiate individual and systemic investigations.

#### Access to mechanism

- Complaints may be raised by a person with a disability or any other person or organisation on behalf of a person with a disability. The complainant should have 'sufficient interest' in the matter to establish their basis for making the complaint or for raising the systemic issues.
- A nexus would exist between the reactive and proactive roles of the mechanism, via established referral processes.

- There would be no costs attached to the lodging of a complaint, but the mechanism would retain the right to not accept a complaint or refer it to another body.
- Complaints could be handled by the mechanism where these had proved irresolvable at the local level, where they had been referred for investigation /and or resolution by the responsible Minister or other nominated authority or where they contained an element of urgency, seriousness or other persuasive factors.

#### Type of complaints

- Complaints may be made in relation to a range of services for people with disabilities, including government-run services, government-subsidised services and privately provided services.
- Complaints may cover:
  - Failure to provide a product or service considered to be a right or entitlement. (This would necessitate some discussion/consideration of what constitutes a right or entitlement);
  - Failure to provide a satisfactory product or service against agreed or prescribed standards;
  - Failure to treat a person in a manner consistent with respecting that person's rights and dignity;
  - Abuse, exploitation or neglect of a person;
  - Dissatisfaction with any aspect of a person's experiences which is within the responsibility of another to provide and within the power of that body to rectify.

#### Siting of the mechanism

- The establishment of a new stand-alone mechanism is not seen as politically viable or cost effective in the current environment. It is therefore thought appropriate that the mechanism be co-located with an existing entity.
- Options for the siting of the complaints mechanism with an existing entity are as follows: Office of the Health Services Commissioner (HSC), Intellectual Disability Review Panel (IDRP), Victorian Ombudsman, Equal Opportunity Commission (EOC), Office of the Public Advocate (OPA).
- There is no clear 'stand out' option in the context of the principles previously articulated on page 1 and 2 of this document.
- Co-location with the IDRP is not favoured as this entity lacks the organisational infrastructure to support the mechanism.

- Co-location with the Ombudsman is also not preferred as that organisation is generic in focus with no particular expertise or skill in dealing with disability issues.
- The importance of the principle of separating health and disability is also seen as highly influential in any selection and therefore leads to a conclusion that the HSC is not the preferred option for siting of the mechanism. This separation principle was emphasised in the recent presentation on his office by the New Zealand Health and Disability Commissioner. The HSC is also not favoured due to its administrative link with the Department of Human Services, the primary funder of disability services.
- EOC and OPA therefore emerge as primary options. EOC focuses on discrimination, which means that disability complaints will be a new complaint focus for that body. EOC has limited involvement in systemic/advocacy work. OPA does not have a formal track record in the investigation of complaints, but does have expertise in systemic work.
- This leads to the option that the reactive and proactive roles of the complaint mechanism be located in two entities, specifically, that EOC take on the reactive role and OPA the proactive role. EOC and OPA are administratively linked to the Department of Justice, thereby emphasising a rights and justice focus.
- This option usefully identifies an expanded role for the EOC in complaint investigation. The infrastructure and experience for complaint investigation already exists within the EOC. It is also a body, which is clearly associated with a rights perspective as well as being quite distinct from disability funding bodies. OPA is well placed to handle the systemic issues that would emerge from the proactive role of the mechanism and currently undertakes systemic work as it arises and as resources allow.

The Public Advocate therefore, as a preliminary position, supports the establishment of a complaints mechanism in which the reactive role would be located with the EOC and the proactive role with OPA.

**(Note: This is part of a recent OPA submission to the Department of Human Services in relation to the proposed review of the *Intellectually Disabled Persons' Services Act 1986*)**