



Office of the Public Advocate

Submission to Australian Human Rights Commission

Australia's implementation of the Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment

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Contact: John Chesterman

Director of Strategy

Office of the Public Advocate

Ph: 03 9603 9567

Email: john.chesterman@justice.vic.gov.au

Prepared by:

Eleanore Fritze

Office of the Public Advocate

Level 1, 204 Lygon Street, Carlton, Victoria 3053

Tel: 1300 309 337

www.publicadvocate.vic.gov.au



Introduction

The Office of the Public Advocate (OPA) welcomes the opportunity to respond to the Australian Human Rights Commission's consultation paper on Australia's implementation of the Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT).

About the Office of the Public Advocate

OPA is a statutory office, independent of government and government services that works to protect and promote the rights, interests and dignity of people with disability.¹

OPA provides a number of services to work towards these goals, including the provision of advocacy, investigation and guardianship services to people with cognitive impairments and mental illness. In 2015–16 OPA was involved in 1645 guardianship matters, 494 investigations and 61 new cases requiring advocacy.

Under the *Guardianship and Administration Act 1986* (Vic), OPA is required to arrange, coordinate and promote informed public awareness and understanding about substitute decision making laws and any other legislation dealing with or affecting persons with disability.²

The OPA Advice Service provides information on the rights of people with disability, and matters that may affect people with disability, including:

- guardianship and administration
- enduring powers of attorney
- consent to medical or dental treatment
- referral to OPA's Community Visitors Program.

The issues raised by people contacting OPA are often complex, requiring a high level of expertise. During 2015–16, OPA's Advice Service responded to 17,469 enquiries – 23 per cent more than the previous year due to the introduction of the *Powers of Attorney Amendment Act 2016* (Vic). Most calls (61 per cent) related to guardianship, administration or enduring powers of attorney. Ten per cent of all enquiries related to violence, abuse, exploitation or neglect.

OPA coordinates four volunteer programs: the Community Visitors Program, the Community Guardian Program, the Independent Third Person Program, and the Corrections Independent Support Officer Program. The office provides training and support to more than 800 volunteers.

Community Visitors are empowered by law to visit Victorian accommodation facilities for people with a disability or mental illness at any time, unannounced. They monitor and report on the adequacy of services provided, in the interests of residents and patients. The work of the Community Visitors is relevant to this submission. Their potential role under OPCAT is discussed briefly at the conclusion of this submission.

¹ *Guardianship and Administration Act 1986* (Vic) pt 3.

² *Guardianship and Administration Act 1986* (Vic) s 15(e).



The Public Advocate has a number of other advocacy roles and responsibilities in relation to the *Disability Act 2006* (Vic).³ The Disability Act Officer advocates for people with disability who receive services under the Act or are subject to restrictive interventions, detention and compulsory treatment imposed under the Act. The Disability Act Officer provides advocacy on matters including the detention and treatment of persons with an intellectual disability who are considered to be a significant risk of serious harm to the community.⁴

About this submission

This submission focusses on the following three points, which OPA considers are particularly important when considering how OPCAT should operate in Australia:

1. Ensuring that deprivations of liberty and places of detention are understood to include informally imposed detention and restrictive practices in social care and residential settings.
2. The challenge of providing necessary information to the national preventive mechanism (NPM).
3. The importance of meaningfully involving people with lived experience.

The role of the Community Visitors under the implementation of OPCAT is also briefly discussed.

1. Ensuring that deprivations of liberty and places of detention are understood to include informally imposed detention and restrictive practices in social care and residential settings

OPCAT's objective is to 'establish a system of regular visits undertaken by independent international and national bodies to places where people are deprived of their liberty, in order to prevent torture and other cruel, inhuman or degrading treatment or punishment'.⁵ The national or domestic visiting body, the NPM, is only empowered to inspect 'places of detention'.⁶ Therefore, it is important to understand the range of places that constitute places of detention and, consequently, which people will receive the benefit of the NPM's functions.

Article 4(1) of OPCAT defines a 'place of detention' as 'any place under [a State's] jurisdiction and control where persons are or may be deprived of their liberty, either by virtue of an order given by a public authority or at its instigation or with its consent or acquiescence'. 'Deprivation of liberty' is in turn defined in art 4(2) as follows:

[D]eprivation of liberty means any form of detention or imprisonment or the placement of a person in a public or private custodial setting which that person is not permitted to leave at will by order of any judicial, administrative or other authority.

³ The Public Advocate is a Governor in Council appointment and independent of government. If the Public Advocate considers that a supervised treatment order (STO) should be reviewed by VCAT, the Public Advocate may request the Senior Practitioner to make an application to VCAT pursuant to s 196(3) of the *Disability Act 2006* (Vic). Furthermore, if the Public Advocate believes that a person is being detained outside the parameters of the Disability Act, the Public Advocate can apply to VCAT for an order directing the authorised program officer to make an application for a STO: *Disability Act 2006* (Vic) s 194(1)(b).

⁴ The Disability Act Officer also has a role in relation to the protection of tenancy rights for group home residents and reports made by independent persons to the Public Advocate in relation to the use of restrictive interventions within a behavioural support plan: Office of the Public Advocate, *Advocacy Services* <<http://www.publicadvocate.vic.gov.au/our-services/advocacy-services>> accessed 5 July 2017.

⁵ OPCAT, art 1.

⁶ OPCAT, art 4.



There are many instances of deprivations of liberty imposed through formal legal channels on people with a disability that will clearly fall within the NPM's jurisdiction, including:

- imprisonment in prison following a finding of guilt through the criminal law process
- detention in a mental health service, residential treatment facility or prison following a finding of unfitness to be tried and/or not guilty because of mental impairment
- detention in a mental health service for compulsory mental health treatment under mental health laws, such as the *Mental Health Act 2014* (Vic)
- detention in a residential service for compulsory disability treatment, such as pursuant to a supervised treatment order (STO) under the *Disability Act 2006* (Vic)
- detention in a treatment centre for compulsory detoxification, withdrawal and/or substance dependence treatment, such as pursuant to a detention and treatment order under the *Severe Substance Dependence and Treatment Act 2010* (Vic).

However, there are a wide range of more informal social care practices which would likely fall within the definition of 'deprivation of liberty'. Therefore, the range of settings in which these practices occur should also be considered places of detention in relation to which the NPM will have jurisdiction and responsibility.

Where and how are these other deprivations of liberty occurring?

Many people with cognitive disabilities, mental illness or age-related disabilities are admitted to and reside in social care settings such as disability group homes, supported residential services (SRSs), aged care accommodation and public and private mental health facilities. Within these facilities they may be subject to very high levels of supervision and restrictions – up to and including complete and continuous deprivations of liberty – to which they do not, or are unable, to give informed consent. These restrictions on liberty may be achieved through one or more of the following mechanisms:

- **Environmental restraint** – environmental controls such as locked doors, keypad controls on doors, perimeter fencing and other building design features may restrict an individual's freedom to come and go at will. Similarly, being constantly supervised or escorted by staff⁷ also severely restricts a person's liberty. Such environmental restraints are very common in these social care settings.⁸
- **Mechanical restraint** – the use of equipment or devices such as bed rails, or strapping applied to wrists, chests or other parts of the body, to restrict movement. Mechanical restraints almost always cause significant harm or risk to the well-being of the individual.
- **Physical restraint** – where one person uses their physical body to restrict an individual's freedom to move or act.

⁷ The *Disability Act 2006* (Vic) defines 'detain' to include 'constantly supervising or escorting a person to prevent the person from exercising freedom of movement': s 3(1).

⁸ Williams, Chesterman and Laufer, 'Consent versus scrutiny: Restricting liberties in post-Bournewood Victoria', 2014, *Journal of Law and Medicine*, vol 21, p 646.



- **Seclusion** – confining an individual in a room where they are unable to leave or interact with other individuals. This form of restraint is typically used in mental health facilities when a patient receives too much stimulation from other patients or their environment, and their behaviour becomes agitated, aggressive or erratic.
- **Chemical restraint** – the administration of substances to restrict an individual's freedom to move or act, rather than to treat a medical condition. The substances used for this purpose include anti-psychotic and sedative medications and libido suppressants. They are widely used in aged care accommodation.⁹
- **Psychological manipulation and coercion** – the use of interpersonal power and threats to coerce behavioural compliance and prevent freedom of movement. For example, a voluntary patient in a mental health service may be told that they will be placed on a compulsory treatment order if they try to leave.

Not all restrictive interventions involve deprivations of liberty. Courts have held that difference between a restriction on freedom of movement and a deprivation of liberty is 'one of degree or intensity, not one of nature or substance',¹⁰ because the rights to liberty and freedom of movement both express the same fundamental value: freedom.¹¹ Restrictions on freedom of movement and liberty can therefore be seen to fall along a continuum and there is no clear dividing line between them.

In Victoria, restrictive interventions imposed by disability service providers are regulated under the *Disability Act 2006* (Vic). This regulation and the role of the Senior Practitioner (Disability) are discussed further below.

The evolving understanding of deprivation of liberty in social care settings

In *HL v UK* [2004] ECHR 471 (known as the *Bournemouth* case), the European Court of Human Rights stated that:

[T]o determine whether there has been a deprivation of liberty, the starting point must be the specific situation of the individual concerned and account must be taken of a whole range of factors arising in a particular case such as the type, duration, effects and manner of implementation of the measure in question.¹²

⁹ 'About half of people in residential aged care facilities and up to 80% of those with dementia are receiving psychotropics, although this varies between facilities. There is evidence to suggest that in some cases these medications are being prescribed inappropriately': Carmelle Peisah and Ellen Skladzien, *The use of restraints and psychotropic medications in people with dementia: a report for Alzheimer's Australia*, Paper 38, March 2014, p 16. The Australian Law Reform Commission also found that chemical restraint is 'reportedly widely used on people with dementia' and noted evidence given by the Department of Health and Aging to the Senate Inquiry into dementia that there is 'a high and inappropriate utilisation of antipsychotics in the elderly... which are prescribed at a rate inconsistent with the age-specific prevalence' of the disorders for which those medications are usually prescribed: *Equality, Capacity and Disability in Commonwealth Laws*, Report 124, 2014, pp 244-245.

¹⁰ *HL v UK* [2004] ECHR 471, [89]; *Stanev v Bulgaria* [2012] ECHR 46 [115]; *Kracke v Mental Health Review Board* [2009] VCAT 646, [664].

¹¹ *Antunovic v Dawson* [2010] VSC 377, [73], citing *Kracke v Mental Health Review Board* [2009] VCAT 646, [665].

¹² *HL v UK* [2004] ECHR 471, [89].



In *Antunovic v Dawson* [2010] VSC 377, the Supreme Court of Victoria considered the situation of Ms Antunovic, who was subject to a community treatment order with no residential condition under the *Mental Health Act 1986* (Vic). She wanted to live at home with her mother but had been told by her psychiatrist that she had to live at a 'community care unit' operated by the mental health service. Even though she was permitted to leave the unit during the day, and notwithstanding the restraint involved purely psychological coercion, the court held that this amounted to a limitation on her freedom of movement.¹³ The court also held that this was a restraint against which habeas corpus applied.¹⁴ However, because the restraint on Ms Antunovic's liberty was 'partial', the court left open the question of whether she was also being deprived of liberty or detained for the purposes of s 21 of the *Charter of Human Rights and Responsibilities Act 2006* (Vic) (the Charter) as it did not need to decide the issue.¹⁵

Subsequently, in *Stanev v Bulgaria* [2012] ECHR 46, the European Court of Human Rights determined that a man placed in a social care home was 'deprived of liberty' for the purposes of art 5 of the *European Convention on Human Rights*, notwithstanding the home was unlocked and he was permitted leave:

[T]he Court observes that the applicant was housed in a block which he was able to leave, but emphasises that the question whether the building was locked is not decisive. While it is true that the applicant was able to go to the nearest village, he needed express permission to do so. Moreover, the time he spent away from the home and the places where he could go were always subject to controls and restrictions.¹⁶

In *P v Cheshire West and Cheshire Council; P and Q v Surrey County Council* [2014] UKSC 19 (known as *Cheshire West*), the leading case in the United Kingdom (UK), the UK Supreme Court emphasised that there must be a universal standard for what constitutes a deprivation of liberty:

... what it means to be deprived of liberty must be the same for everyone, whether or not they have physical or mental disabilities. If it would be a deprivation of my liberty to be obliged to live in a particular place, subject to constant monitoring and control, only allowed out with close supervision, and unable to move away without permission even if such an opportunity became available, then it must also be a deprivation of liberty to a disabled person. The fact that my living arrangements are comfortable, and indeed make my life as enjoyable as it could possibly be, should make no difference. A gilded cage is still a cage.¹⁷

Accordingly, the court in *Cheshire West* held that the 'acid test' for whether a person in a social care situation who lacks the capacity to consent to their care/treatment arrangements is subject to a deprivation of liberty is whether the person is:

- under continuous supervision and control; and
- not free to leave.¹⁸

¹³ *Antunovic v Dawson* [2010] VSC 377, [76].

¹⁴ *Ibid*, [100]-[101], [176].

¹⁵ *Ibid*, [76].

¹⁶ *Ibid*, [124] (citations removed).

¹⁷ *P v Cheshire West and Cheshire Council; P and Q v Surrey County Council* [2014] UKSC 19, [46].

¹⁸ *Ibid*, [49].



In contrast to some earlier approaches, the UK Supreme Court also held that the following factors are *not* relevant to the question of whether a person is deprived of their liberty:

- Whether the facility is locked or lockable.¹⁹
- The person's lack of awareness of the detention.²⁰
- The person's compliance or lack of objection.
- The relative normality of the placement (whatever the comparison made).
- The reason or purpose behind a particular placement (regardless of how benevolent it is).²¹

Under what authority are these deprivations of liberty occurring?

In the absence of free and informed consent from the person concerned or a formal order from a court or tribunal, it is common practice for facilities to impose the restrictions relying on the informal consent of family members, or their belief that the common law doctrine of necessity or their duty of care permits or requires them to do so. However, it is increasingly accepted that depriving a person of liberty in these circumstances may not be lawful or compatible with human rights.

In 2004, the European Court of Human Rights' judgment in the *Bournewood* case significantly changed the legal landscape in this field in Europe. The case concerned a profoundly autistic and non-verbal man, HL, who was being detained and medicated in a hospital ward. Because he was compliant and did not resist, he had not been formally detained under the UK's *Mental Health Act 1983*. In the absence of HL's ability to provide informed consent to the restrictions, the hospital relied on the common law doctrine of necessity to authorise their actions. However, the European Court of Human Rights found that the lack of procedural safeguards regarding the initial admission and the lack of access to a court to review the lawfulness of the detention breached art 5(1) and (4) of the *European Convention on Human Rights*.

The *Bournewood* case is relevant to Australia, and in particular Victoria, because the Charter protects the right to liberty in extremely similar terms to art 5 of the *European Convention on Human Rights*. It is therefore quite possible that proceedings against a residential service provider in relation to a person who is effectively detained without their informed consent or any other formal authorisation could produce a similar result to the *Bournewood* case. The Victorian Law Reform Commission acknowledged this in its 2012 review of restrictions on liberty in residential care,²² and confirmed that '[t]here is no common law or statutory power permitting [a] family member or friend to provide substituted consent to these practices... [and] no statutory power, or any clear common law power, that permits the staff at the residential facility to undertake these practices'.²³

Despite the legality of the authority to impose such restrictions on liberty being in doubt, OPA believes this creates a greater imperative to recognise and provide oversight for them, particularly because the practices are so widespread (see also 'Why this matters' below).

¹⁹ *HL v UK* [2004] ECHR 471, [92]; also *P v Cheshire West and Cheshire Council; P and Q v Surrey County Council* [2014] UKSC 19, [43].

²⁰ *P v Cheshire West and Cheshire Council; P and Q v Surrey County Council* [2014] UKSC 19, [35].

²¹ *Ibid*, [50].

²² *Guardianship: Final Report*, 2012, p 329.

²³ *Ibid*, p 318.



The definition of ‘deprivation of liberty’ in art 4(2) of OPCAT includes restrictions imposed ‘by order of any... other authority’ (which is implicitly a non-judicial and non-administrative authority). Having regard to the important purposes of OPCAT, it is submitted that this should be understood to include the informal orders and directions given by residential service providers exercising power and control over their residents which deprive them of their liberty.

Are these places under the State’s jurisdiction and control?

As noted above, in order to constitute a ‘place of detention’, the place must be ‘under [the State’s] jurisdiction and control’, with the deprivation of liberty occurring ‘by virtue of an order given by a public authority or at its instigation or with its consent or acquiescence’. Social care facilities such as disability group homes, SRSs, aged care accommodation and mental health facilities fall within the State’s (in other words, Australia’s) jurisdiction and control for the following reasons:

- The State has enacted legislation which governs and regulates many of these places, such as the *Disability Act 2006* (Vic), the *Mental Health Act 2014* (Vic), the *Supported Residential Services (Private Proprietors) Act 2010* (Vic) and the *Aged Care Act 1997* (Cth) (and associated regulations).
- The State funds and/or provides financial subsidies to operators of these places.
- The State or public authorities operate and directly manage many of these places.
- Given the State is on notice about informal deprivations of liberty occurring in many of these settings (for instance, through reports such as the Victorian Law Reform Commission’s 2012 *Guardianship: Final Report*, which explored restrictions on liberty in residential care), and has taken no steps to end such practices, it can be considered that they are occurring with the consent and/or acquiescence of the State. This is particularly so where the State or a public authority has conducted an assessment and made recommendations which led to the person’s admission and consequent detention, such as an aged care assessment by the Aged Care Assessment Team (ACAT, or ACAS in Victoria).

Why this matters

While expanding the traditional conception of places of detention to include social care settings where people are informally detained will have cost implications, it is important for the NPM to have jurisdiction and responsibilities in relation to these places of detention for a range of reasons.

As noted above, the legality, necessity and justification for such practices are increasingly being called into question. However, many people with disability who are deprived of their liberty are vulnerable to coercion and pressure from those around them, have reduced ability to assert their rights and interests, and often have very limited contact with independent or external people (such as advocates or lawyers) who may be able to assist them. Existing regulation and oversight mechanisms across Australia are inconsistent and patchy.²⁴

²⁴ Australian Law Reform Commission, *Equality, Capacity and Disability in Commonwealth Laws*, Report 124, 2014, pp 248-251.



Furthermore, numerous inquiries and investigations²⁵ have confirmed that violence, abuse and other rights violations occur regularly against people with disabilities in residential and related services, even where motivations may be benign or well-intentioned, while people with disabilities and their supporters often struggle to satisfactorily report and have these issues addressed.

OPA endorses the position expressed in OPCAT's preamble that 'the protection of persons deprived of their liberty against torture and other cruel, inhuman or degrading treatment or punishment can be strengthened by non-judicial means of a preventive nature, based on regular visits to places of detention'. Ensuring that the jurisdiction and responsibilities of the NPM are understood to include these practices and places of detention is therefore critically important to help protect the rights of these vulnerable people.

2. The challenge of providing necessary information to the NPM

In order to enable NPMs to fulfil their mandate, OPCAT requires States to 'undertake to grant them... [a]ccess to all information concerning the number of persons deprived of their liberty in places of detention... as well as the number of places and their location'.²⁶ Given that many instances of deprivations of liberty in social care settings are currently imposed under an informal authority rather than through any explicit judicial or administrative order, and such practices are not currently recorded or reported, it will be challenging for Australia to comply with this obligation. Australia will therefore need to establish a mechanism to collect this information in order to provide the NPM with access to it.

Of relevance, the *Disability Act 2006 (Vic)* already contains mechanisms that require the approval, recording and/or reporting of particular 'restrictive interventions'²⁷ and civil detention used against people with disability, predominantly through the statutory role of the Senior Practitioner (Disability) which sits within the Office of Professional Practice in the Department of Health and Human Services. The Senior Practitioner has powers and functions under the Act for ensuring that the rights of persons who are subject to restrictive interventions and compulsory treatment are protected and that appropriate standards in relation to these practices are complied with.²⁸

Part 7 of the Act regulates the use of restrictive interventions falling short of detention, in particular chemical restraint, mechanical restraint and seclusion. Restraint and seclusion may only be used where particular criteria are met and they have been documented in a 'behaviour support plan'.²⁹ All behaviour support plans involving restraint or seclusion must be provided to the Senior Practitioner for review.³⁰

²⁵ See, for example, Office of the Public Advocate, *Violence against people with cognitive impairments: Report from the Advocacy/Guardianship program at the Office of the Public Advocate, Victoria*, 2010; Office of the Public Advocate, *Sexual assault in Supported Residential Services: Four case studies*, 2012; Victorian Ombudsman, *Reporting and investigation of allegations of abuse in the disability sector*, 2015; Senate Community Affairs References Committee, *Violence, abuse and neglect against people with disability in institutional and residential settings, including the gender and age related dimensions, and the particular situation of Aboriginal and Torres Strait Islander people with disability, and culturally and linguistically diverse people with disability*, 2015; Family and Community Development Committee, Parliament of Victoria, *Inquiry into abuse in disability services*, 2016; Australian Law Reform Commission, *Elder abuse – a national legal response*, 2017.

²⁶ OPCAT, art 20(a).

²⁷ Restrictive intervention 'means any intervention that is used to restrict the rights or freedom of movement of a person with a disability including chemical restraint, mechanical restraint [and] seclusion': *Disability Act 2006 (Vic)* s 3(1).

²⁸ *Disability Act 2006 (Vic)* ss 23-24.

²⁹ *Disability Act 2006 (Vic)* ss 140-141, 145.

³⁰ *Disability Act 2006 (Vic)* s 145(4).



The Senior Practitioner can also direct a disability service provider to prepare a behaviour support plan in relation to restrictive interventions other than restraint and seclusion.³¹ A disability service provider may only detain a person with intellectual disability in accordance with Part 8 of the Act, which, among other things, establishes a civil detention and compulsory treatment order called a 'supervised treatment order' (STO), for people with intellectual disability who pose a significant risk of serious harm to others.³² The Senior Practitioner must be notified of all STO applications and an application can only proceed if the Senior Practitioner issues a certificate.³³ The Senior Practitioner is responsible for supervising the implementation of all STOs.³⁴ As a result, the Senior Practitioner is a repository of information about all civil detentions of people with disabilities who are civilly detained or subject to significant restrictive interventions under the Act.

OPA is currently exploring options for legal and practice reform in this area with a view to creating a framework for regulating what are currently informal deprivations of liberty. In order to support the Australia's OPCAT obligations and bring greater transparency and accountability to existing practices, the proposed framework would involve some mechanism to ensure formal recording of all deprivations of liberty and the places in which they occur.

3. The importance of meaningfully involving people with lived experience

It is important to ensure that people with disability and with lived experience of detention and other practices that OPCAT covers are meaningfully involved in all aspects of the implementation and operation of OPCAT. As well as consultation about implementation, they should also be involved in training those carrying out NPM functions, and where possible included as members of the teams undertaking NPM visits and inspections.

People with disabilities and with lived experience of the practices and places of detention will often notice different things and be better able to gain information from the people subject to detention during inspection visits, which increases the validity and effectiveness of the exercise. For this reason, the unique expertise, perspectives and insight of people with lived experience is well recognised in other jurisdictions such as the United Kingdom, where service users are now routinely included in a wide range of review, audit and inspection teams.

The *ITHACA Toolkit for Monitoring Human Rights and General Health Care in Mental Health and Social Care Institutions*,³⁵ designed for OPCAT NPMs and others, is a well-considered, practical guide to effective monitoring of human rights in these particular settings. It encourages the involvement of service users and people with disabilities in monitoring and making recommendations following inspections wherever possible.³⁶ The *ITHACA Toolkit* will also be useful when considering how Australia's new NPM can best carry out its functions.

³¹ *Disability Act 2006* (Vic) s 150(2)(b).

³² *Disability Act 2006* (Vic) pt 8, div 5.

³³ *Disability Act 2006* (Vic) s 191(3).

³⁴ *Disability Act 2006* (Vic) s 195(1).

³⁵ ITHACA Project Group, 2010, available at <http://www.mdac.info/en/resources/ithaca-toolkit>

³⁶ *Ibid*, p 5.



4. Role of Community Visitors

As noted in the Consultation Paper, the Australian Government has decided to vest the NPM function across multiple federal, state and territory bodies, which will enable states and territories to harness and adapt existing inspection mechanisms. OPA coordinates one of the existing inspection mechanisms in Victoria, the Community Visitors Program.

OPA's Community Visitors are volunteers empowered under the *Disability Act 2006* (Vic), the *Supported Residential Services (Private Proprietors) Act 2010* (Vic) and the *Mental Health Act 2014* (Vic) to visit Victorian disability accommodation services, supported residential services and mental health facilities to monitor and report on the adequacy of services provided in the interests of residents and patients. In 2015-16, Community Visitors conducted 5268 site visits to 1356 facilities across Victoria.

Community Visitors observe the environment and staff interaction with residents and patients, make enquiries and inspect documents, and where possible communicate with residents and patients to ensure they are being cared for and supported with dignity and respect, and to identify any issues of concern. They visit unannounced and write a brief report at the conclusion of the visit detailing whom they have spoken to, what documents they have looked at, any issues of concern, as well as good practice they have observed.

Community Visitors raise issues with management of the service and the Department of Health and Human Services and, in cases of abuse or neglect, Community Visitors notify the Public Advocate. The findings, observations and recommendations of Community Visitors are compiled in their annual report to Victorian Parliament.

Community Visitors are also well-placed to identify and monitor systemic issues occurring in these settings. For example, under the *Mental Health Act 2014* (Vic), Community Visitors visit mental health services, including acute and secure extended care units. Over the years, they have identified many patients who are ready for discharge but who continue to be detained in locked mental health units due to a lack of alternative accommodation and support. Community Visitors continue to monitor the numbers and reasons for long-stay patients in these settings, and report current data in their annual report.

Under the *Disability Act 2006* (Vic), among other things, Community Visitors visit residential facilities and make inquiries regarding the facilities' use of restrictive interventions and compulsory treatment.

Community Visitors, however, are not empowered to inspect or report on aged care facilities or other places where people with disabilities may be detained outside the auspices of the three enabling Acts referred to above.

OPA envisages that the Community Visitors Program may be designated as an NPM body, along with other bodies. However, the current mandate and practical capabilities of the Community Visitors would need to be expanded to meet OPCAT requirements.