

# WHAT ROLE FOR ADULT GUARDIANSHIP IN AUTHORISING RESTRICTIVE PRACTICES?

KIM CHANDLER\*, BEN WHITE\*\* AND LINDY WILLMOTT\*\*\*

*This paper undertakes the first comprehensive analysis of the role that Australian guardianship laws play in regulating restrictive practices for people with intellectual and cognitive impairment. It identifies and critiques the five possible legal bases for authorising such decisions in the guardianship system before concluding that the law should be reformed to place decision-making about this issue on a clear, certain and consistent basis. This should be achieved by legislative reform and should not have to rely on tribunal decision-making. The paper also questions whether the guardianship system is an appropriate vehicle for regulating restrictive practices. Historically, restrictive practices were not part of decision-making regimes for adults with impaired capacity but it appears that it is now widely assumed to be a logical home for such practices. If that is to be the case, the guardianship system must maintain its clear focus on adults with intellectual and cognitive impairments and that the rights, interests and welfare of this cohort are paramount in decision-making about restrictive practices.*

## I INTRODUCTION

‘Restrictive practices’ refer to interventions that limit a person’s right to freedom of movement. Restrictive practices include mechanical, physical and chemical restraint, seclusion, and detention (also called ‘containment’).<sup>1</sup> In real terms, this means using physical force to stop people from moving or to pin them to the ground, the use of splints, body suits and ties to restrain people, the administration of psychotropic medication to control a person’s behaviour, and the confinement of people in rooms or other spaces by themselves. Restrictive practices can also involve locking buildings, wards or other rooms to prevent people from leaving.<sup>2</sup> Because restrictive practices infringe on bodily integrity and/or involve controlling a person’s freedom of movement (often in very significant ways), they

\* BA (UQ), BSocWk(Hons) (UQ), Juris Doctor (UQ)

Australian Centre for Health Law Research, Faculty of Law, Queensland University of Technology.

\*\* LLB (Hons) (QUT), DPhil (Oxf)

Professor and Director, Australian Centre for Health Law Research, Faculty of Law, Queensland University of Technology.

\*\*\* BCom (UQ), LLB (Hons) (UQ), LLM (Cantab), PhD (QUT)

Professor and Director, Australian Centre for Health Law Research, Faculty of Law, Queensland University of Technology.

1 Australian Law Reform Commission, *Equality, Capacity and Disability in Commonwealth Laws: Final Report*, Report No 124 (2014) 244 [8.5].

2 Victorian Law Reform Commission, *Guardianship: Final Report*, Report No 24 (2012) 318 [15.1].

give rise to civil and/or criminal liability where they are not authorised, justified or excused by law.<sup>3</sup>

Restrictive practices are used across many settings (eg mental health, residential aged care, disability care and health facilities), not without significant controversy regarding their use,<sup>4</sup> and are regulated in a range of ways including through mental health, disability and guardianship legislation as well as through a plethora of guidelines and policies.<sup>5</sup> The Australian Law Reform Commission ('ALRC') has noted 'substantial discrepancy in the regulation of restrictive practices across jurisdictions'<sup>6</sup> while Williams, Chesterman and Laufer observe that the intersection between state and Commonwealth legislation, along with common law doctrines protecting liberty, 'conspire to make the legal framework in this area exceedingly complex'.<sup>7</sup>

Much of the critical examination of regulation of restrictive practices, most notably in Australia by McSherry and her colleagues, has focused on these interventions in the mental health system.<sup>8</sup> Of particular note is the major interdisciplinary 'Seclusion and Restraint Project: Report' prepared for the National Mental Health Commission.<sup>9</sup> This paper looks instead at restrictive practices used in relation to people with *intellectual and cognitive impairment*, such as intellectual disability, dementia or acquired brain injury, and how they are regulated.

Unlike the mental health setting where each state and territory has a regime that deals with issues such as involuntary detention and treatment,<sup>10</sup> there is no comprehensive legal framework that authorises and regulates detaining and restraining people with intellectual and cognitive impairment. Yet the restrictive practices described above are also used on this cohort of people, sometimes, although not always, because of 'challenging behaviours' or 'behaviours of

3 Kim Chandler, Ben White and Lindy Willmott, 'The Doctrine of Necessity and the Detention and Restraint of People with Intellectual Impairment: Is There Any Justification?' (2016) 23 *Psychiatry, Psychology and Law* 361, 362.

4 Surabhi Kumble and Bernadette McSherry, 'Seclusion and Restraint: Rethinking Regulation from a Human Rights Perspective' (2010) 17 *Psychiatry, Psychology and Law* 551; Phillip French, Jeffrey Chan and Rod Carracher, 'Realizing Human Rights in Clinical Practice and Service Delivery to Persons with Cognitive Impairments who Engage in Behaviours of Concern' (2010) 17 *Psychiatry, Psychology and Law* 245.

5 Michael Williams, John Chesterman and Richard Laufer, 'Consent versus Scrutiny: Restricting Liberties in Post-Bournewood Victoria' (2014) 21 *Journal of Law and Medicine* 641; Judy Allen and Tamara Tulich, '"I Want to Go Home Now": Restraint Decisions for Dementia Patients in Western Australia' (2015) 33(2) *Law in Context: A Socio-Legal Journal* 1; Australian Law Reform Commission, above n 1, 248–9 [8.26]–[8.27].

6 Australian Law Reform Commission, above n 1, 249 [8.27].

7 Williams, Chesterman and Laufer, above n 5, 641.

8 See, eg, Cath Roper, Bernadette McSherry and Lisa Brophy, 'Defining Seclusion and Restraint: Legal and Policy Definitions versus Consumer and Carer Perspectives' (2015) 23 *Journal of Law and Medicine* 297; Kumble and McSherry, above n 4; Bernadette McSherry, 'The Legal Regulation of Seclusion and Restraint in Mental Health Facilities' (2013) 21 *Journal of Law and Medicine* 251.

9 Melbourne Social Equity Institute, 'Seclusion and Restraint Project: Report' (Report, University of Melbourne, August 2014) <[http://socialequity.unimelb.edu.au/\\_data/assets/pdf\\_file/0017/2004722/Seclusion-and-Restraint-report.PDF](http://socialequity.unimelb.edu.au/_data/assets/pdf_file/0017/2004722/Seclusion-and-Restraint-report.PDF)>.

10 Ian Freckelton, 'Mental Health Law' in Ben White, Fiona McDonald and Lindy Willmott (eds), *Health Law in Australia* (Thomson Reuters, 2<sup>nd</sup> ed, 2014) 699.

concern'; namely behaviours that expose the person, support staff and others in the community to a risk of significant harm.

There is growing recognition of and concern about the use of restrictive practices on people with intellectual and cognitive impairment in Australia.<sup>11</sup> Federal, state and territory disability Ministers have endorsed a national approach to reduce restrictive practices through the *National Framework for Reducing and Eliminating the Use of Restrictive Practices in the Disability Service Sector*.<sup>12</sup> The ALRC also identified the use of restrictive practices in both aged care and disability services as a significant issue,<sup>13</sup> noting that the United Nations Committee on the Rights of Persons with Disabilities has expressed concern about the use of restrictive practices in Australia.<sup>14</sup> Many commentators have also highlighted that restrictive practices are often used in lieu of appropriate support and have argued instead for the need to understand the causes and triggers of challenging behaviours, with a focus on changing services, systems and environments rather than resorting to restrictive practices.<sup>15</sup>

How best to regulate restrictive practices for this group of people in the disability and aged sectors is the subject of ongoing debate. For example, consideration is currently being given in Australia to an appropriate regulatory framework for the authorisation of restrictive practices under the National Disability Insurance Scheme ('NDIS').<sup>16</sup> Only four states and territories specifically regulate the use of restrictive practices for people with intellectual and cognitive impairment

11 Melbourne Social Equity Institute, above n 9, 161–2.

12 Department of Social Services (Cth), *National Framework for Reducing and Eliminating the Use of Restrictive Practices in the Disability Service Sector* (May 2013) <<https://www.dss.gov.au/our-responsibilities/disability-and-carers/publications-articles/policy-research/national-framework-for-reducing-and-eliminating-the-use-of-restrictive-practices-in-the-disability-service-sector>>.

13 Australian Law Reform Commission, above n 1, 243–8 [8.1]–[8.25].

14 Committee on the Rights of Persons with Disabilities, *Concluding Observations on the Initial Report of Australia, Adopted by the Committee at Its Tenth Session (2–13 September 2013)*, UN Doc CRPD/C/AUS/CO/1 (21 October 2013) 5 [35]. The United Nations Special Rapporteur on Torture has also called for an absolute ban on the use of solitary confinement and restraint in health care settings: see Juan E Méndez, *Report of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, 22<sup>nd</sup> sess, Agenda Item 3, UN Doc A/HRC/22/53 (1 February 2013).

15 Jeffrey Chan et al, 'Is It Time to Drop the Term "Challenging Behaviour"?' (2012) 15(5) *Learning Disability Practice* 36; Australian Centre for Disability Law et al, 'Disability Rights Now: Civil Society Report to the United Nations Committee on the Rights of Persons with Disabilities' (Report, August 2012) 91–101 <<http://www.pwd.org.au/issues/crpd-civil-society-shadow-report-group.html>>; see Jeanne Hayes and Elizabeth 'Lisa' M Hannold, 'The Road to Empowerment: A Historical Perspective on the Medicalization of Disability' (2007) 30 *Journal of Health and Human Services Administration* 352; Royal College of Psychiatrists, British Psychological Society and Royal College of Speech and Language Therapists, 'Challenging Behaviour: A Unified Approach' (College Report No CR144, Royal College of Psychiatrists, June 2007) <<http://www.rcpsych.ac.uk/usefulresources/publications/collegereports/cr/cr144.aspx>>.

16 Jade Maloney et al, 'National Disability Insurance Scheme Quality and Safeguarding Framework' (Consultation Report, Department of Social Services (Cth), 31 August 2015) <<https://engage.dss.gov.au/ndis-qsf/ndis-quality-and-safeguarding-framework-consultation-report/>>. Note also that the New South Wales Law Reform Commission, *Review of the Guardianship Act 1987: Background Paper* (2016) specifically includes the role of restrictive practices under guardianship legislation in its terms of reference: at v [6].

through legislation.<sup>17</sup> Victoria and the Northern Territory have a framework for administrative decision-makers to approve the use of restrictive practices while Queensland allows substitute decision-makers to decide through its guardianship system. Tasmania's regime has elements of both administrative and guardianship models. All four of these regulatory regimes are confined to the use of restrictive practices in government funded disability services.<sup>18</sup>

In the absence of specific legislative regimes, or in those jurisdictions that do regulate in this way, outside of state funded disability services, the legal basis for authorising restrictive practices for people with intellectual and cognitive impairment is not straightforward.<sup>19</sup> To date, it seems that the state and territory guardianship regimes have been relied upon to provide this authority, even when there are no specific provisions permitting restrictive practices. However, as will be seen, there are some questions about at least some of the various legal bases that have been advanced to rely on guardianship law as authorising these interventions. Also significant is that, despite the critical role that guardianship appears to play in authorising restrictive practices for this cohort, it has been the subject of only very limited academic legal and regulatory analysis. For example, Williams, Chesterman and Laufer do consider whether guardianship should play a role in regulating restrictive practices but they focus on particular reform proposals in Victoria.<sup>20</sup> Allen and Tulich consider particular aspects of Western Australian guardianship law in their review of restraint decisions for patients with dementia, but, again, this is part of a wider review and the guardianship analysis is therefore necessarily limited in scope.<sup>21</sup>

The purpose of this paper is to undertake the first comprehensive analysis of the role that Australian guardianship laws play in regulating restrictive practices for people with intellectual and cognitive impairment. A review of tribunal decisions,<sup>22</sup> policies of guardianship bodies and the limited academic and other writing in the field reveals five possible legal bases on which guardianship law may authorise restrictive practices: specific legislative provisions about restrictive practices, health care or medical treatment decision-making powers, accommodation powers, personal decision-making powers of guardians, and specific coercive powers granted to guardians. The paper also critically analyses each of these

17 Kim Chandler, Lindy Willmott and Ben White, 'Rethinking Restrictive Practices: A Comparative Analysis' (2014) 14(2) *QUT Law Review* 90.

18 Ibid 91.

19 For an analysis of where restrictive practices may be excused in accordance with the doctrine of necessity, see Chandler, White and Willmott, 'The Doctrine of Necessity and the Detention and Restraint of People with Intellectual Impairment', above n 3, 362.

20 Williams, Chesterman and Laufer, above n 5.

21 Allen and Tulich, above n 5.

22 We note though that: (a) tribunals with guardianship jurisdiction have not and/or do not produce reasons for all of their decisions, and (b) not all reasons for decisions produced are publicly available. Further, different tribunals adopt different approaches to what they count as a restrictive practice. So, a practice that one tribunal considers to be a restrictive practice is not regarded as such by another tribunal, making it difficult to sometimes identify judgments where these practices are being considered. This means that it is not possible to provide a complete picture of tribunal decision-making in this area.

legal bases to determine whether they present a justifiable basis on which to rely in authorising restrictive practices. A key finding is that absent specific legislative authorisation either through restrictive practices or coercive powers provisions in the legislation, questions remain about authorising restrictive practices through the guardianship system. This is despite the apparent widespread reliance on it, including with some apparent endorsement of this position by guardianship bodies.

The paper then turns to a critique of the existing law. In the first part of the critique, drawing on the preceding legal analysis, we conclude that the current law is uncertain, unclear and inconsistent. We also argue the current law may offend the principle of legality. The second part of the critique engages with the more fundamental question as to whether restrictive practices should be regulated by the guardianship system. We argue that doing so risks the adult-focused nature of the guardianship system and that this area of law, at least as it currently stands, lacks sufficient safeguards and is unlikely to bring about the desired practice changes to reduce reliance on restrictive practices.

## II AUTHORISATION OF RESTRICTIVE PRACTICES UNDER STATE AND TERRITORY GUARDIANSHIP SYSTEMS

Historically, power in Australia in relation to persons who lacked decision-making capacity was vested in each state's Supreme Court through the *parens patriae* jurisdiction. The Court had authority to appoint a committee to look after either or both the person and the property of incapacitated adults.<sup>23</sup> But with both the move towards deinstitutionalisation and the growing recognition of the rights of people with disability, there was a need for more accessible mechanisms for personal decision-making.<sup>24</sup>

As such, beginning in the 1980s, all states and territories began to develop legislative schemes for the appointment of substitute decision-makers who could make both financial and personal decisions for incapacitated adults.<sup>25</sup> With some minor exceptions, these schemes allow for four different types of decision-makers: decision-makers appointed by the person while they had capacity in an advance directive or a general or enduring document ('adult-appointed decision-makers'); guardians appointed by tribunals to make decisions about personal matters ('guardians'); administrators or managers, appointed by tribunals to

23 Terry Carney and David Tait, *The Adult Guardianship Experiment: Tribunals and Popular Justice* (Federation Press, 1997) 10.

24 Ibid 18.

25 Ibid; Nick O'Neill and Carmelle Peisah, *Capacity and the Law* (Sydney University Press, 2011) [5.3]–[5.4] <<http://www.austlii.edu.au/au/journals/SydUPLawBk/2011/1.html>>. For example, in Victoria, legislative reforms arose from The Minister's Committee Considering Rights and Protective Legislation for Intellectually Handicapped Persons, Minister of Health (Vic), *Report of the Minister's Committee on Rights & Protective Legislation for Intellectually Handicapped Persons* (1982). The *Guardianship and Administration Board Act 1986* (Vic) commenced in 1987. The *Disability Services and Guardianship Act 1987* (NSW) commenced in 1989.

make decisions about financial matters ('administrators'); and decision-makers for medical treatment or health care empowered by legislation where no-one has been appointed ('default decision-makers for medical treatment'). In addition, some guardianship tribunals (or 'super tribunals' with guardianship jurisdiction) are granted power to make certain decisions for adults who lack capacity.

Some common principles are included in the guardianship legislation in each state and territory to govern how decisions for others should be made. For example, most jurisdictions recognise that: powers exercised or decisions made should be the least restrictive of the person's rights as possible;<sup>26</sup> the views of the person should be sought and taken into account;<sup>27</sup> and that the person should be encouraged to live a normal life in the community and to maintain supportive relationships.<sup>28</sup> These principles reflect the contemporary concern with the rights of people with disability and the emphasis on 'liv[ing] as normal a life as possible, and in the community rather than in institutions'.<sup>29</sup> Yet the legislation also continues the centuries old connection with the medieval *parens patriae* jurisdiction with a requirement to exercise powers and make decisions in the best interests of the person.<sup>30</sup>

It is also worth noting that in Victoria and the Australian Capital Territory the relevant tribunals must also interpret legislation (including guardianship legislation) consistently with the human rights enumerated in the Victorian

- 26 *Guardianship and Management of Property Act 1991* (ACT) s 4(2)(d); *Guardianship Act 1987* (NSW) s 4(b); *Guardianship of Adults Act 2016* (NT) s 4(4)(a); *Guardianship and Administration Act 2000* (Qld) sch 1 s 7(3)(c); *Guardianship and Administration Act 1993* (SA) s 5(d); *Guardianship and Administration Act 1995* (Tas) s 6(a); *Guardianship and Administration Act 1986* (Vic) s 4(2)(a); *Guardianship and Administration Act 1990* (WA) s 4(6).
- 27 *Guardianship and Management of Property Act 1991* (ACT) ss 4(2)(a)–(b); *Guardianship Act 1987* (NSW) s 4(d); *Guardianship of Adults Act 2016* (NT) s 4(3)(a); *Guardianship and Administration Act 2000* (Qld) sch 1 s 7(3)(b); *Guardianship and Administration Act 1993* (SA) s 5(b); *Guardianship and Administration Act 1995* (Tas) s 6(c); *Guardianship and Administration Act 1986* (Vic) s 4(2)(c); *Guardianship and Administration Act 1990* (WA) s 4(7).
- 28 *Guardianship and Management of Property Act 1991* (ACT) s 4(2)(f); *Guardianship Act 1987* (NSW) s 4(c); *Guardianship and Administration Act 2000* (Qld) sch 1 s 5; *Guardianship and Administration Act 1993* (SA) s 5(c).
- 29 O'Neill and Peisah, above n 25, [5.4.1]; Terry Carney, 'The Limits and the Social Legacy of Guardianship in Australia' (1989) 18 *Federal Law Review* 231, 232; Terry Carney, 'Civil and Social Guardianship for Intellectually Handicapped People' (1982) 8 *Monash University Law Review* 199.
- 30 *Guardianship and Management of Property Act 1991* (ACT) s 4(2)(a); *Guardianship Act 1987* (NSW) s 4(a) (expressed as 'welfare and interests'); *Guardianship of Adults Act 2016* (NT) s 4(2); *Guardianship and Administration Act 2000* (Qld) sch 1 s 7(5) (expressed as 'proper care and protection'); *Guardianship and Administration Act 1993* (SA) s 5(d) (expressed as 'proper care and protection'); *Guardianship and Administration Act 1995* (Tas) s 6(b); *Guardianship and Administration Act 1986* (Vic) s 4(2)(b); *Guardianship and Administration Act 1990* (WA) s 4(2). The position is slightly different in South Australia and the ACT. In South Australia, while the guardian or tribunal exercising a power or making a decision under the *Guardianship and Administration Act 1993* (SA) is required to make a decision that is consistent with the 'proper care and protection' of the person (at s 5(d)), the paramount consideration must be what, in the opinion of guardian or tribunal, would 'be the wishes of the person ... if he or she were not mentally incapacitated' (at s 5(a)). In the ACT, a list of decision-making principles provides that 'the protected person's wishes ... must be given effect to, unless making the decision in accordance with the wishes is likely to significantly adversely affect the protected person's interests': *Guardianship and Management of Property Act 1991* (ACT) s 4(2)(a).

*Charter of Rights and Responsibilities Act 2006* (Vic) and the *Human Rights Act 2004* (ACT).<sup>31</sup>

The most relevant decision-makers under guardianship regimes for the authorisation of restrictive practices are default decision-makers for medical treatment or health care and guardians appointed for personal matters.<sup>32</sup> In the main these relevant decision-makers rely on one of five legal bases to authorise restrictive practices, which are now discussed.

## **A Authorisation of Restrictive Practices under Explicit Statutory Provisions**

The first basis on which restrictive practices may be authorised under the guardianship system is where guardianship legislation contains specific statutory provisions permitting guardians and/or guardianship tribunals to do this. Only Queensland and Tasmania rely on the guardianship system to authorise restrictive practices. As noted earlier, Victoria and the Northern Territory also have specific provisions authorising restrictive practices but this occurs outside their guardianship systems. They rely instead on an administrative model,<sup>33</sup> and so these jurisdictions will not be discussed further.

In Queensland, a guardian appointed for restrictive practice matters can consent to physical, mechanical and chemical restraint as well as restricting access to objects if authorised by the tribunal.<sup>34</sup> The Queensland Civil and Administrative Tribunal ('QCAT') can authorise containment (ie detention) and seclusion,<sup>35</sup> as well as physical, mechanical and chemical restraint and restricting access to objects.<sup>36</sup> In Tasmania, the Guardianship and Administration Board can approve 'personal restriction[s]' (such as physical restraint)<sup>37</sup> and 'environmental restriction[s]'.<sup>38</sup> In both states, safeguards include that certain criteria must be met

31 *Charter of Human Rights and Responsibilities Act 2006* (Vic) s 32(1); *Human Rights Act 2004* (ACT) s 30. See, eg, *PJB v Melbourne Health* (2011) 39 VR 373, where the Victorian Supreme Court held that it was obliged to interpret the provisions of the *Guardianship and Administration Act 1986* (Vic) in accordance with the right to freedom of movement in the *Charter of Human Rights and Responsibilities Act 2006* (Vic); and *Re ER (Mental Health and Guardianship and Management of Property)* [2015] ACAT 73 (29 October 2015) [81], where the tribunal held that it was obliged to interpret the *Guardianship and Management of Property Act 1991* (ACT) 'in accordance with the right to liberty and security of person' in the *Human Rights Act 2004* (ACT).

32 To a lesser degree adult-appointed decision-makers may also play a role in consenting to restrictive practices. In all states and territories, adults with capacity can make provision for a future time when they may lose their decision-making capacity. The process for this varies according to the state and territory and the type of decisions to be made.

33 Chandler, Willmott and White, 'Rethinking Restrictive Practices', above n 17, 98–9.

34 *Guardianship and Administration Act 2000* (Qld) s 80ZE.

35 *Ibid* s 80V.

36 *Ibid* s 80X(2).

37 *Disability Services Act 2011* (Tas) s 42.

38 *Ibid*.



before restrictive practices can be consented to and there is regular review by the tribunals.<sup>39</sup> Time limits are also imposed on the use of these practices.<sup>40</sup>

This provides clear legislative authority for the use of restrictive practices, although this authorisation only extends to people with intellectual and cognitive impairment in government funded disability services.<sup>41</sup> Therefore, it would not extend more broadly to the use of such practices in hospitals and other health facilities, aged care facilities, other supported residential services (such as boarding houses) or where care is provided by private carers or family. For those who fall outside of funded disability services in these states, the use of restrictive practices would need to be justified on one of the four remaining legal bases outlined below.

## **B Authorisation of Restrictive Practices as Medical Treatment or Health Care**

The second mechanism for authorising restrictive practices is for guardians or default decision-makers for medical treatment to consent to these practices as medical treatment or health care. There is no common law mechanism for providing substitute consent for medical treatment or health care for adults who lack the capacity to consent to such treatment.<sup>42</sup> Therefore, the state and territory guardianship regimes play an important role in facilitating medical substitute decision-making. Guardians, for example, may be appointed by a tribunal with specific authority to consent to medical treatment or health care. Also, in all jurisdictions except for the Northern Territory, there is provision in the guardianship legislation for default decision-makers to consent to medical treatment or health care where there is no formally appointed decision-maker.<sup>43</sup>

Default decision-makers, chosen from a priority list, often starting with the person's spouse with whom they are in a close relationship, are empowered by respective guardianship legislation to provide consent or authorisation for

39 For example, the practice must be the least restrictive of the person's freedom and only carried out for the benefit of the person: *Guardianship and Administration Act 2000* (Qld) ss 80V, 80ZE; *Disability Services Act 2011* (Tas) ss 38, 43.

40 In Queensland, an approval for containment and seclusion by QCAT is limited to a period of 12 months (*Guardianship and Administration Act 2000* (Qld) s 80Y(2)) and in Tasmania the Guardianship and Administration Board's approval of personal restrictions are limited to a maximum of 90 days (*Disability Services Act 2011* (Tas) ss 39(3), 44(3)).

41 In Tasmania, under the *Disability Services Act 2011* (Tas) s 14(1)(a), grants of funding may be provided to both a person or an organisation to provide disability services, or to a person, or another person nominated by a person with a disability to enable the provision of disability services (a 'funded private person'): at s 14(1)(c). The restrictive practices regulation regime applies to both: at s 36(1).

42 *Re T (Adult: Refusal of Treatment)* [1993] Fam 95.

43 Lindy Willmott, Ben White and Shih-Ning Then, 'Withholding and Withdrawing Life-Sustaining Medical Treatment' in Ben White, Fiona McDonald and Lindy Willmott (eds), *Health Law in Australia* (Thomson Reuters, 2<sup>nd</sup> ed, 2014) 543, 574.



medical treatment or health care on behalf of the person who lacks capacity.<sup>44</sup> In NSW, South Australia, Western Australia, Victoria and Tasmania, this position is called the 'person responsible'. In Queensland, it is called a 'statutory health attorney' and in the ACT, the 'health attorney'.

The key question is whether restrictive practices, such as physical, chemical and mechanical restraint, seclusion, and detention can be characterised as medical treatment or health care. The answer to this is not straightforward and depends both on the law of the particular jurisdiction and the type of practice sought to be authorised.

## 1 Definition of 'Medical Treatment' or 'Health Care'

In most states and territories, the legislation provides for a statutory framework for substitute consent to what is termed 'medical treatment'.<sup>45</sup> The definitions are broadly similar,<sup>46</sup> and while they may specifically exclude some treatments such as very minor treatment (for example, first aid),<sup>47</sup> the administration of medication not requiring a prescription in recommended doses,<sup>48</sup> or 'special' treatment (such as sterilisation),<sup>49</sup> they are usually inclusive. For example, in New South Wales, 'medical or dental treatment' includes 'medical treatment (including any medical or surgical procedure, operation or examination and any prophylactic, palliative

44 In NSW, it is the 'person responsible' who if no guardian is appointed begins with the person's spouse with whom there is a close relationship (*Guardianship Act 1987* (NSW) ss 33A(4)(b), 36(1)(a)). In South Australia, it is the 'person responsible' who if no guardian is appointed begins with a prescribed relative (*Consent to Medical Treatment and Palliative Care Act 1995* (SA) ss 14(1) (definition of 'person responsible'), 14B(1)). In WA, it is the 'person responsible' who, if there is no enduring guardian or appointed guardian, begins with the person's spouse or de facto partner who lives with the person (*Guardianship and Administration Act 1990* (WA) s 110ZD). In Victoria, it is the 'person responsible' who, if there is no enduring or appointed guardian, begins with the person's spouse or domestic partner who has a close relationship with the person (*Guardianship and Administration Act 1986* (Vic) ss 37(1) (definition of 'person responsible'), 39(1)(b)). In the ACT, it is the 'health attorney' who begins with the person's domestic partner (*Guardianship and Management of Property Act 1991* (ACT) ss 32B (definition of 'health attorney'), 32D). In Tasmania, it is the 'person responsible' who if no guardian is appointed begins with the person's spouse (*Guardianship and Administration Act 1995* (Tas) ss 4(1) (definition of 'person responsible'), 39). In Queensland, it is the 'statutory health attorney' who begins with a close spouse (*Powers of Attorney Act 1998* (QLD) s 63). The Northern Territory does not have a scheme for non-appointed/statutory decision-makers for health care.

45 *Guardianship and Management of Property Act 1991* (ACT) ss 32B, 32D; *Guardianship Act 1987* (NSW) s 36; *Guardianship and Administration Act 2000* (Qld) s 66; *Powers of Attorney Act 1998* (Qld) ss 62–3; *Consent to Medical Treatment and Palliative Care Act 1995* (SA) s 14B; *Guardianship and Administration Act 1995* (Tas) ss 4, 39; *Guardianship and Administration Act 1986* (Vic) s 39; *Medical Treatment Act 1988* (Vic) s 5A; *Guardianship and Administration Act 1990* (WA) s 110ZD.

46 *Guardianship and Management of Property Act 1991* (ACT) s 32A; *Guardianship Act 1987* (NSW) s 33; *Consent to Medical Treatment and Palliative Care Act 1995* (SA) s 4; *Guardianship and Administration Act 1995* (Tas) s 3; *Guardianship and Administration Act 1986* (Vic) s 3; *Guardianship and Administration Act 1990* (WA) s 3.

47 See, eg, *Guardianship and Administration Act 2000* (Qld) sch 2 s 5(3)(a); *Guardianship and Administration Act 1995* (Tas) s 3(1) (definition of 'medical or dental treatment' or 'treatment').

48 *Guardianship Act 1987* (NSW) s 33(1) (definition of 'medical or dental treatment' or 'treatment'); *Guardianship and Administration Act 2000* (Qld) sch 2 s 5(3)(c); *Guardianship and Administration Act 1995* (Tas) s 3(1) (definition of 'medical or dental treatment' or 'treatment').

49 See, eg, *Guardianship and Management of Property Act 1991* (ACT) s 32A (definition of 'medical treatment').

or rehabilitative care) normally carried out by or under the supervision of a medical practitioner'.<sup>50</sup>

In other jurisdictions, such as Queensland and the Northern Territory, legislation provides for consent to 'health care',<sup>51</sup> which is broader than but incorporates the concept of 'medical treatment'. In most cases, to qualify as medical treatment or health care it must be carried out by or under the supervision of a medical practitioner.<sup>52</sup>

The concept of medical treatment has generally been interpreted widely by the courts.<sup>53</sup> For example, in *B v Croydon Health Authority*,<sup>54</sup> it was held to include 'treatment given to alleviate the symptoms of the disorder as well as treatment to remedy its underlying cause'.<sup>55</sup> When considering whether the force feeding by nasogastric tube of a psychiatric patient who had stopped eating would constitute medical treatment under the *Mental Health Act 1983* (UK) c 20, the England and Wales Court of Appeal held that treatment could encompass not only that which would be 'likely to alleviate or prevent a deterioration of his condition', but also includes actions taken to prevent the patient causing harm to himself due to his underlying psychopathic disorder.<sup>56</sup>

Similarly, in *Reid v Secretary of State (Scot)*,<sup>57</sup> the House of Lords held 'that medical treatment could include [both] treatment which alleviates or prevents a deterioration of the symptoms of the disorder, even if the treatment would have no effect on the disorder itself'.<sup>58</sup> Both the *B* and *Reid* decisions were relied upon in *R (Munjaz) v Mersey Care NHS Trust* by the England and Wales Court of Appeal to find that the use of seclusion of a psychiatric patient could constitute treatment.<sup>59</sup>

In Australia, a broad definition of treatment was also adopted by the Queensland Supreme Court in *Adult Guardian v Langham*,<sup>60</sup> where it was found that the force feeding of a patient in a mental health service was treatment for the purpose of the *Mental Health Act 2000* (Qld).<sup>61</sup> Chesterman J rejected the idea that treatment was simply curative of the underlying disease,<sup>62</sup> or that a clear distinction could be

50 *Guardianship Act 1987* (NSW) s 33(1) (definition of 'medical or dental treatment' or 'treatment').

51 *Advance Personal Planning Act 2013* (NT) s 3; *Guardianship of Adults Act 2016* (NT) s 3; *Guardianship and Administration Act 2000* (Qld) s 66; *Powers of Attorney Act 1998* (Qld) s 63.

52 *Guardianship Act 1987* (NSW) s 33(1) (definition of 'medical or dental treatment' or 'treatment'); *Consent to Medical Treatment and Palliative Care Act 1995* (SA) s 4(1) (definition of 'medical treatment'); *Guardianship and Administration Act 1995* (Tas) s 3(1) (definition of 'medical or dental treatment' or 'treatment'); *Guardianship and Administration Act 1986* (Vic) s 3(1) (definition of 'medical or dental treatment').

53 Although note the argument against a broad definitional approach based on the principle of legality noted by Allen and Tulich, above n 5, 9.

54 [1995] Fam 133 ('B').

55 Ibid 141 (Neill LJ).

56 Ibid 138–9 (Hoffmann LJ, quoting *Mental Health Act 1983* (UK) c 20, s 3(2)(b)), 141 (Neill LJ).

57 [1999] 2 AC 512 ('Reid').

58 [2004] QB 395, 427 ('R (Munjaz)').

59 Ibid 427–8 (Hale LJ), citing *Reid* [1999] 2 AC 512; *B* [1995] Fam 133.

60 [2006] 1 Qd R 1, 7 [17] (Chesterman J) ('Langham').

61 The *Mental Health Act 2000* (Qld) has since been repealed and replaced with the *Mental Health Act 2016* (Qld).

62 *Langham* [2006] 1 Qd R 1, 7 [16]–[19] (Chesterman J).

made between treating the underlying disease and symptoms of the disease. The artificial nutrition and hydration therefore could be considered treatment because the refusal to eat or drink was an action caused by delusions in the patient brought on by underlying disease, the mental illness.

The significance of this broad definition of medical treatment, which can encompass not just treatment of the disorder itself but its symptoms, is that practices such as seclusion and restraint could be considered to be treatment, if they help alleviate any distress or anxiety that is a manifestation of the person's underlying condition (for example, their intellectual impairment).<sup>63</sup>

## 2 Seclusion as Medical Treatment

As mentioned above, seclusion, which involves the isolation of a person in a room or an area from which they cannot leave of their own volition, was held to be capable of being medical treatment by the England and Wales Court of Appeal in *R (Munjaz)*.<sup>64</sup>

After this decision, the seclusion of a 45 year old man with an intellectual disability, but no mental illness, who was residing in a mental health hospital was considered to be a form of treatment by the then Queensland Guardianship and Administration Tribunal (predecessor to the current Queensland Civil and Administrative Tribunal).<sup>65</sup> WCM was administered medication to sedate him and he was placed in seclusion in response to aggressive behaviours he displayed at times, such as yelling, pounding walls and doors, and punching windows. The Tribunal, relying on the broad definition of treatment in *R (Munjaz)* and *Reid*, as well as the Queensland Supreme Court decision in *Langham*,<sup>66</sup> was satisfied that WCM's destructive behaviours and aggression were a manifestation of his intellectual disability and that the seclusion had a therapeutic effect, moderating WCM's aggressive behaviour.<sup>67</sup>

The Queensland Tribunal came to a similar conclusion in *Re MLI*,<sup>68</sup> the case of an 18-year-old man with an intellectual disability who sometimes displayed behaviours of concern including 'self-harm, aggression to others, property destruction and fire setting'.<sup>69</sup> The Tribunal drew on the reasoning in *Re WCM* and also noted that case's reliance on the England and Wales Court of Appeal decision of *R (Munjaz)*. It concluded that a guardian could consent to seclusion as health care if it was used to maintain or treat a mental condition, and was carried out under the direction or supervision of a health provider.<sup>70</sup> The Tribunal was adamant, however, that seclusion could only be authorised as health care in

63 *Re MLI* [2006] QGAAT 31 (19 May 2006) [43].

64 [2004] QB 395.

65 *Re WCM* [2005] QGAAT 26 (26 May 2005). Note this was prior to the commencement of the *Disability Services and Other Legislation Amendment Act 2008* (Qld) on 1 July 2008 in Queensland allowing guardians to be appointed specifically for restrictive practice matters.

66 [2006] 1 Qd R 1.

67 *Re WCM* [2005] QGAAT 26 (26 May 2005) [38].

68 [2006] QGAAT 31 (19 May 2006).

69 *Ibid* [1], [45].

70 *Ibid* [45]–[47].

certain circumstances, that is, as ‘a strategy put in place by a health professional either a psychologist or other professional trying to manage aggressive behaviours to minimise the distress to the adult’.<sup>71</sup> The Tribunal further emphasised:

The important distinction here is that the distancing of people from the adult or the placing of the adult in a quiet room is aimed at assisting the adult to come to terms with the management of his condition. The strategy is not put in place permanently but as a situation arises and is of short duration and monitored regularly. Importantly the strategy is put in place to de-escalate distress and not to protect the staff.<sup>72</sup>

Of significance for these tribunal decisions is that the England and Wales Court of Appeal decision in *R (Munjaz)*, that they relied upon, was later overturned by the House of Lords. While the House of Lords decision did not directly turn on whether seclusion could be considered treatment, the majority of the Lord Justices cast doubt on whether the use of seclusion could be properly characterised as a part of a person’s treatment program,<sup>73</sup> with Lord Hope commenting that ‘[t]here is general agreement that the sole aim of this procedure is to control such behaviour where it is likely to cause harm to others’.<sup>74</sup> The Lord Justices also highlighted the potentially deleterious effects of seclusion on a person.

These statements by the House of Lords, while obiter dicta, suggest at least that a cautious approach is needed to the previous finding of *R (Munjaz)* that seclusion could be considered medical treatment. The same can be said of the findings of the Queensland Tribunal decisions that relied on *R (Munjaz)*. Others have gone further and suggested that seclusion may no longer be capable of being medical treatment.<sup>75</sup> The position is not settled but it is suggested for any possibility of seclusion to be considered medical treatment, it must clearly be only for the person’s benefit (and not the benefit of others) and must be demonstrably needed from a therapeutic perspective as determined by a health professional such as a psychologist.<sup>76</sup>

### 3 Chemical Restraint

Chemical restraint involves the use of medication (usually psychotropic medication) to control a person’s behaviour. Because some medications may have a dual purpose or effect, that is, both a therapeutic effect and a controlling effect on

71 Ibid [51].

72 Ibid.

73 *R (Munjaz) v Mersey Care NHS Trust* [2006] 2 AC 148, 181–3 (Lord Bingham), 198 (Lord Steyn), 198–9 (Lord Hope), 213–4 (Lord Scott), 218 (Lord Brown).

74 Ibid 198.

75 O’Neill and Peisah, above n 25, [12.11.2]. O’Neill and Peisah do consider the possibility though that the position may be different in Queensland and that seclusion may be considered to fall within the definition of medical treatment (presumably given the previous findings of the Queensland Tribunal): at [12.11.2].

76 In a survey conducted in 2014 via the National Mental Health Commission, 80–90 per cent of participants agreed that the use of seclusion and restraint compromised the therapeutic relationship: S A Kinner et al, ‘Attitudes towards Seclusion and Restraint in Mental Health Settings: Findings from a Large, Community-Based Survey of Consumers, Carers and Mental Health Professionals’ (2016) 26 *Epidemiology and Psychiatric Sciences* 535, 538.

a person's aggressive behaviour, some tribunal decisions reflect an unwillingness to characterise its use as medical treatment.

The Guardianship and Administration Board of Western Australia was one of the first tribunals to consider this issue and this jurisdiction has since had a series of cases on this point. First, in *Re Application for Guardianship Order (BCB)*,<sup>77</sup> the Board considered whether the use of chemical and physical restraint on an elderly person with dementia in an aged care facility could be considered medical treatment. BCB was intermittently agitated and physically aggressive and was administered anti-psychotic medication (Serenace) as a 'calmative'. In addition, he displayed 'significant schizophreniform symptoms' and was administered anti-psychotic medication to control his delusions.<sup>78</sup> Evidence was provided that over the previous four months he had been 'restrained 19 times[:] 18 chemically and once by way of a chair restraint'.<sup>79</sup> The predominant reason for this was fighting with or threatening other residents.

The Board considered whether the purpose of the medication might be the determinative factor:

In relation to chemical restraint it may be arguable that a medical practitioner may prescribe drugs for a particular person to control inappropriate behaviour relating to an underlying medical condition and when the drug is being used for that purpose, it is treatment. However, if the drug is used for behaviour management for the convenience of staff it would fall outside that category.<sup>80</sup>

Ultimately the Board found that such a sharp distinction could not always be made between restraints used for control and those used for treatment, expressing that whether physical or chemical restraint could be considered treatment would have to be decided on a case-by-case basis depending on its purpose.<sup>81</sup> In this case, the Board ultimately appointed a guardian specifically to consent to physical and chemical restraint.

The approach in *BCB* was later endorsed by the Board's successor, the Western Australian State Administrative Tribunal, in *JP*,<sup>82</sup> a case of a 59-year-old man with an acquired brain injury who had 'severe ... physical, cognitive and behavioural deficiencies'<sup>83</sup> and resided in an aged care facility. The Tribunal ultimately rejected the submission of the Public Advocate that the medication administered (namely Zprexia, prescribed by his GP for suppression of his more aggressive behaviour and Largactil, prescribed for his delusions) was not a restraint, and appointed JP's daughter to consent specifically to restraint.<sup>84</sup>

<sup>77</sup> (2002) 28 SR (WA) 338 ('*BCB*').

<sup>78</sup> *Ibid* 342–3.

<sup>79</sup> *Ibid* 343.

<sup>80</sup> *Ibid* 347.

<sup>81</sup> *Ibid* 348.

<sup>82</sup> [2008] WASAT 3 (8 January 2008).

<sup>83</sup> *Ibid* [22].

<sup>84</sup> *Ibid* [90].

In *ADP*, the Tribunal had to consider whether the medication administered to a person with dementia residing in a nursing home was ‘treatment’.<sup>85</sup> The olanzapine was put in ADP’s food without his knowledge. While his GP stated that it was for his ‘paranoid psychosis’, the Tribunal found the diagnosis was not corroborated by current specialist psychiatric assessment.<sup>86</sup> Further, the dosage administered indicated a level of restraint was intended.<sup>87</sup> Both nursing staff and the doctor had explained to the Tribunal that the medication was needed to ensure ADP remained ‘settled’ and that ‘without it his behaviour would become unmanageable and jeopardise his placement at the nursing home’.<sup>88</sup> Ultimately, due to the evidence in relation to both the purpose of the medication and the extent of its use (or dosage) the Tribunal was not satisfied that the olanzapine was administered solely to treat a medical condition and so appointed a guardian to consider whether to consent to chemical and physical restraint.<sup>89</sup> Later, in *PN*, in the absence of a psychiatric condition, the Tribunal decided that antipsychotic medication to control aggression was a restraint and thus outside the definition of ‘treatment’ in the Act, and therefore the guardian needed ‘specific authority to consent to it being administered’.<sup>90</sup>

This Western Australian tribunal jurisprudence demonstrates a reluctance to accept chemical restraint as being medical treatment that could be authorised by guardians or default decision-makers who only have power to decide about medical treatment. Underpinning these decisions have been concerns about the dual purposes of treating a person’s condition but also exercising control over him or her through the medication. A common response has been for tribunals to appoint a guardian with specific powers to consent to restrictive practices, although as is discussed below, the legal basis for these appointments can be questioned.

But not all tribunals have taken this approach. The New South Wales Civil and Administrative Tribunal has published a Fact Sheet entitled ‘Restrictive Practices and Guardianship’ to provide guidance on how it will handle restrictive practices.<sup>91</sup> After noting that the *Guardianship Act 1987* (NSW) does not define restrictive practices, and that chemical restraint is a restrictive practice, the Tribunal then advises that such a decision is ‘generally not covered by a restrictive practices function as consent for the medication should be obtained under the medical consent provisions’ of the Act.<sup>92</sup> In other words, despite being a restrictive practice, chemical restraint is medical treatment. Thus, the appropriate consent

85 [2005] WASAT 131 (10 June 2005).

86 Ibid [25]–[26].

87 Ibid [27].

88 Ibid [15].

89 Ibid [44].

90 [2008] WASAT 158 (4 July 2008) [15].

91 NSW Civil & Administrative Tribunal, ‘Restrictive Practices and Guardianship’ (Fact Sheet, August 2016) <[http://www.ncat.nsw.gov.au/Documents/gd\\_factsheet\\_restrictive\\_practices\\_and\\_guardianship.pdf](http://www.ncat.nsw.gov.au/Documents/gd_factsheet_restrictive_practices_and_guardianship.pdf)>.

92 Ibid 1.

is from a decision-maker with power to consent to medical treatment, and this would include a default decision-maker.<sup>93</sup>

A similar approach appears to be taken in South Australia. The Public Advocate's policy on guardianship consent advises that where chemical restraint is not due to mental illness and force is not required to administer the medication, consent can be obtained from the relevant medical decision-maker (including a default decision-maker).<sup>94</sup> Of note is that the policy is explicit in making clear that chemical restraint which can be consented to in this way is for behavioural control. This means the view noted above in the Western Australian tribunal jurisprudence that medication only or primarily for behaviour control falls outside medical treatment or health care appears not to apply in South Australia and an appropriate medical decision-maker could consent to chemical restraint in those circumstances.

The position is different again in Victoria. By contrast with a number of jurisdictions which specifically exclude the administration of medication not requiring a prescription from the definition of medical treatment, Victoria is unique in excluding *all medication* as long as, where it is prescribed, it is used for the purpose, and in accordance with the dosage, recommended by a medical practitioner; or, where it is not prescribed, it is used in accordance with the manufacturer's instructions.<sup>95</sup> As such, medication used in this way does not require consent. Presumably, should staff of a facility seek to use medication for a different purpose than stated by the medical practitioner, or at a different (for example, higher) dosage, then consent would be required.

#### 4 *Physical restraint*

Physical restraint is often used to implement other forms of restrictive practices, in particular, chemical restraint and seclusion. The published tribunal decisions generally reveal a reluctance to consider physical restraint to be medical treatment. There is one case where physical restraint was considered to be health care and that was when it was used in conjunction with seclusion. In *Re WCM*, the Queensland Tribunal held that seclusion and restraint could be considered

93 Note that there are some limitations on the medical treatment that a medical decision-maker can consent to; see, eg, NSW Civil & Administrative Tribunal, above n 91, 3; see also Public Guardian, 'Determining whether to Consent to the Use of Restraint on an Elderly Person in a Care Facility' (Position Statement 11, Department of Attorney General and Justice (NSW), September 2011), 2 <[http://www.publicguardian.justice.nsw.gov.au/Documents/11\\_restraint\\_sep2011.pdf](http://www.publicguardian.justice.nsw.gov.au/Documents/11_restraint_sep2011.pdf)>. We have been unable to locate NSW Civil and Administrative Tribunal decisions considering the issue of chemical restraint to understand this reasoning. This may be due to it being seen as within the scope of a medical decision-maker (including a default decision-maker) and so these matters are not brought before the Tribunal for its consideration.

94 Office of the Public Advocate (SA), 'Guardian Consent for Restrictive Practices in Disability Settings' (Policy, 1 July 2014), 9 <[http://www.opa.sa.gov.au/files/44\\_opa\\_sa\\_policy\\_on\\_guardian\\_consent\\_for\\_restrictive\\_practices\\_october\\_2012.pdf](http://www.opa.sa.gov.au/files/44_opa_sa_policy_on_guardian_consent_for_restrictive_practices_october_2012.pdf)>; Office of the Public Advocate (SA), 'Guardian Consent for Restrictive Practices in Residential Aged Care Settings' (Policy, 10 March 2015), 8 <[http://www.opa.sa.gov.au/files/227\\_guardian\\_consent\\_for\\_restrictive\\_practices\\_in\\_aged\\_care\\_settings\\_v6.pdf](http://www.opa.sa.gov.au/files/227_guardian_consent_for_restrictive_practices_in_aged_care_settings_v6.pdf)>.

95 *Guardianship and Administration Act 1986* (Vic) s 3(1) (definition of 'medical or dental treatment').



health care if it is used to relieve the symptoms of a mental condition and has ‘a therapeutic effect on aggression and disruptive behaviour, which are the manifestations of the mental condition’.<sup>96</sup>

Other tribunals have taken a different approach. In both *BCB*<sup>97</sup> and *BTO*,<sup>98</sup> the use of physical restraint and the need for a guardian to be appointed was considered alongside the use of chemical restraint. In both cases, the Guardianship and Administration Board of Western Australia did not provide a definitive answer as to whether chemical or physical restraint could be considered treatment, rather finding that it would need to be considered on a case-by-case basis depending on the purpose, the reason for its use and who prescribed it.<sup>99</sup>

In *SJ and MET*, the Western Australian Tribunal did, however, draw a clear distinction between physical restraint and treatment.<sup>100</sup> This case concerned a 19-year-old woman with an intellectual disability and severe behavioural disturbances. She was a patient in a hospital who was refusing treatment for a life-threatening but treatable medical condition. While the Tribunal considered it was in the best interests of the woman that authority was given for restraint to facilitate the treatment that was needed, it found that the restraint did not form part of the treatment itself,<sup>101</sup> stating:

The use of a 24 hour guard, the suggested use of restraints on the hands of the represented person, and medication to manage her behaviour used in the past are or would be attempts to control the voluntary movements of the represented person, albeit for the purposes of delivering health care which she needs and are therefore in our view restraints. It is not appropriate that such restraints be seen as an incident of treatment itself. In the case of the guard placed on the room of the represented person we conclude that this is clearly a restraint on her movement and not part of treatment.<sup>102</sup>

That physical restraint is distinct from medical treatment or health care is also reflected in the guardianship legislation of a number of states, as physical restraint, where appropriate, is authorised separately. Queensland, for example, specifically provides for the use of the ‘minimum force necessary and reasonable’ by a health provider when ‘carry[ing] out health care authorised under’ the *Guardianship and Administration Act 2000* (Qld).<sup>103</sup>

## 5 Conclusion

There is an argument that chemical restraint, physical restraint and seclusion could be considered medical treatment or health care, at least in some

96 [2005] QGAAT 26 (26 May 2005) [48].

97 (2002) 28 SR (WA) 338.

98 [2004] WAGAB 2 (14 October 2004).

99 Ibid [36]; *BCB* (2002) 28 SR (WA) 338, 348.

100 [2006] WASAT 210 (28 July 2006).

101 Ibid [36].

102 Ibid.

103 *Guardianship and Administration Act 2000* (Qld) s 75.

circumstances. This would depend on a broad definition of medical treatment that includes treatment to alleviate the *symptoms* of the disorder as well as to remedy its underlying cause. Therefore, if medication was administered or seclusion used that alleviated the symptoms of anxiety that was a manifestation of a mental condition (such as intellectual disability or cognitive impairment), then this may be regarded as medical treatment or health care.<sup>104</sup> Consistent with the fiduciary nature of the jurisdiction, the use of such practices would also have to be considered to be in the best interests of the person and not used for another purpose such as the convenience of staff.<sup>105</sup>

However, there are difficulties with accepting such an approach. The case authorities that concluded most clearly that restrictive practices could be medical treatment have now been doubted. And, in other cases, some tribunals have shown a great deal of reluctance to accept that various practices could be medical treatment, generally preferring instead to appoint a guardian with power to consent to restrictive practices. This is particularly evident in the case of chemical restraint, where the use of medication may serve a dual purpose (that is, both for treatment and control). Drawing on the Western Australian Tribunal jurisprudence, tribunals may well look to both the primary purpose of the medication as well as whether its use (for example, dosage) is proportionate to the mental condition of the person with intellectual impairment.<sup>106</sup> These factors of purpose and proportionate use were key considerations for the Tribunal in *ADP* to conclude that the medication was for restraint, not treatment.<sup>107</sup> That said, New South Wales and South Australian guardianship bodies appear to take a different approach and regard chemical restraint as medical treatment, although their reasoning for doing so is not clear.

What does appear clear though is that detention, in particular, long-term or indefinite detention, will not be interpreted as medical treatment. In *Re MLI*, for example, while the Tribunal was prepared to consider that seclusion could be health care, it went on to say that ‘what could not be authorised under health care would be permanent detention of a person to control their aggressive behaviours’.<sup>108</sup>

### **C Authorisation of Restrictive Practices under the Accommodation Function**

One basis on which adults who lack capacity could be placed in a facility by guardians is by using the guardians’ ‘accommodation’ function to decide where a person should live. As O’Neill and Peisah point out,<sup>109</sup> all Australian jurisdictions

104 *Re WCM* [2005] QGAAT 26 (26 May 2005).

105 *Ibid* [47]; *BCB* (2002) 28 SR (WA) 338, 347.

106 *ADP* [2005] WASAT 131 (10 June 2005).

107 *Ibid* [25]–[27], [35], [44].

108 [2006] QGAAT 31 (19 May 2006) [50].

109 O’Neill and Peisah, above n 25, [7.5.2].

contemplate guardians having authority in relation to accommodation either explicitly in statute,<sup>110</sup> or by the guardianship legislation conferring on the guardian all the functions or powers that a guardian has at law or in equity, thereby authorising a decision about where a person shall live.<sup>111</sup> Yet uncertainty arises about the extent of this power when a person expresses a desire to leave or attempts to leave their accommodation.

O'Neill and Peisah suggest that the accommodation function enables a guardian 'to use normal practices to keep the premises appropriately locked and to provide safe boundaries to the property'.<sup>112</sup> This would, they argue, include using gate opening devices designed for children to prevent people with dementia or other forms of intellectual impairment from 'entering unsafe parts of the property or leaving the property unsupervised when they lack the capacity to look after their own safety'.<sup>113</sup> O'Neill and Peisah also consider such a power extends to permitting nursing and other staff in hospitals, aged care facilities and other accommodation-providing residential support for people with intellectual disabilities, to use 'normal nursing techniques of diversion and engagement of the person to draw them away from situations in which they may inappropriately or unsafely leave the premises'.<sup>114</sup> Further, should they leave the premises, such a power could also authorise 'their carers [to] guide, direct or help them back'.<sup>115</sup> Yet such practices, whether or not they are designed to keep an adult safe, are still restrictions on freedom of movement and could therefore potentially attract both civil and criminal liability. In Queensland, this is recognised in the *Disability Services Act 2006* (Qld) which provides immunity for service providers who utilise locked gates, doors and windows to prevent harm to an adult with intellectual or cognitive disability.<sup>116</sup>

Further, it also appears questionable whether a general power in relation to accommodation would extend to exercising greater control over the person (above and beyond the strategies referred to above) through restrictive practices, for example, keeping a person at their place of accommodation when he or she would like to leave. In such cases, O'Neill and Peisah argue that a guardian needs a stronger form of accommodation function or power and that this should be explicitly stated in the tribunal's order.<sup>117</sup>

In a 2015 case in the Victorian Civil and Administrative Tribunal it was decided that a guardian's accommodation power did extend to keeping a person in a

110 *Guardianship and Management of Property Act 1991* (ACT) s 7(3)(a); *Guardianship Act 1987* (NSW) s 6E(1)(a); *Guardianship of Adults Act 2016* (NT) ss 3, 21(1); *Guardianship and Administration Act 2000* (Qld) s 33(1), sch 2 s 2(a); *Guardianship and Administration Act 1995* (Tas) s 25(2)(a); *Guardianship and Administration Act 1986* (Vic) s 24(2)(a); *Guardianship and Administration Act 1990* (WA) s 45(2)(a);

111 *Guardianship and Administration Act 1993* (SA) s 31.

112 O'Neill and Peisah, above n 25, [7.5.2].

113 Ibid.

114 Ibid.

115 Ibid.

116 *Disability Services Act 2006* (Qld) pt 8 div 2.

117 O'Neill and Peisah, above n 25, [7.5.2].

locked facility.<sup>118</sup> The Tribunal considered that the term ‘where a person lives’ should be given its ‘ordinary meaning’ which could include living in a locked facility.<sup>119</sup> However, the Tribunal did emphasise that such a power should be made clear in the Tribunal’s order, particularly given the represented person objected to residing in the locked facility.<sup>120</sup>

This is inconsistent with the earlier decision of *Re MLI*,<sup>121</sup> where the Queensland Tribunal noted that there is no specific power in the guardianship legislation of that State that ‘authorises [a] guardian to keep a person in [the] particular accommodation’.<sup>122</sup> The Tribunal quoted Holmes J sitting in the Queensland Mental Health Court in *Re Graham*,<sup>123</sup> a case where a person was detained in an authorised mental health service but not subject to an involuntary treatment order under the *Mental Health Act 2000* (Qld):

The basis of his being maintained at The Park Centre for Mental Health seems to be the *Guardianship and Administration Act 2000*. It is not obvious to me at the moment that the power to restrain him goes any further than what is given in s 75 of that Act, which is the ability to use force for health care. I am not entirely satisfied that that means that there could be a restraint of Mr Graham for other purposes.<sup>124</sup>

The Tribunal concluded from this statement by Holmes J that ‘there is no power to keep a person in a place should they wish to leave except for the purposes of health care’ and that ‘the power to keep a person in the place only applies to health providers’.<sup>125</sup>

## **D Authorisation of Restrictive Practices Based on the Implied Breadth of Guardians’ Powers**

The fourth basis on which restrictive practices could be authorised, and probably the most common, relies on the implied breadth of guardians’ powers to consent to a wide range of matters, including restrictive practices. These powers are described as ‘implied’ because they are purported to be given in the absence of explicit statutory authorisation or a recognised restrictive practice function in legislation. This basis for authorising restrictive practices is reflected in the approach of a number of tribunals, where appointments have been made with such powers despite the absence of specific legislative authority to do so. As discussed above, the Western Australian Tribunal made decisions where, not satisfied that medication administered to an adult with an intellectual impairment was solely

118 *NLA (Guardianship)* [2015] VCAT 1104 (23 July 2015).

119 *Ibid* [37].

120 *Ibid* [125].

121 [2006] QGAAT 31 (19 May 2006).

122 *Ibid* [64].

123 [2005] QMHC 22 (5 August 2005).

124 *Re MLI* [2006] QGAAT 31 (19 May 2006) [65], quoting *Re Graham* [2005] QMHC 22 (5 August 2005) [3].

125 *Re MLI* [2006] QGAAT 31 (19 May 2006) [66].

for treatment, a guardian was appointed to consent to restraint.<sup>126</sup> The then NSW Guardianship Tribunal (now the NSW Civil and Administrative Tribunal) has also appointed guardians with ‘restrictive practice’ functions. For example, in *HAO*,<sup>127</sup> the Tribunal appointed a guardian to consent to the restrictive practice of restricting HAO’s freedom of movement through a locked gate on the fence of his property, while in *OMF*,<sup>128</sup> the Tribunal appointed a guardian with restrictive practice functions for a young woman with mental illness living in supported accommodation. Most recently, the NSW Civil and Administrative Tribunal has published a Fact Sheet outlining its position that it can appoint guardians with restrictive practices functions.<sup>129</sup> Policy documents of the Office of the Public Advocate in South Australia also make clear its view that guardians are able to consent to at least some restrictive practices by virtue of their appointment.<sup>130</sup> And in Victoria, the Victorian Law Reform Commission appears to have assumed (although without outlining why) that guardians ‘with appropriate powers’ in Victoria could authorise at least some restrictive practices.<sup>131</sup> We note, however, that the Commission recommended this power be clarified to avoid doubt.<sup>132</sup>

As we have seen, tribunals prefer to appoint a guardian to make decisions about restrictive practices rather than, for example, allow guardians or default decision-makers with only power in relation to medical treatment or health care to decide. This may be for a number of reasons. First, as argued above, without such an appointment, a power in relation to medical treatment may not provide sufficient authority to make decisions about restrictive practices. But, in addition to this, guardians may be perceived to provide a greater degree of safeguards.<sup>133</sup> For example, the NSW Tribunal expressed in *SDF* that the right guardians can provide regular review of practices and advocacy for the person.<sup>134</sup> Further, of significance is that a tribunal can choose to appoint a particular guardian who is well suited to these difficult decisions whereas the relevant default decision-maker may not be the best placed person to decide. Tribunals have also identified that the appointment of a guardian to consent to restrictive practices has the effect of making the ‘intervention transparent and to put squarely in front of the guardian as decision-maker the need to consider whether the intervention is beneficial for the person and not for the convenience of care or medical staff of the institution in which the person is residing’.<sup>135</sup> Finally, a guardian’s appointment is subject to regular review by the appointing tribunal and so entrusting restrictive practices

126 See, eg, *JP* [2008] WASAT 3 (8 January 2008).

127 [2010] NSWGT 15 (19 March 2010).

128 [2008] NSWGT 5 (1 February 2008).

129 NSW Civil & Administrative Tribunal, above n 91.

130 Office of the Public Advocate (SA), ‘Guardian Consent for Restrictive Practices in Disability Settings’, above n 94; Office of the Public Advocate (SA), ‘Guardian Consent for Restrictive Practices in Residential Aged Care Settings’, above n 94.

131 Victorian Law Reform Commission, *Guardianship: Final Report*, above n 2, 320 [15.14].

132 *Ibid* 338 [15.131].

133 *SJ and MET* [2006] WASAT 210 [32] (28 July 2006).

134 [2013] NSWGT 1 (17 January 2013) [19].

135 *JP* [2008] WASAT 3 (8 January 2008) [65]. See also comments in *SJ and MET* [2006] WASAT 210 (28 July 2006) [32].

decision-making to a guardian establishes at least some indirect supervision of these decisions.

However, the fundamental question is whether tribunals, in the absence of specific legislative authority to confer power on guardians to make decisions about restrictive practices, are able to make such appointments. The basis for doing so appears to be the implied breadth of guardians' powers. The argument is that except to the extent that their powers may be limited by the tribunals that appoint them, guardians with full or plenary appointments generally have undefined powers so long as they exercise their authority in accordance with the decision-making principles in the legislation.

In New South Wales, a plenary guardianship order, for example, gives the guardian full custody of the person, and in New South Wales and South Australia, such an order authorises the guardian to fulfil 'all the functions of a guardian ... at law or in equity'.<sup>136</sup> In Western Australia, Victoria and Tasmania, it is expressed differently, with guardians vested with those powers equivalent to a person in a parental relationship with a child,<sup>137</sup> reflecting the close connection between the exercise of the protective jurisdiction with respect to adults with impaired capacity and children.<sup>138</sup> In Queensland and the Northern Territory, unless otherwise ordered by the Tribunal, a guardian is authorised to do anything in relation to personal matters the adult could have done if the adult had capacity,<sup>139</sup> whereas in the ACT, the Tribunal may 'appoint a guardian ... with the powers that the [Tribunal] is satisfied are necessary or desirable to make decisions for the person in accordance with the decision-making principles'.<sup>140</sup>

There has been only limited tribunal discussion of whether the breadth of the guardian's powers to perform all functions of a guardian at law or in equity, or alternatively to exercise those powers equivalent to a person in a parental relationship with a child, extends to authorising restrictive practices. Noting that the functions of a guardian were undefined in the *Guardianship Act 1987* (NSW), the New South Wales Administrative Decisions Tribunal opined (in the context of a different guardianship matter) that the object of guardianship should be interpreted according to the general law's historical understanding of the scope and role of a guardian. The Tribunal described this as 'to enable the making of decisions that the subject would have been able to make had he or she had legal capacity to do so'.<sup>141</sup>

This question was then addressed in *EKR (Guardianship)* where the Tasmanian Guardianship and Administration Board considered (prior to the introduction of the restrictive practices legislative provisions) whether a guardian could consent

136 *Guardianship Act 1987* (NSW) s 21(1)(b); *Guardianship and Administration Act 1993* (SA) s 31.

137 *Guardianship and Administration Act 1995* (Tas) s 25(1); *Guardianship and Administration Act 1986* (Vic) s 24(1); *Guardianship and Administration Act 1990* (WA) s 45(1).

138 John Seymour, 'Parens Patriae and Wardship Powers: Their Nature and Origins' (1994) 14 *Oxford Journal of Legal Studies* 159, 176; *Re Eve* [1986] 2 SCR 388, 408 (La Forest J).

139 *Guardianship of Adults Act 2016* (NT) s 21(2); *Guardianship and Administration Act 2000* (Qld) s 33.

140 *Guardianship and Management of Property Act 1991* (ACT) s 7(2).

141 *FI v Public Guardian* [2008] NSWADT 263 (16 September 2008) [44].

to detention of an adult in a mental health service.<sup>142</sup> The Solicitor-General had provided advice to the Public Guardian, the statutory official with responsibility for adults with impaired capacity, that a guardian did not have this authority. The Board disagreed, drawing on the broad powers of guardians in Tasmania, that is, ‘all the powers and duties which the full guardian would have in Tasmania if he or she was a parent and the represented person his or her child’.<sup>143</sup> Guardianship, the Board found, ‘remains a system of custody in the ordinary sense of the word’,<sup>144</sup> and that ‘[c]ompulsion is a necessary part of guardianship practice’.<sup>145</sup>

The Queensland Tribunal in *Re JD*<sup>146</sup> also considered that a guardian with plenary powers could authorise restrictive practices. The case involved the question of whether a young woman with an intellectual disability could be detained in an authorised mental health service on the authority of her guardian.<sup>147</sup> An interim order was made appointing the Adult Guardian (the relevant statutory official in Queensland at that time) for accommodation matters but not personal matters generally. The Adult Guardian had expressed the intention to consent to the detention of JD at the mental health facility drawing on the accommodation function, with the use of force if necessary.<sup>148</sup> However, the Department of Health, which administered the facility, considered that a guardian could not consent to a person’s detention in an authorised mental health service when ‘that person [was] calm and expresse[d] a desire to leave’.<sup>149</sup>

The Tribunal, in reviewing its interim order, suggested that it still considered an accommodation function could enable JD to be kept at the place where the Adult Guardian had chosen she should reside, and returned there if necessary.<sup>150</sup> However, seemingly to put the matter beyond doubt, the Tribunal relied not on the accommodation power but the implied broad powers of a guardian with plenary powers for all personal matters. The Tribunal considered the definition of ‘personal matter’ was sufficiently broad to encompass such a decision to be made if it was in the best interests of the adult.<sup>151</sup>

There has been some limited academic consideration of this issue by Allen and Tulich in relation to Western Australian law. Noting that in that jurisdiction (as in others), the powers of guardians are expressed in terms of the powers a parent would have in relation to their child, Allen and Tulich argue that this would

142 [2009] TASGAB 2 (19 February 2009).

143 Ibid [12], quoting *Guardianship and Administration Act 1995* (Tas) s 25.

144 *EKR (Guardianship)* [2009] TASGAB 2 (19 February 2009) [30].

145 Ibid [31].

146 [2003] QGAAT 14 (19 September 2003).

147 Ibid.

148 Ibid [11].

149 Ibid [12].

150 Ibid [45].

151 Ibid [27], [37]. However, the Tribunal noted the uncertainty associated with guardians’ powers to consent to restrictive practices and recommended that the Adult Guardian appeal to the Supreme Court raising this as a question of law: at [52]–[53]. The Tribunal’s ultimate order was to make a further initial interim order for 28 days to allow for the recommended appeal (which appears not to have occurred). Given the way in which this matter was heard and resolved, its utility in ascertaining the likely legal position is limited.



preclude a guardian having power to consent to one type of restrictive practice: indefinite detention.<sup>152</sup> The rationale for this is that there is case law which suggests that such a decision is beyond parental power and can only be authorised by the courts. In both *Re Beth*<sup>153</sup> and *Re Thomas*,<sup>154</sup> the Victorian and New South Wales Supreme Courts respectively concluded that the authorisation of detention, restraint and involuntary treatment (including chemical restraint) were beyond the powers of guardians and parents of children. On this reasoning, a guardian's power would be similarly limited and they could not authorise such a course of action in relation to an adult.<sup>155</sup>

In conclusion, it appears that a number of tribunals consider they have power to appoint guardians to authorise restrictive powers based on the breadth of the implied powers of guardians. However, this finding is predicated on a limited number of published decisions and there has been only limited reasoning by tribunals in support of this position along with some policy statements of other guardianship bodies. While it appears to be settled practice, the legal basis supporting the scope of this decision-making power has not been properly articulated.

## **1 Impact of Specific Restrictive Practices Provisions on the Breadth of Guardians' Implied Powers**

Doubts may also be raised about the applicability of this argument that plenary powers include the ability to consent to restrictive practices in jurisdictions which have legislated to provide *specific* powers to guardians to consent to restrictive practices. A useful case study is Queensland, as its Tribunal is now specifically empowered to appoint a guardian with restrictive practice functions,<sup>156</sup> who can be authorised to consent to physical, chemical and mechanical restraint and restrict access to objects.<sup>157</sup> The Tribunal is also specifically authorised by the legislation to approve the use of seclusion and detention (known as 'containment'), and if providing such authorisation, can also consent to other restrictive practices.<sup>158</sup>

Of note is that there are published Tribunal decisions considering whether guardians can be authorised to consent to restrictive practices before and after these reforms were introduced in Queensland. For example, in 2003, before the restrictive practices provisions were passed, as discussed above in *Re JD*,<sup>159</sup> the Tribunal concluded that the plenary powers of a guardian appointed for 'personal matters' were sufficiently broad to allow a guardian to make decisions which

152 Allen and Tulich, above n 5, 10.

153 (2013) 42 VR 124.

154 *Director-General, Department of Community Services; Re Thomas* (2009) 41 Fam LR 220.

155 See also *Re Sally* [2009] NSWSC 1141 (20 October 2009); *Re Sadie* [2015] NSWSC 140 (18 February 2015); *Secretary, Department of Family and Community Services; Re Julian* [2014] NSWSC 399 (2 April 2014).

156 *Guardianship and Administration Act 2000* (Qld) s 80ZD.

157 *Ibid* s 80U (definition of 'restrictive practice'), citing *Disability Services Act 2006* (Qld) s 144.

158 *Ibid* ss 80V(1), 80X.

159 [2003] QGAAT 14 (19 September 2003).

‘may [both] restrain or contain the adult’.<sup>160</sup> In 2005, the Tribunal in *Re WCM*<sup>161</sup> concluded that certain restrictive practices could come within the definition of ‘health care’ and so be consented to by a guardian. A similar conclusion was reached in 2006 in *Re MLI*,<sup>162</sup> although by this time the Tribunal had noted the introduction of the specific legislative framework for restrictive practices that had been introduced into the Victorian Parliament.<sup>163</sup> The Tribunal was careful to point out that a guardian could not consent to any restrictive practices ‘except to the limited degree they consent to these practices as a guardian for health care in certain specific circumstances’.<sup>164</sup>

By 2009, in *Re AAG*,<sup>165</sup> which was decided after the specific restrictive practices provisions had commenced in Queensland, the Tribunal indicated that its previous reasoning may now need to be re-examined. No guardian was appointed at this point because the hearing was adjourned (reasons for the later hearing do not appear to be available), but the Tribunal made clear that the new legislative landscape raised questions about the ability of guardians without specific powers in relation to restrictive practices to consent to such practices.<sup>166</sup>

It could be argued that with the enactment of a specific restrictive practices regime in Queensland’s guardianship system, only guardians with specific restrictive practices functions should be able to consent to such practices. This means that guardians for personal matters would *not* be able to consent to restrictive practices. This is particularly significant if this reasoning applies to those who are not in receipt of state funded disability services and so fall outside the restrictive practices regime and therefore cannot have a restrictive practices guardian appointed. Such persons, it could be argued, could not have restrictive practices consented to *at all* on the basis that the Queensland Parliament has considered this issue and concluded that such appointments only be available to the cohort for whom it has legislated. Of course, this is not to say it does not happen in practice.<sup>167</sup>

Section 80T of the *Guardianship and Administration Act 2000* (Qld) may mean that the above line of reasoning should be qualified with respect to health care decision-makers. This section states that these restrictive practices provisions do not limit the extent to which a substitute decision-maker is authorised to make health-care decisions for adults who are not in receipt of state disability funding and so fall outside that regime. This may mean that if restrictive practices can

160 Ibid [37].

161 [2005] QGAAT 26 (26 May 2005).

162 [2006] QGAAT 31 (19 May 2006).

163 Ibid [45], citing Disability Bill 2006 (Vic), introduced into the Victorian Legislative Assembly 1 March 2006.

164 *Re MLI* [2006] QGAAT 31 (19 May 2006) [59].

165 [2009] QGAAT 43 (27 May 2009).

166 Ibid [51]–[52].

167 There is one published case after the legislative amendments in Queensland where a guardian was appointed in the context of discussions about the need for possible ‘consent to the use of medication for the purpose of restraining SBA rather than treating him for a medical condition’: *SBA* [2015] QCAT 28 (20 January 2015) [10].

also be characterised as health care then the specific restrictive practices regime does not preclude a health care decision-maker authorising this practice.

Although the focus of discussion here has been on Queensland, similar arguments could be advanced in relation to Tasmania,<sup>168</sup> and perhaps also Victoria and the Northern Territory (although their restrictive practices are authorised administratively rather than through the guardianship system).

## **E Coercive Powers in Australian Guardianship Legislation**

A number of jurisdictions specifically empower guardianship tribunals to authorise guardians to enforce their decisions. The use of these ‘coercive powers’ may provide the extra authority needed to consent to certain restrictive practices, and is the fifth and final basis on which such practices may be authorised under guardianship systems.

In New South Wales, a guardianship order may specify that a guardian (or another specified person, or person authorised by the guardian) is empowered to take actions ‘to ensure that the person under guardianship complies with any decision of the guardian in the exercise of the guardian’s functions’.<sup>169</sup> The Tribunal refers to these as ‘coercive powers’.<sup>170</sup> These powers were considered by the New South Wales Supreme Court in *White v Local Health Authority*,<sup>171</sup> where the Court considered an application for a writ of habeas corpus in relation to a woman whose involuntary admission to a mental health facility had been authorised by her guardian. While the Mental Health Review Tribunal had ordered her release, the guardian had refused to authorise this. The Court ordered her release, granting the writ, because of the order of the Mental Health Review Tribunal. Nevertheless, the Court did recognise that guardians could theoretically authorise such detention. In particular, the Court referred to the coercive powers in the Act as ‘leav[ing] little doubt that [the] displacement of the wishes of the person under guardianship can occur’.<sup>172</sup>

In Tasmania, the Board can make a guardianship order that empowers a guardian (or another specified person) ‘to take such measures or actions ... to ensure that the represented person complies with any decision of the guardian in the exercise of the [guardian’s] powers and duties’.<sup>173</sup> The guardian is protected from ‘any action [in] false imprisonment or assault or any other action, liability or claim or demand arising [from] the taking of [the] measure or action’.<sup>174</sup>

168 Although note that the Tasmanian Board has appointed a guardian to authorise treatment and restraint in a mental health service after the restrictive practices amendments: *LL (Guardianship)* [2012] TASGAB 15 (19 June 2012).

169 *Guardianship Act 1987* (NSW) s 21A(1).

170 *DLH* [2013] NSWGT 4 (17 April 2013) [24].

171 [2015] NSWSC 417 (13 April 2015); see also *Darcy (by her tutor Aldridge) v NSW* [2011] NSWCA 413 (21 December 2011).

172 *White v Local Health Authority* [2015] NSWSC 417 (13 April 2015) [74]–[75].

173 *Guardianship and Administration Act 1995* (Tas) s 28(1).

174 *Ibid* s 28(2).

In Victoria, the Tribunal may, when making a guardianship order, or at any time a guardianship order is in force, specify that the guardian can ‘take specified measures or actions to ensure that the represented person complies with the guardian’s decisions’.<sup>175</sup> The guardian is protected from liability for ‘any action for false imprisonment or assault or any other action ... arising out of ... taking [the] measure or action’.<sup>176</sup> The measure or action must be reasonable in the circumstances and in the best interests of the person.<sup>177</sup> Such an order must be reassessed within 42 days.<sup>178</sup>

Finally, in South Australia, an application can be made to the Tribunal in respect of a protected person (that is, a person subject to guardianship) or a person who has appointed a substitute decision-maker under an advance care directive, for an order that the person reside ‘with a specified person or [at] a specified place’, an order that the person reside with a such a person or at a such a place that the appropriate authority thinks fit, or an order that the person is detained in the place where he or she will reside.<sup>179</sup> An order may also be sought to authorise ‘persons from time to time involved in the care of the person to use [reasonable] force ... for the purpose of ensuring the proper medical or dental treatment, day-to-day care and well-being of the person’.<sup>180</sup> Importantly there is also a requirement for the Tribunal to review these orders within six months of making the initial order and then at least annually.<sup>181</sup>

The point of such powers is that they may overcome the potential problem of the lawfulness of guardians enforcing their decisions and importantly also authorising others, such as support staff and police officers, to enforce guardians’ decisions. However, these coercive powers have been strictly construed. For example, the South Australian District Court found that an earlier version of the coercive powers enabling detention in the *Guardianship and Administration Act 1993* (SA)<sup>182</sup> only allowed a guardian to consent to the detention of a person in their place of residence. Thus, the Public Guardian’s attempt to consent to a person’s detention by police in another health facility, when the person was found by police on the street engaging in potentially self-harming behaviour, or behaviour dangerous to others, was not authorised by the strict words of the provision.<sup>183</sup>

175 *Guardianship and Administration Act 1986* (Vic) s 26.

176 *Ibid* s 26(2).

177 *Ibid*.

178 *Ibid* s 26(1A).

179 *Guardianship and Administration Act 1993* (SA) ss 3(1) (definition of ‘protected person’), 32(a1), 32(1)(a)–(b).

180 *Ibid* s 32(1)(c).

181 *Ibid* s 57(1)(a).

182 *Ibid* s 32 (as amended by *Guardianship and Administration (Approved Treatment Centres) Amendment Act 1994* (SA) s 2).

183 *Re Carter* (Unreported, District Court of South Australia, Judge Russell, 4 August 1997).

### III A CRITIQUE OF CURRENT REGULATION OF RESTRICTIVE PRACTICES IN THE GUARDIANSHIP SYSTEM

Having charted the various ways in which the guardianship system in Australia deals with restrictive practices, we turn now to a critique of that regulation. This is done in two parts. The first part is a critique which identifies problems with the existing law. The current law is shown to be inconsistent (both from a national uniformity perspective and within particular jurisdictions), uncertain and unclear.<sup>184</sup> This critique of current law also argues that it may not comply with the principle of legality.

The second part of the critique asks a more fundamental question: should restrictive practices be regulated by the guardianship system? We argue that restrictive practices sit awkwardly within an adult guardianship framework which has the adult as its central focus. We also consider that guardianship systems are not designed to bring about the changes to systems and practices that are critical in this field, and lack the needed safeguards that are traditionally present in regimes that deprive people of their liberty.

#### A *Current Law Governing Restrictive Practices in the Guardianship System Is Problematic*

##### 1 *Law Is Inconsistent*

A clear trend that emerges from the above discussion of the law governing restrictive practices in the guardianship system is the significant variation nationally. For example, some jurisdictions have specific restrictive provisions in their guardianship legislation (Queensland and Tasmania), others confer a legislative grant to guardians of ‘coercive powers’ (New South Wales, Tasmania, Victoria and South Australia), while a third group has no specific legislative mention of restrictive or coercive powers in their guardianship regime (Northern Territory, Australian Capital Territory and Western Australia). Another example is the quite disparate approaches to the authorisation of chemical restraint by guardianship tribunals.<sup>185</sup> As with many areas of law, this is no doubt a product of guardianship law being a matter of state and territory responsibility. However, this remains a significant problem, especially given that key sectors where restrictive practices occur, such as the aged care system, are also regulated at the national level. We add our voice to the calls of others<sup>186</sup> for national uniformity or at least harmonisation in this area.

<sup>184</sup> This point has also been made in relation to the regulation of restrictive practices generally (including beyond guardianship): Australian Law Reform Commission, above n 1, 249; Williams, *Chesterman and Laufer*, above n 5, 641.

<sup>185</sup> See above discussion in Part II(B)(3).

<sup>186</sup> For example: Australian Law Reform Commission, above n 1, 251–9 [8.36]–[8.74] (and the various submissions noted therein on this topic).

But even more troubling is the inconsistency in legal approach *within* a jurisdiction. The prime examples of this are the two jurisdictions that specifically regulate restrictive practices through their guardianship system: Queensland and Tasmania. These systems provide clear authorisation for restrictive practices and establish a process for these decisions that include at least some safeguards such as prescribed criteria to meet before restrictive practices can be consented to, regular review by tribunals and the imposition of time limits on the use of these practices.<sup>187</sup> However, these regimes only apply to those receiving state-funded disability services. This means that restrictive practices in hospitals and other health facilities, aged care facilities, other supported residential services (such as boarding houses) or where care is provided by private carers or family are not subject to these safeguards and fall to be regulated on some other legal basis. It is hard to justify this differential treatment of these two cohorts based on how they are funded.<sup>188</sup>

## 2 *Law Is Unclear and Uncertain*

Specific restrictive practices legislation and provisions granting guardians coercive powers are clear in their authorisation of decision-making in relation to restrictive practices. It also seems likely that an accommodation power on its own (without further specific authorisation by a tribunal) would *not* be sufficient to grant powers in relation to restrictive practices.<sup>189</sup> However, the remaining two possible legal bases for authorisation — which are the significant ones in practice — remain unclear and uncertain.<sup>190</sup>

Turning first to the power to consent to medical treatment or health care, there is some uncertainty about whether various restrictive practices could fall within this definition. As outlined above, restrictive practices have sometimes been considered to be health care where an adult's behaviours of concern are seen as symptomatic of an underlying mental condition that requires 'treatment'. Nevertheless, in some jurisdictions, tribunals have expressed a reluctance to consider practices as falling within the definition, particularly where the extent of the practice (for example, the dosage) belies a purpose aimed at control rather than treatment, or at least tribunals seem to view it as a matter which can only be discerned on a case-by-case basis by an appointed guardian. This casts doubt on the ability of a medical decision-maker, particularly one relying on automatic legislative powers as a default decision-maker rather than being appointed by a tribunal, to confidently make decisions about restrictive practice matters. In other jurisdictions, chemical restraint is assumed to be part of medical treatment by guardianship bodies although arguably some uncertainty remains as the rationale for their position has not been articulated.

187 See above Part II(A).

188 See, eg, Queensland Law Reform Commission, *A Review of Queensland's Guardianship Laws*, Report No 67 (2010) vol 3, 361–4.

189 But see *NLA (Guardianship)* [2015] VCAT 1104 (23 July 2015).

190 Allen and Tulich, above n 5, 20.

The final basis for authorising restrictive practices, and this appears to be the most commonly utilised basis for doing so, is relying on the implied breadth of guardians' powers to authorise restrictive practices. A number of jurisdictions' tribunals have appointed guardians to make decisions about restrictive practices, and while the argument is more compelling for them than for medical treatment or health care and accommodation functions, reliance on this ground has tended to be by way of assertion; there has been limited argument advanced by tribunals as to the basis for their appointments of guardians with these powers. Indeed, in jurisdictions where guardians' powers are said to be analogous to those exercised by a parent in relation to a child, there is a suggestion that this means indefinite detention is specifically outside a guardian's powers given recent Supreme Court findings suggesting parents could not decide such a matter for their child.<sup>191</sup>

Assuming that a guardian's power is broad enough to encompass restrictive practices, an associated, but distinct, unresolved issue is whether a standard plenary appointment as guardian will grant powers in relation to restrictive practices or whether the tribunal needs to specifically confer such a power. Arguably, if the implied powers of a plenary guardian are as wide as is stated, then a specific appointment for restrictive practices functions is not needed as a plenary appointment carries with it powers in relation to restrictive practices. The implications of this are significant. If all plenary guardians have powers to authorise restrictive practices, regardless of whether or not they have been specifically given this power by a tribunal, then that confers this very significant power on a large number of substitute decision-makers without any formal consideration of this matter by the appointing tribunals.

### 3 *Law Offends the Principle of Legality*

A final criticism of some of the legal bases that may support the authorisation of restrictive practices discussed above is that it may offend the principle of legality. This is because there is a granting or recognition of power to make decisions about restrictive practices without specific legislative authorisation. The principle of legality is a common law principle of statutory interpretation that requires specific words to be used in a statute to abrogate a person's fundamental rights.<sup>192</sup> The principle of legality has a long history in English common law.<sup>193</sup> It has been emphatically adopted in numerous High Court decisions,<sup>194</sup> with the authoritative

191 Ibid 10; see also *Re Beth* (2013) 42 VR 124; *Director-General, Department of Community Services; Re Thomas* (2009) 41 Fam LR 220.

192 Chief Justice J J Spigelman, 'Principle of Legality and the Clear Statement Principle' (2005) 79 *Australian Law Journal* 769, 775; *Coco v The Queen* (1994) 179 CLR 427, 437 (Mason CJ, Brennan, Gaudron and McHugh JJ).

193 *R v Secretary of State, Home Department; Ex parte Simms* [2000] 2 AC 115, 131.

194 *Bropho v Western Australia* (1990) 171 CLR 1, 18; *Wentworth v New South Wales Bar Association* (1992) 176 CLR 239, 252; *The Daniels Corporation International Pty Ltd v Australian Competition and Consumer Commission* (2002) 213 CLR 543, 553 [11]; *Re Bolton; Ex parte Beane* (1987) 162 CLR 514, 523; *Plaintiff S157/2002 v Commonwealth* (2003) 211 CLR 476, 492 [30]; *Al-Kateb v Godwin* (2004) 219 CLR 562, 577 [19].



statement<sup>195</sup> expressed in a unanimous judgment in *Coco v The Queen*<sup>196</sup> by Mason CJ, Brennan, Gaudron and McHugh JJ:

The courts should not impute to the legislature an intention to interfere with fundamental rights. Such an intention must be clearly manifested by unmistakable and unambiguous language. General words will rarely be sufficient for that purpose if they do not specifically deal with the question because, in the context in which they appear, they will often be ambiguous on the aspect of interference with fundamental rights.<sup>197</sup>

The principle of legality is enlivened when it is identified by a court that the statute under consideration engages a common law fundamental right or freedom. Once the engagement of these rights or freedoms is identified, then, except to the extent that clear statutory language is used, the principle requires that the legislation be given a ‘rights-protective construction’.<sup>198</sup> It operates as a presumption against the fact that the legislation sought to abrogate the identified right or freedom. The need for clear and unambiguous words indicates that Parliament has confronted the issue squarely and considered the ramifications, including the political costs of affecting those rights.<sup>199</sup>

The use of restrictive practices on people with intellectual and cognitive impairment engages two fundamental rights: liberty and security of the person. These liberty and security rights have a strong basis in modern western liberal democracies. They are not only human rights, expressed as civil and political rights in contemporary human rights instruments,<sup>200</sup> but also strongly protected by the English common law.<sup>201</sup>

Applying the principle of legality means that it would not be sufficient to point to the implied breadth of a plenary guardian’s powers or generic powers to make medical or health decisions to conclude that these powers also include the power to interfere with a person’s liberty and security. Making decisions for another (which is specifically authorised by guardianship legislation) is quite different from restraining a person physically or through medication or by means of mechanical devices. It is also different from secluding a person from others against their wishes, and it is again quite different from detaining a person in a locked room or facility and preventing them from leaving. As such, the principle

195 Chief Justice J J Spigelman, ‘The Common Law Bill of Rights’ (Speech delivered at the McPherson Lectures, University of Queensland, 10 March 2008) 21.

196 (1994) 179 CLR 427.

197 Ibid 437.

198 Dan Meagher, ‘The Principle of Legality as Clear Statement Rule: Significance and Problems’ (2014) 36 *Sydney Law Review* 413, 423.

199 *R v Secretary of State, Home Department; Ex parte Simms* [2000] 2 AC 115, 131.

200 See, eg, *International Covenant on Civil and Political Rights*, opened for signature 16 December 1966, 999 UNTS 171 (entered into force 23 March 1976). This treaty entered into force for Australia, except article 41, on 13 November 1980. They are also specifically recognised in the disability setting through the *Convention on the Rights of Persons with Disabilities*, opened for signature 30 March 2007, 2515 UNTS 3 (entered into force 3 May 2008) art 14.

201 For example, in *Ex parte Walsh; Re Yates* (1925) 37 CLR 36, 79, Isaacs J emphasised the long history and importance of the common law right to liberty, whereas the common law right to bodily security is protected by the law of trespass: *Collins v Wilcock* [1984] 1 WLR 1172, 1177 (Goff LJ).

of legality cast doubts on the power of plenary guardians and health decision-makers, absent clear and unambiguous statutory authority, to authorise restrictive practices.

To avoid offending this common law principle, guardianship legislation would need to specifically authorise restrictive practices, for example, as has been done in Queensland and Tasmania. But this raises a wider and more fundamental question: should restrictive practices be part of the guardianship system?

## **B Should Restrictive Practices Be Regulated in the Guardianship System?**

### **1 Guardianship as a Default Home for Restrictive Practices is a Modern Assumption**

Some view guardianship as the logical home for regulating restrictive practices for adults with intellectual or cognitive impairment, perhaps because this is the regime through which the state generally facilitates decision-making for this group of people. There is considerable evidence for this. Queensland and Tasmania have embedded their restrictive practice framework within their guardianship laws. Further, various law reform commissions have examined restrictive practices in the guardianship setting. Most recent is the NSW Law Reform Commission's review of that State's guardianship legislation, as the terms of reference for that review specifically included consideration of restrictive practices.<sup>202</sup> And before that, the Victorian Law Reform Commission's report on guardianship laws included recommendations about a new collaborative authorisation process through the guardianship system for deprivations of liberty in residential care.<sup>203</sup> The Commission also recommended that, when appointing guardians, the Victorian Civil and Administrative Tribunal 'should consider whether to include an express power to authorise deprivations of liberty' and that the Tribunal's power to do this be made clear in the guardianship legislation.<sup>204</sup> Other evidence of guardianship being seen as a home for restrictive practices can be seen in the guidelines and frameworks established by guardianship bodies to facilitate and regulate decisions being made about these matters within the guardianship system.<sup>205</sup>

But assumptions about the role of restrictive practices in guardianship can be challenged when it is considered that, historically, neither the *parens patriae* jurisdiction nor a committee of the person facilitated or authorised the use of

202 New South Wales Law Reform Commission, above n 16, v.

203 Victorian Law Reform Commission, *Guardianship: Final Report*, above n 2, 339 [15.133]–[15.135].

204 Ibid 338 [15.131].

205 See, eg, NSW Civil & Administrative Tribunal, above n 91; Office of the Public Advocate (SA), 'Guardian Consent for Restrictive Practices in Disability Settings', above n 94; Office of the Public Advocate (SA), 'Guardian Consent for Restrictive Practices in Residential Aged Care Settings', above n 94.

detention or restraint on people with mental illness or intellectual impairment.<sup>206</sup> The Crown's historical powers in relation to 'idiots' and 'lunatics' under the statute *De Prerogativa Regis* 1324, 17 Edward 2, Payton emphasises, were 'not police power statutes requiring close confinement of persons *non compos mentis* for the public safety, but rather *parens patriae* undertakings in the interest of the *non compos mentis* person themselves'.<sup>207</sup> The defining characteristic of this jurisdiction was the fiduciary nature of the relationship, which in turn was critical to the legitimacy of the power exercised over those deprived of the control of their property and person.<sup>208</sup> The power to detain this cohort of people came later (during the period from the later 18<sup>th</sup> to the late 20<sup>th</sup> centuries), and from a different source.<sup>209</sup> In response to fears of abuse and wrongful commitment,<sup>210</sup> as well as growing community fears about what was viewed as a growth in the 'feeble minded' class and urban degeneration,<sup>211</sup> there was a proliferation of statutes that sought to regulate the care of the mentally ill and people with intellectual impairment.

In England, for people with intellectual impairment, this movement culminated in the introduction of the *Mental Deficiency Act* 1913, 3 & 4 Geo V, c 28, primarily an outcome of the *Report of the Royal Commission on the Care and Control of the Feeble-Minded*, published in 1908.<sup>212</sup> It was this and subsequent legislation — not the appointment of a committee of the person under the *parens patriae* jurisdiction — that provided a legal basis for detention and involuntary treatment in the 19<sup>th</sup> and 20<sup>th</sup> centuries. Thus, the modern tendency to utilise guardianship to authorise detention and restraint of people with intellectual impairment in community settings is a new development and invites us to reconsider the assumption made by some that guardianship is an appropriate vehicle for regulating restrictive practices.

## 2 Restrictive Practices Risk Losing the Adult Focus of Guardianship Systems

A significant risk of including restrictive practices as part of the guardianship system is it can jeopardise the long-standing focus on the rights, interests and welfare of the adult on whose behalf decisions are being made.<sup>213</sup> At the centre of guardianship systems are adults with impaired capacity. The firm focus on the interests of these adults is reflected in guardianship legislation with the various

206 We note though that the *parens patriae* jurisdiction has been used to authorise restrictive practices in relation to children: see Australian Law Reform Commission, above n 1, 282–3 [10.46].

207 Sallyanne Payton, 'The Concept of the Person in the *Parens Patriae* Jurisdiction over Previously Competent Persons' (1992) 17 *Journal of Medicine and Philosophy* 605, 626.

208 Ibid 617.

209 Clive Unsworth, 'Mental Disorder and the Tutelary Relationship: From Pre- to Post-Carceral Legal Order' (1991) 18 *Journal of Law and Society* 254, 259.

210 A Highmore, *A Treatise on the Law of Idiocy and Lunacy* (George Lamson, 1822) 43.

211 David Wright, *The Study of Idiocy: The Professional Middle Class and the Evolution of Social Policy on the Mentally Retarded in England, 1848 to 1914* (MA Thesis, McGill University, 1990).

212 Great Britain, Royal Commission on the Care and Control of the Feeble-Minded, (1908).

213 Williams, Chesterman and Laufer, above n 5, 656.

legislative principles that require consideration of the adult's rights, interests and welfare to be at the heart of substitute decision-making.<sup>214</sup> This means that the interests of others are secondary, and their relevance in guardianship decision-making depends on the impact this may have on the adult. This clear focus on the adult in the guardianship system has been repeatedly stated in tribunal decisions: 'The exercise of this jurisdiction must be for the benefit, and in the best interests, of the person in need of protection as an individual, not for the benefit of the state or for the convenience of carers'.<sup>215</sup> This resolute focus on the adult is also reflected in the guardianship's predecessor, the *parens patriae* jurisdiction, with clear judicial statements that the jurisdiction will only be exercised in the best interests of the adult and *not the interests of others*.<sup>216</sup>

The problem with including restrictive practices in guardianship systems is that restrictive practices regulation often considers not only the rights, interests and welfare of the adult involved, but also takes into account wider considerations such as a risk of harm to others (such as health professionals, support staff and the community) and to property. Unlike consent to health care or support services, for example, the use of restrictive practices introduces a much wider range of (often competing) interests — those of the adult, those of health professionals and support staff, and those of the general community. The use of restrictive practices involves balancing these competing interests and finding a way to secure the adult's and often other people's safety whilst introducing restraints that are the least restrictive to the adult's rights in the circumstances. These types of considerations do not tend to arise for other types of decisions made by guardians.

For example, the Victorian *Disability Act 2006* (Vic) permits restraint or seclusion where there is harm to the person themselves or others (including where that harm could arise through damage to property).<sup>217</sup> Likewise, the coercive powers provisions in the South Australian guardianship legislation specifically contemplate these powers being granted where 'the health or safety of the person or the *safety of others* would be seriously at risk'.<sup>218</sup> A final example is Queensland's *Guardianship and Administration Act 2000* (Qld) which includes a risk of harm to others as a result of the adult's behaviour as one of the criteria for a guardian to consider in authorising the use of restrictive practices.<sup>219</sup> This shift to include wider non-adult related factors in decision-making dilutes the razor-sharp focus needed on the rights, interests and welfare of the adults concerned and puts at risk this essential feature of guardianship regimes.

214 See discussion at above nn 26–31 of the principles in the various Australian guardianship legislation.

215 *CCT v Public Guardian* [2016] NSWCATAD 71 (18 April 2016) [24], citing *P v NSW Trustee and Guardian* [2015] NSWSC 579 (18 May 2015). For recent illustrations of this adult-focus by guardianship tribunals across different jurisdictions, see *GXS (Guardianship)* [2016] VCAT 1514 (27 October 2016); *YNG* [2015] QCAT 471 (20 November 2015); *KJC* [2016] NSWCATGD 9 (12 April 2016); *NXC* [2016] NSWCATGD 13 (22 March 2016); *SM* [2016] WASAT 109 (13 September 2016).

216 See, eg, *Re Eve* [1986] 2 SCR 388, 427 (La Forest J); *Northridge v Central Sydney Area Health Service* (2000) 50 NSWLR 549, 554 [22] (O'Keefe J).

217 *Disability Act 2006* (Vic) s 140(a).

218 *Guardianship and Administration Act 1993* (SA) s 32(2) (emphasis added).

219 *Guardianship and Administration Act 2000* (Qld) s 80ZE.

One response to this argument is that consideration of the safety and welfare of others and of property could also be in the interests of the adult.<sup>220</sup> This is because there are adverse consequences (such as criminal liability) for the adult of such behaviour and so it is in their interests that they be stopped from doing this. While it is true that this could sometimes be the case, this cannot be said for all (or even many) cases and so is an argument which needs to be carefully examined on a case-by-case basis. Such arguments also tend to overlook the very genuine harm that restrictive practices cause to people who are subjected to them.<sup>221</sup> A final response is: if restrictive practices are genuinely in the interests of the person who is being restrained and only intended to be used for their benefit, why is it necessary to include references to harm to others and to property as part of the decision-making process? If there was truly only a focus on the adult, then the interests of the adult alone would be a sufficient criterion for decision-making, and references to harm to others and property would not be needed.

### **3 Guardianship Systems as Currently Designed Lack Sufficient Safeguards**

There is what Freckelton calls a ‘problematic tradition’ in the care of people with disabilities which ‘has too often been paternalistic and variously justified by convenience, necessity and what have been asserted to be the best interests of the person concerned’.<sup>222</sup> Part of this is a long history of restrictive practices being used inappropriately. They have been employed for the convenience of staff and family rather than for the benefit of the adult with an intellectual or cognitive impairment or for a genuine need to protect others.<sup>223</sup> They have been used because resourcing or staffing of care facilities has been inadequate.<sup>224</sup> They have been used because the triggers for challenging behaviours have not been understood<sup>225</sup> and restraint was the proffered response, rather than seeking positive changes to the adult’s environment or utilising appropriate models of support and accommodation. This history, along with the profound implications that restrictive practices have for liberty and security of this vulnerable group, point to the need to establish robust safeguards for decision-making about restrictive practices.<sup>226</sup> These safeguards

220 See, eg, the arguments considered by the Victorian Law Reform Commission, *People with Intellectual Disabilities at Risk: A Legal Framework for Compulsory Care*, Report No 48 (2003), 23–4 [2.28].

221 See Kirsten Moore and Betty Haralambous, ‘Barriers to Reducing the Use of Restraints in Residential Elder Care Facilities’ (2007) 58 *Journal of Advanced Nursing* 532, 533. See also the evidence outlined in Claire Spivakovsky, ‘Restrictive Interventions in Victoria’s Disability Sector: Issues for Discussion and Reform’ (Discussion Paper, Office of the Public Advocate (Vic), August 2012) 7–8; Kumble and McSherry, above n 4, 553–4.

222 Ian Freckelton, ‘Habeas Corpus and Involuntary Detention of Patients with Psychiatric Disorders’ (2011) 18 *Psychiatry, Psychology and Law* 473, 480.

223 This concern is noted in Australian Law Reform Commission, above n 1, 245 [8.11].

224 See Moore and Haralambous, above n 221. This concern is also noted in Australian Law Reform Commission, above n 1, 245 [8.12]; Victorian Law Reform Commission, *People with Intellectual Disabilities at Risk*, above n 220, 25 [2.32], 99 [5.37].

225 See, eg, Spivakovsky, above n 221, 6–7.

226 Allen and Tulich, above n 5, 22.

are needed not only to ensure good decision-making for individuals but to drive changes to practice reducing reliance on restrictive practices at a systems level.<sup>227</sup>

Yet there are not sufficient safeguards for decisions about restrictive practices in the guardianship system. This is in stark contrast to other regimes that deprive people of liberty and security such as the involuntary treatment frameworks under mental health legislation. Such frameworks generally include requirements for professional assessments, treatment plans which are regularly reviewed, regular review by a tribunal, and the right to seek an ad hoc review of detention and involuntary treatment by a tribunal, usually with a right of appeal to a higher court.<sup>228</sup> While there are some safeguards in Queensland and Tasmania where there is specific restrictive practices legislation, the reliance on guardians as the primary decision-maker for restrictive practices is insufficient.<sup>229</sup>

It is true that tribunals with guardianship jurisdiction, when involved, do provide careful external scrutiny of the restrictive practices used on people with intellectual and cognitive impairments. Some of their decisions considered in this paper are evidence of that. This happens more often in Queensland and Tasmania with greater involvement by the tribunals in at least some types of these decisions. And even in other jurisdictions that do not have restrictive practices frameworks, tribunals often attempt to replicate the sorts of safeguards found in legislation when crafting their orders. For example, the NSW Civil and Administrative Tribunal will require that a guardian appointed with a restrictive practices function seek a behaviour plan as part of their deliberations about whether or not to consent.<sup>230</sup> But these orders are not based on a legislative framework and so safeguards remain on a weaker footing. More importantly, tribunals are only involved in a small number of restrictive practices cases.

Instead, guardians are the key decision-makers authorising restrictive practices in the guardianship system and they make the overwhelming majority of these decisions. Relying on guardians (or default medical decision-makers) in a guardianship model is problematic for a number of reasons. First, it is arguable whether guardians have the ‘expertise’ needed either to assess whether restraints are necessary in the circumstances, or whether a person’s ‘challenging behaviours’ may be due to a lack of appropriate support, medical reasons or an inappropriate environment.<sup>231</sup> Of course, a guardian will often know the person very well and this is a critically important form of knowledge or ‘expertise’ in these decisions. But there are also complex clinical questions which often require specialist health or medical expertise.<sup>232</sup> Given guardians will generally not have such expertise, there is a risk that they will be ‘rubber stamping’ poor practices in disability

227 Department of Social Services (Cth), above n 12.

228 Chandler, White and Willmott, ‘The Doctrine of Necessity and the Detention and Restraint of People with Intellectual Impairment’, above n 3, 379.

229 See also the discussion above in Part III(A).

230 NSW Civil & Administrative Tribunal, above n 91, 3.

231 Williams, Chesterman and Laufer, above n 5, 656; Australian Law Reform Commission, above n 1, 245 [8.12], 252–3 [8.45]–[8.46]; Department of Social Services (Cth), above n 12.

232 Williams, Chesterman and Laufer, above n 5, 654.

and aged care services not knowing that restrictive practices could possibly be avoided or, if needed, that they could be provided in a less restrictive manner.<sup>233</sup>

Secondly, there is a risk that guardians will be in a position of power imbalance in relation to the relevant disability or aged care service provider. Part of this relates to likely differentials in expertise as mentioned above, but a guardian is also likely to be dependent on the provider for the ongoing position within the facility for the person for whom they are deciding. Pressure could be brought to bear on the guardian that the continued placement of the person within the facility can be maintained only if restrictive practices are employed. The guardian may then be confronted with the choice of consenting to arguably unnecessary restraints to stay in the facility or removing the person from the facility. The latter choice brings not only upheaval and distress for the person involved but is also dependent on a 'suitable' place being available elsewhere, that the acceptance of that place would not be conditional upon accepting the same use of restrictive practices, and that a transfer is logistically and financially possible.

Finally, decision-making by guardians generally occurs in relation to a single individual, usually a family member or loved one. This means that each guardian will generally only see the particular issues that arise in relation to the decisions that they are making for that single individual. To illustrate, guardians for two residents in the same facility are unlikely to be aware if their respective loved ones are subject to very different restrictive practices regimes. This shows that the decision-making framework designed to authorise restrictive practices lacks effective oversight and cannot address systemic concerns. The guardianship system provides very little scope to uncover and advocate for systemic issues that might arise in relation to restrictive practices in the disability and aged care sectors.

This is not to say that these three problems of guardians deciding restrictive practices arise in relation to all guardians. An obvious counter example is when the Public Advocate or Public Guardian is appointed as the decision-maker, as they would have expertise, independence from the service provider and a somewhat wider view of how restrictive practices decisions are made across sectors given they would be deciding for more than one person. That said, the above problems are tensions embedded in a system reliant on guardians which tend towards less than optimal decision-making on both individual and systemic levels.

## **IV CONCLUSION**

This paper is the first comprehensive analysis of the role that Australian guardianship laws play in regulating restrictive practices for people with intellectual and cognitive impairment. It identified and critiqued the five possible legal bases for authorising such decisions in the guardianship system before

233 See also *ibid* 655, which describes the risk of a 'mechanistic' use of guardianship just to authorise existing practice.



concluding that the law should be reformed to place decision-making about this issue on a clear, certain and consistent basis. This should be achieved by legislative reform and should not have to rely on tribunal decision-making.

The paper then questioned whether the guardianship system is an appropriate vehicle for regulating restrictive practices. Historically, restrictive practices were not part of decision-making regimes for adults with impaired capacity but it appears that it is now widely assumed to be a logical home for such practices. If that is to be the case, the guardianship system must maintain its clear focus on adults with intellectual and cognitive impairments and that the rights, interests and welfare of this cohort are paramount in decision-making about restrictive practices. Further, if a decision is made to regulate restrictive practices within guardianship, there must be reform to develop robust safeguards to ensure high quality decision-making in individual cases and to embed systemic oversight and monitoring to achieve improvements in practice, including reducing reliance on restrictive practices.

Reform can be slow to happen so, in the meantime, tribunals should consider carefully the basis on which they appoint guardians or allow decisions to be made about restrictive practices. If they continue to rely on the implied powers of guardians to make these decisions, as we anticipate they will, we suggest that this should only be done by way of making an appointment with a specific restrictive practices power. This, as has been mentioned by one tribunal, makes transparent the significant nature of the decisions being made.<sup>234</sup> By making such appointments as ones about restrictive practices, this also provides a basis for identifying such cases for regular review, hence providing greater scrutiny. The tribunals without specific legislative frameworks for restrictive practices may also wish to consider framing their orders, as a number of tribunals have done, so as to embed the sorts of safeguards that specific legislation can contain.

As the authors have noted elsewhere, however, considerations of whether an adult is detained should not only be extended to those who are objecting to their confinement or living in 'locked facilities'.<sup>235</sup> For example, when considering whether two people with disabilities were subject to a deprivation of liberty in *Surrey County Council v P*,<sup>236</sup> Baroness Hale applied the test for deprivation of liberty utilised by the European Court of Human Rights in *HL v United Kingdom*.<sup>237</sup> Baroness Hale found that whether the deprivation of liberty was in the person's best interests, or those subject to it showed 'tacit acceptance', are irrelevant considerations.<sup>238</sup> The issue was whether the person was under continuous supervision, and whether they were free to leave.<sup>239</sup> Such a test could

234 *JP* [2008] WASAT 3 (8 January 2008) [65]. See also comments in *SJ and MET* [2006] WASAT 210 (28 July 2006) [32].

235 Chandler, White and Willmott, 'The Doctrine of Necessity and the Detention and Restraint of People with Intellectual Impairment', above n 3, 378.

236 [2014] AC 896.

237 [2004] IX Eur Court HR 191.

238 *Surrey County Council v P* [2014] AC 896, 919, 922.

239 *Ibid*.

be applied successfully to many people living in aged care facilities, or other facilities or group homes for people with disabilities, who either show no desire to leave, but who would be stopped from leaving the facility if they attempted to leave, or simply believe that they cannot leave the facility.<sup>240</sup>

But ultimately more is needed than just providing a way to lawfully authorise restrictive practices for people with intellectual and cognitive impairments in Australia's disability and aged care systems. Substantive reform is required to achieve systems with improvements to reduce, and eventually eliminate, the reliance on such practices.

240 See *Antunovic v Dawson* (2010) 30 VR 355.