Inquiry into indefinite detention of people with cognitive and psychiatric impairment in Australia

Submission to the Family and Community Development Committee

28 April 2016

# About Victoria Legal Aid

Victoria Legal Aid (VLA) is a major provider of legal advocacy, advice and assistance to socially and economically disadvantaged Victorians. Our organisation works to improve access to justice and pursues innovative ways of providing assistance to reduce the prevalence of legal problems in the community. We assist people with their legal problems at courts, tribunals, prisons and psychiatric hospitals as well as in our 14 offices across Victoria. We also deliver early intervention programs, including community legal education, and assist more than 100,000 people each year through Legal Help, our free telephone advice service.

VLA is the leading provider of legal services to Victorians with disabilities and mental illness, with more than 21,000 clients in 2014–15 (or one in five) disclosing that they fall within this category.

VLA’s specialist services to people with disability and mental illness includes:

* The Mental Health Disability Law Sub-Program (MHDL Program), which provides expert legal advice and advocacy to people diagnosed with mental health issues and those who experience some form of disability, particularly cognitive neurological disability.
* Independent Mental Health Advocacy (IMHA), a statewide non-legal advocacy service for people receiving compulsory treatment under the *Mental Health Act 2014* (Vic) (Mental Health Act). IMHA advocates support and assists people to make or participate in decisions about their assessment, treatment and recovery.

## Our practice experience in relation to indefinite detention

VLA is a key provider of legal and other advocacy services to those who are in indefinite detention because of cognitive or psychiatric impairment. VLA provides advice, legal representation and other advocacy services in areas including:

* People who have been found not guilty but are indefinitely detained at Thomas Embling Hospital (Thomas Embling) (if they have a mental illness) or a residential treatment facility (if they have a cognitive disability) pursuant to a custodial supervision order under the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic) (CMIA), or who are at risk of being removed from the community and placed in such a facility under the CMIA.
* People with intellectual disabilities who are detained under the *Disability Act 2006* (Vic) (Disability Act) in a residential treatment facility for compulsory treatment following a (quasi-) criminal order or in a disability residential service pursuant to a supervised treatment order.
* People with mental illness who are detained in psychiatric hospitals pursuant to a compulsory inpatient treatment order under the Mental Health Act.
* People with disabilities who are informally detained – without any clear legal authority – in residential services, aged care facilities or hospital facilities.

## Summary of submission

Indefinite detention of people with cognitive and psychiatric disabilities raises fundamental issues of compatibility with Australia’s international human rights obligations and values of fairness and equality before the law.

Our clients are placed in indefinite detention pursuant to a number of pieces of legislation in Victoria, and there is significant variation in the policies and processes adopted under these different legal frameworks. While Victoria is often viewed as having relatively advanced frameworks for the detention of people, our practice experience is that these provisions should be significantly improved.

This submission focuses on three themes that run through the different legal frameworks under which people are placed in indefinite detention, comments on areas of concern in the Victorian framework, and sets out principles that should be observed in any legislative basis for the detention of people with disability. These are:

1. **Clear legislative authority for detention with appropriate safeguards:** Any detention should be clearly authorised in legislation and accompanied by appropriate safeguards, including decision-making by an independent court or tribunal based on cogent evidence, with appropriate rights of appeal and review, and a right to legal representation.
2. **Alternatives to indefinite detention:** In order to be justified, indefinite detention under the schemes such as the Victorian CMIA must be a last resort, with all alternative options (including detention and supervision under civil orders in the community) meaningfully explored first.
3. **Clear and effective pathway back into the community:** Indefinite detention of a person on the basis of a cognitive or psychiatric impairment can only be justified where there are available effective pathways for a person to move back into the community, and only where it takes place in the least restrictive and most therapeutic environment possible. Appropriate options for moving out of detention should be at the forefront in decision-making and create momentum to progress people back into the community.
4. Clear legislative authority for detention with appropriate safeguards

VLA’s work with multiple legislative regimes that both authorise and regulate indefinite detention informs our view that crucial safeguards are needed to best protect the rights of people with psychiatric or cognitive impairments. In this section we:

* describe essential features of legislation authorising detention
* highlight a best practice standard for regulation of indefinite detention, and
* identify two key areas that would benefit from immediate reform.

## Essential features of legislation authorising detention

We consider the following to be essential features of legislation that authorises detention:

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

Measured against these standards, there are essential changes that are necessary to improve Victorian laws.

## Victoria’s Disability Act: a best-practice example

The legislation that best meets these requirements in Victoria is the Disability Act, particularly in relation to Supervised Treatment Orders (STO). The STO framework permits the detention of people with an intellectual disability who pose a significant risk of harm to others for the purposes of compulsory treatment.

The framework for these orders goes beyond the essential features set out above in important ways.

It includes:

* A statutory requirement that the interventions imposed will benefit the person.
* Effective legal scrutiny and oversight of the day-to-day treatment and restrictive interventions imposed on the person under the order (rather than just focus on making, confirming or revoking orders).
* Effective independent clinical scrutiny and oversight of the treatment, restrictive intervention and need for detention (through the involvement of the Senior Practitioner – Disability).
* A requirement to actively plan pathways towards less restrictive treatment and minimising restrictions over time.

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

## Informal detention – lack of legal authority, lack of oversight

A particular area of concern for VLA is informal detention, that is, where people are detained without clear legal authority and proper oversight. In our practice experience, this occurs in two contexts in Victoria:

1. **Aged care and disability residential services.** People in aged care facilities and disability residential services are regularly informally detained, generally in the absence of any clear legal authority and it is therefore not subject to any legal or clinical oversight.
2. **Cognitive disability.** In many cases, people with cognitive disabilities on non-custodial forensic supervision orders (NSCO’s) are detained and unable to freely leave their accommodation. There is no formal or practical oversight of their detention (either clinical or legal).

## Informal detention – aged care and disability residential services

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

### Consenting to informal detention?

While some people with disabilities comply with or acquiesce to very high levels of informal supervision and restrictions on their liberty, they may nevertheless not be giving full, free and informed consent for this because:

* They lack the mental capacity to give informed consent, for instance because of significant cognitive deficits, acute symptoms of mental illness, medication side effects or some other factor; or
* They are only complying under pressure or duress, for instance because they suspect or have been told that they would be put under a legal order and forced to comply, or would face some other consequence, if they did not.

### Barriers to supporting people who are informally detained

A range of factors prevent people subject to informal detention from seeking assistance:

* Awareness of their rights and the legal process.
* Awareness of the availability of legal services, and ways of accessing legal assistance.
* Lack of resources and/or ability to independently seek help.
* The impact of institutionalisation and being discouraged from seeking legal assistance by family, service providers or the accommodation facility.

### Case study: guardianship and informal detention

In Victoria, a guardian’s direction that a person reside in a locked facility, pursuant to an ‘accommodation’ power, is relied upon as the legal basis for detention. It is notable that Victoria’s *Guardianship and Administration Act 1986* (VIC) does not specifically authorise detention and provides no process for oversight of a person’s detention. People subject to guardianship orders have no legal avenue to challenge a guardian’s decision on its merits and there is no regular review of such a decision. Further, once an accommodation decision is made, a guardianship order will often be revoked, meaning that the person will remain detained in the accommodation.

The Victorian Law Reform Commission considered informal restrictions on liberty in residential care in its report on guardianship laws in 2012 but ultimately did ‘not propos[e] any changes to these practices even though the existing informal arrangements clearly lack any legal foundation’.[[1]](#footnote-1)

Nevertheless, due to the significant human rights implications and consistent with developments in other jurisdictions such as the UK, a statutory regime would ensure that what is currently informal detention is subject to rigorous, independent oversight and safeguards.

**Barbara’s experience**

Barbara was diagnosed with a degenerative disease about four years ago. She is now in her late 60s. A guardian was recently appointed with the power to make accommodation decisions for her. After years living independently or in supported accommodation, her guardian decided that she should be accommodated in a locked psychogeriatric facility that caters to people with advanced dementia (which Barbara does not have). Barbara’s guardian also directed staff at the facility to not allow Barbara to access the community unescorted during the day.

**James’s experience**

James, who is in his mid-60s, has an alcohol-related brain injury. His guardian decided he should be accommodated in a locked nursing home to prevent him accessing alcohol in the community. He now has minimal supervised leave during the day and no overnight leave, despite having these freedoms in his previous accommodation.

In both of the above cases there was no clear legislative power to detain the person, there was no regular review and effectively no oversight.

## Informal detention – Cognitive disability

In Victoria, most people found unfit to be tried or not guilty by reason of mental impairment who have cognitive disabilities are placed on non-custodial supervision orders (NCSO) rather than custodial supervision orders (CSO).[[2]](#footnote-2)

In many cases, people with cognitive disabilities on NSCOs are subject to high levels of restriction amounting to detention by their disability service provider (for instance, being unable to freely leave their accommodation). In the absence of clear legislative authority for detention, we consider that unless a person in this situation is also subject to a Disability Act STO, this may constitute unlawful detention.[[3]](#footnote-3)

These clients cognitive impairment may limit their knowledge of their legal rights and their capacity to self-advocate. Appropriate protections such as clear legislation authority, provision for oversight and review, and access to legal representation would provide important safeguards against unlawful detention under NSCOs.

1. Alternatives to indefinite detention

Those who are found to be ‘not guilty’ of a criminal offence due to mental impairment should not be subject to unnecessary or unjustified deprivation of their liberty if appropriate therapeutic and rehabilitative supports are available in the community, and the management of risk does not require detention. Prolonged indefinite detention frequently occurs as a result of forensic supervision orders made by a judge after a criminal act and is a significant interference with a person’s liberty and autonomy. Such detention can extend for longer than the sentence a person would be required to serve were they found guilty of the offence. Detention for those with disabilities who are found not guilty of an offence should only ever be a last resort, and this part of the submission focuses on strengthening the alternatives to custodial orders.

## Considering community-based alternatives to forensic supervision orders

The framework for the indefinite detention of people in Victoria following a criminal act and a finding of mental impairment is the CMIA. After a CMIA finding, the court may either unconditionally discharge a person, or declare them liable to supervision. If liable to supervision, the court must make either a custodial supervision order (CSO) or non-custodial supervision order (NCSO).

A CSO is the most restrictive form of order available under the CMIA. It is usually served at Thomas Embling Hospital. An NSCO is served in the community, with multiple reviews and community based interventions, and the possibility that non-compliance will lead to revocation and a return to custody on a CSO.

In considering a disposition under the CMIA, judges usually concentrate on which of these two orders are appropriate, without considering the alternative protection provided by other legislation such as the Mental Health Act and Disability Act. These two acts provides effective, less restrictive mechanisms for supervision, compulsory treatment and detention. They do not have the stigma of ongoing association with the criminal justice system and decisions about ongoing detention are made by reference to criteria relating specifically to the persons condition. They are flexible in that they allow for appropriate changes in the levels of intervention and restraint in response to changes in a person’s condition. Under the current framework, civil orders in the community are rarely considered as an alternative to a forensic supervision order[[4]](#footnote-4).

If indefinite detention is to be a last resort, then all alternative options should be explored first. The CMIA is currently structured so that practitioners, judges and the relevant government departments are not required to effectively explore alternatives to forensic supervision orders. They should be required to investigate any less restrictive options to manage risk and a particular order should only be made if those less restrictive options would be inadequate to manage that risk. [Jon’s case](#Jons_experience) provided a relatively rare example of the system functioning in this way.

**Jon’s experience**

Jon has a low moderate intellectual disability. He engaged in behaviour with a potentially sexual motive with children on two separate occasions. After a long delay, police laid charges against Jon.

Before he was charged by police, Jon’s disability service provider developed a detailed ‘behaviour support plan’[[5]](#footnote-5) for him. The plan included various behaviour support strategies and restrictive interventions, including supervision in the community at high-risk times of the day.

Jon was assessed as being unfit to be tried. His lawyer sought to have the charges withdrawn on the basis the behaviour support plan was effectively addressing Jon’s potential risk.

An NCSO would not have provided any greater supports or risk reduction and would have exposed Jon to the risk of variation to a CSO, and therefore to indefinite detention, should he have become non-compliant with the order, even if only in a minor way (see [Variation from community supervision to indefinite custodial detention](#_Variation_from_community) on page 7). After Jon’s lawyers provided considerable information about the operation of the Disability Act, the prosecutors agreed that the behaviour support plan was sufficient to manage any future risk and his charges were withdrawn.

## Variation from community supervision to indefinite custodial detention

Active consideration of alternative civil mechanisms for treatment and support is important not just at the time of the initial disposition but during the life of a forensic supervision order, particularly where it is proposed to vary a person from a non-custodial forensic supervision order to a custodial one.

VLA has a significant number of clients who were initially placed on NCSOs but whose orders were later varied to CSOs due to ‘management’ and minor non-compliance issues. We see this most with people with dual disabilities (co-occurrence of mental illness and an intellectual disability or acquired brain injury), personality issues or substance issues, which can mean they struggle to follow blanket rules and become impatient with the restrictions placed on them. Once at Thomas Embling, they often struggle to progress through the system due to these personality factors. This ongoing detention is often completely disproportionate to their original offending and ongoing risk.

Limits on the circumstances when a non-custodial forensic supervision order can be changed to a custodial one are necessary if indefinite detention is to be a last resort. If heightened risks emerge during the period of the NCSO, there are civil orders including detention mechanisms that can be relied on instead. The particular client group most at risk of non-compliance with an NSCO is the same group that may well find themselves in prolonged detention should their NSCO be revoked. This can result in periods of indefinite detention that significantly exceed the maximum term the person would have received for their offence.

**Loretta’s experience**

Loretta is a woman in her late 60s with a diagnosis of schizoaffective disorder. In 2009, Loretta was found not guilty by reason of mental impairment of arson and placed on an NCSO. Unfortunately, she experienced side effects from her mental health treatment and became non-adherent with her oral medication. In 2013, she was apprehended and placed in Thomas Embling. Initially her treating team wanted to discharge her back into the community. However, when she revisited her accommodation (a boarding house) she decided it wasn’t a safe or appropriate place to return to given there was drug use in the premises and broken property. Her treating team then decided to pursue an application to vary her NCSO to a CSO, with the expressed intention that an order for indefinite detention would motivate Loretta to better engage with rehabilitation programs. Two years later, Loretta remains detained at Thomas Embling.

**Sunil’s experience**

Sunil, who has schizophrenia and a traumatic brain injury, was placed on an NCSO in 2009 after being found not guilty because of mental impairment of intentionally causing injury, making threats to kill and false imprisonment. After some years in the community, his accommodation service became concerned at his alcohol use and consequent anti-social behaviour. Despite expert evidence that his alcohol use and anti-social behaviour were unrelated to his mental state, which had remained stable for the last year despite ongoing substance use, the court nevertheless found that he was likely to endanger himself or members of the public ‘due to his mental impairment’ and so varied his NCSO to a CSO. Sunil has remained indefinitely detained in Thomas Embling since then as he has struggled to sufficient engage with what the treating team consider the necessary steps to enable discharge back to the community. He has also struggled on occasion to avoid substances available within the hospital.

1. Clear and effective pathways back into the community

Indefinite detention of a person on the basis of a cognitive or psychiatric impairment depends for its justification on the efficacy of pathways for a person to move back into the community. In this part of the submission, we consider firstly the difficulties patients experience in effectively navigating pathways though and out of detention both in forensic and mainstream settings.

## Clear and effective pathways back into the community

The justification for indefinite detention of a person with a disability is their access to therapeutic services designed to progress them back into a community setting. Appropriate options for moving out of detention should be at the forefront in decision-making and there should be momentum to progress people back into the community. The STO model provides a best-practice example of this as it includes a requirement for planning with a view to reducing restrictions over time.

In our advocacy work for people under the CMIA or those subject to inpatient treatment order (ITO) under the Mental Health Act, we see many instances of prolonged, indefinite detention where there is insufficient impetus or structural supports to enable the person to progress and receive treatment in an environment that would be less restrictive of their freedom.

While we focus here on concerns with progression of clients on ITO’s, the [factors detailed on this page](#factors) are equally relevant to the difficulties we see for those seeking a reduction in restrictions on both custodial and non-custodial forensic orders under the CMIA regime.

Whilst an ITO can only be made for six months, this order can be renewed indefinitely where a person continues to meet the ITO criteria under the Mental Health Act as further applications may be made prior to the expiry of each order. There are people who have been continually detained in the same hospital for many years under an ITO. Our advocacy work focuses on representation at hearings where the primary issue for the decision maker is whether a person continues to meet the criteria under the Mental Health Act. Unlike the best practice framework for STO’s, the Mental Health Act does not require consideration of planning for future reduction of interventions, or for leveraging of supports to transition to a less restrictive environment.

Some examples of issues that arise both CMIA and ITO detention frameworks are:

### Personal factors

* Difficulties some individuals (especially those with multiple disabilities, substance use and personality factors) have complying with rules and effectively working through the required pathways necessary to transition out of detention.
* Limits on individual’s capacity to initiate and broker their own alternative supports in the community (due to their cognitive or psychiatric impairment and ongoing detention) lead to reliance on the support of detaining/treating service to progress pathways out of detention.

### Internal service and staff factors

* Models of care that focus on a person’s perceived ‘best interests’, particularly clinical best interests, and which are not focused on models of ‘supported’ decision making.
* Insufficient resources to obtain information and properly engage with the person in decision-making processes.
* Inadequate use of individualised planning around better supports for the person, risk amelioration and reduction of restrictions over time.
* Imprecision and conservatism in use of data and processes for risk assessment, including concentration on previous offending as a primary indicator of future risk.
* Inappropriate weighting of risk assessment (whether for personal or organisational reasons) and other attitudinal influences on clinicians and service managers when making decisions or recommendations about reduction in restrictions for those detained.
* Stigma against those with mental illness and disability who have a forensic/criminal history. This can limit the person’s access to less restrictive accommodation and orders.
* Key performance indicators and other standards concentrating on processes and outcomes in order to meet targets and/or maintain funding.[[6]](#footnote-6)

### Broader structural factors

* Legislative criteria and/or judicial practices which essentially require the person to establish that they would not be a risk in order to be released or granted more freedoms.
* Rigid pathways for transition and lack of flexibility for people who, due to their disability, struggle to comply with rules that may not be necessary.
* Insufficient resources to implement the treatment and services necessary to allow people to progress to a less-restrictive community setting (for example people who have been approved to have leave are not able to use it because there are insufficient staff to escort them).
* Siloed service systems and facilities, which means they are unable to properly meet people’s full individual needs holistically (the inability of the mental health service system to cater to and support a person with cognitive disability is particularly problematic).
* Lack of appropriate community accommodation or suitably supportive discharge destinations.
* Pressure on treating staff by family members to maintain restrictions.

**Peter’s experience**

Peter has both an intellectual disability and a mental illness. He has been in a SECU for a number of years despite his mental state being stable, because the service has been unable to arrange suitable discharge accommodation. He requires supported accommodation because he is quite vulnerable. He has been seriously assaulted in SECU before by other patients, however for unknown reasons the police investigation did not progress. Staff acknowledge that SECU is not an appropriate care setting for him.

The key issue preventing him from leaving is the separation in service provision between disability services for his intellectual disability, and mental health services for his mental illness. Disability services in his case have deferred to his mental health treatment as he is currently in SECU, yet he really requires supported accommodation to have any option of discharge. Peter lacks capacity to make progress on these issues himself, and there is no impetus to chart individual pathways leading to more appropriate accommodation for him.

**Shari’s experience**

Shari is currently detained in a hospital SECU and has spent most of the last 15 years detained under an ITO. She has had some interaction with the criminal justice system during this time, including occasional periods in Thomas Embling and prison. Each time the Mental Health Tribunal considers her case, her ITO is confirmed or extended. While she is not subject to a CMIA or criminal justice system order, the primary rationale for her ongoing detention is her potential risk to the community.

A significant contributing factor to the prolonged nature of her detention is lack of continuity, both from treating teams and from the Mental Health Tribunal that conducts hearing in her matter.

### Inpatient treatment orders at Thomas Embling Hospital

Detention under and ITO can also occur at Thomas Embling, usually when a person completes a formal prison term and meets the criteria for an ITO under the Mental Health Act. There can be particular issues with graded transition from Thomas Embling into the community as facilities can be reluctant to take patients with a criminal history, in addition to the other factors referred to above. The consequence is that these patients remain detained in a forensic environment.

**Anne’s experience**

Anne is currently detained in Thomas Embling on an ITO. This is her second time there. Following her last admission, she was discharged to a SECU where she spent almost 10 years before a further conviction led to prison, and then transfer back to Thomas Embling as a security patient. Once Anne’s sentence expired, she was immediately placed on an ITO and continued to be detained there. She has expressed a desire to be transferred to a less secure environment, such as a different SECU. Referrals have been made to SECUs, however they have refused to accept her on the basis that they felt she would be unable to be managed and that the best environment for her was Thomas Embling. Anne has been detained in a high secure environment as an involuntary patient under the Mental Health Act now for almost fifteen years, with no plan or impetus to work towards discharging her from the order.

**Mark’s experience**

Mark is an older man who was initially imprisoned and during his sentence, he required compulsory mental health treatment due to mental illness and was transferred to Thomas Embling as a security patient. At the conclusion of his sentence, he was still experiencing psychotic symptoms and was therefore immediately placed on an ITO to continue residing at Thomas Embling. He has since remained in one of their high secure facilities on an ITO for the last 10 years.

His illness has not been able to be completely controlled by medication and this is regularly used as a reason why he cannot be discharged. His treating team consider his risk of reoffending too high for him to be discharged directly to the community and will not explore whether a community arrangement could be workable. Instead, they have been pursuing a transfer to a SECU in the community, however no SECU has been willing to accept the referral due to his previous offending. Without a discharge destination, Mark is unable to leave. Mark complains of becoming very institutionalised. He has spent the majority of his time in the ‘slow stream’ rehabilitation unit where he does not need to cook for himself. There are options for more rehabilitation-focused units, however concerns have been raised about his capacity to look after himself, particularly his ability to cook. Mark cannot see a pathway out of indefinite detention at Thomas Embling.

The case studies provide an array of examples of the types of circumstances that can lead to prolonged indefinite detention. The key issue is that prolonged periods of detention do not currently become a trigger for scrutiny and renewed investment of resources under the current Mental Health Act framework. Incentives to focus on supports, outcomes and alternatives would increase confidence that alternatives to prolonged detention have been explored. A similar mechanism to that provided by STO’s would better achieve this.

1. *Guardianship Final Report*, Victorian Law Reform Commission, 2012, p 336.  
    [↑](#footnote-ref-1)
2. *Review of the Crimes (Mental Impairment and Unfitness to be Tried) Act 1997: report*, Victorian Law Reform Commission, 2014, p.17. [↑](#footnote-ref-2)
3. Section 150A of the Disability Act provides that people with intellectual disabilities must not be detained by a disability service provider otherwise than in accordance with Part 8 of that Act, and an NCSO is not one of the four mechanisms set out in Part 8 which permits detention by a disability service provider. [↑](#footnote-ref-3)
4. Review of the Crimes (Mental Impairment and Unfitness to be Tried) Act 1997: report, Victorian Law Reform Commission, 2014, p.17 which notes there had only been 10 of unconditional release orders in the 12 years from 2000 to 2012 as compared to 149 orders for CSOs or NCSOs over the same period. [↑](#footnote-ref-4)
5. A behaviour support plan is a formal mechanism under the Disability Act, defined as ‘a plan developed for a person with a disability which specifies a range of strategies to be used in supporting the person's behaviour including proactive strategies to build on the person's strengths and increase their life skills’: s 3(1). Certain restrictive interventions applied to the person, such as restraint and seclusion, must be set out in the plan: s 41. [↑](#footnote-ref-5)
6. For instance, in January 2015 it was revealed that a major Melbourne health service had issued a directive to staff to discharge at least three patients from each psychiatric ward every day, regardless of their progress: Patrick Hatch, ‘Monash Health U-turns on compulsory discharge of mental health patients’, *The Age* (23 January 2015). [↑](#footnote-ref-6)