Mr Alan Cameron AO
Commissioner
New South Wales Law Reform Commission
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By email: nsw-lrc@justice.nsw.gov.au

12 May 2017

Dear Commissioner

Submission to the *Review of the Guardianship Act 1987 (NSW)* Question Paper 5: Medical and dental treatment and restrictive practices, Section 7 (Restrictive Practices)

Executive summary

We provide the following comments and recommendations in relation to section 7 (Restrictive practices) of Question Paper 5:

1. The current regulation of restrictive practices in Australia is problematic, inconsistent, unclear and uncertain, unjustifiable at common law, and fails to properly protect the vulnerable cohort subject to these practices.

2. In the absence of a national legislative framework, legislation should be introduced in New South Wales to regulate the use of restrictive practices.

3. Guardianship legislation is not an appropriate mechanism to regulate restrictive practices. New South Wales should instead introduce an administrative legislative model of regulation.

4. Any legislative or regulatory framework introduced in New South Wales should:

    - contain appropriate safeguards to protect the vulnerable cohort of people subject to restrictive practices from abuse, neglect and exploitation.

    - apply to both the public and private sectors, not just government-funded services.

    - aim to realise the rights to liberty and security for people with disability on an equal basis with others, as reflected in the *Convention on the Rights of Persons with Disabilities.*

Background

We are a PhD student, the Directors and Coordinator of the Australian Centre for Health Law Research (ACHLR), a specialist research centre within the Queensland University of Technology's Faculty of Law. The Centre undertakes empirical, theoretical and doctrinal research into complex problems and emerging challenges in the field of health law, ethics, technology, governance and public policy.

This submission builds upon our preliminary submission to this Review dated 4 April 2016.
We provide this submission in response to section 7 of Question Paper 5, which relates to restrictive practices. This submission is based on work undertaken as part of Ms Chandler's PhD thesis on restrictive practices, which has culminated in three collaborative articles[1] which identify specific issues relating to current restrictive practices regimes in Australia which require further consideration, analysis and legal reform. We enclose these articles for your consideration.

Please note that Chandler, White and Willmott's forthcoming article for the *Monash Law Review* has been accepted by the journal but has not yet been published. Accordingly, we enclose a copy of the article to you in confidence and request that it not be circulated outside of the NSWLRC.
The Commission is welcome, however, to cite content or ideas from the article, provided the article is cited as 'forthcoming'.

Response to Section 7, Question Paper 5

This submission provides a brief overview of our views in relation to the law and regulation of restrictive practices in New South Wales. These views are explained more fully in the three journal articles by Chandler, White and Willmott, which are enclosed for your consideration.

Current problems with the regulation of restrictive practices in Australia

Our research has identified a number of significant problems relating to the regulation of restrictive practices in Australia, including:

i. *No basis for restrictive practices under common law*

In our view the legal basis for the detention and restraint of people with intellectual impairment in Australia is ad hoc and unclear, and Australian common law does not support the lawful use of restrictive practices, for the reasons noted in Chandler, White and Willmott's article in *Psychology, Psychiatry and Law*.[2] Given the common law does not support the lawful use of such practices, but they continue to be used in a variety of settings (including disability services, aged care services, hospitals and other health facilities), we consider a statutory approach to the regulation of restrictive practices is needed in jurisdictions where this conduct is currently unregulated, including in New South Wales.

ii. *Law is inconsistent*

In Australia there is no consistent, comprehensive national legal framework that authorises and regulates restrictive practices. Though some jurisdictions have specific restrictive provisions in their guardianship legislation (Queensland and Tasmania), others confer on guardians, through legislation, 'coercive powers' (NSW, 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

[1] Kim Chandler, Ben White and Lindy Willmott, 'What role for adult guardianship in authorising restricted practices?' (2017) *Monash Law Review* (forthcoming); 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(3) *Psychology, Psychiatry and Law* 361-387; Kim Chandler, Lindy Willmott and Ben White, 'Rethinking restrictive practices: a comparative analysis' (2014) *QUT Law Review* 90-122.
[2] 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) *Psychology, Psychiatry and Law* 361-387, 362.

Western Australia).[3] This is problematic, especially given that key sectors where restrictive practices occur, such as the aged care system, are also regulated at the national level.

Also troubling is inconsistency in legal approach within a jurisdiction.[4] For example, Queensland and Tasmania specifically regulate restrictive practices through their guardianship system, but 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.

We consider a national or nationally consistent approach to regulating restrictive practices is desirable rather than a state/territory approach, encompassing all sectors, including the disability sector, and public and privately funded services.

iii. *Law is unclear and uncertain*

There are a number of ways in which restrictive practices are currently authorised under Australian guardianship systems. These include:

- Specific provisions in guardianship legislation (Queensland[5] and Tasmania[6]).
- Under the health care/medical treatment function.[7]
- Under the accommodation function.[8]
- Authorisation based on the implied breadth of guardians' powers.[9]
- Reliance on coercive powers.[10]

These possible bases for authorisation are analysed comprehensively in the *Monash Law Review* article.[11] For the reasons noted in that article, these options are problematic, unclear and uncertain at law, and do not provide adequate legal basis for the authorisation of restrictive practices.[12]

iv. *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 they may offend the principle of legality. This is because there is a granting or recognition of power to make decisions about restrictive practices

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[3] Kim Chandler, Ben White and Lindy Willmott, 'What role for adult guardianship in authorising restricted practices?' (2017) *Monash Law Review* (forthcoming) 24.
[4] Ibid.
[5] *Guardianship and Administration Act 2000* (Qld) Chapter 5B (Restrictive Practices).
[6] *Disability Services Act 2011* (Tas) Part 6 (Regulation of Restrictive Interventions).
[7] For a comprehensive discussion of authorisation of restrictive practices as medical treatment or health care, see Kim Chandler, Ben White and Lindy Willmott, above n 3, 7-15.
[8] For a comprehensive discussion of authorisation of restrictive practices under the accommodation function, see Chandler, White and Willmott, above n 3, 15-16.
[9] For a comprehensive discussion of authorisation based on the implied breadth of guardians' powers, see Chandler, White and Willmott, above n 3, 17-22.
[10] For a comprehensive discussion of authorisation based on reliance on coercive powers, see Chandler, White and Willmott, above n 3, 22-23.
[11] Ibid, 6-23.
[12] J Allen and T Tulich, '"I Want to Go Home Now": Restraint Decisions for Dementia Patients in Western Australia' (2015) 33(2) *Law in Context* 1, 20.

without specific legislative authorisation. Further discussion of the principle of legality is contained in the *Monash Law Review* article.[13]

v. ***Lack of protection for vulnerable people, and persons utilising those practices***

As noted above, in some jurisdictions the use of restrictive practices in other environments such as aged care facilities, hospitals and privately funded disability services remain unregulated. This poses potential risks to the rights of vulnerable people subject to restrictive practices in those settings. A related issue is whether it is lawful, in the absence of a regulatory or legal framework, for health professionals, support workers and others to detain or restrain people. In doing so, there is a risk they may be exposed to criminal and civil liability.

These problems require thorough consideration when determining how New South Wales should regulate restrictive practices.

Legislation to regulate restrictive practices in New South Wales

In New South Wales, it appears that the guardianship regime is currently the basis on which restrictive practices are being authorised; however it would appear these practices are also occurring without authorisation. In the absence of a national approach, we consider that legislation is needed to appropriately regulate restrictive practices in New South Wales, rather than permitting these practices to continue unregulated or inadequately regulated.

Regulatory regimes for restrictive practices perform important functions including regulation of minimum standards of care and support; ensuring such practices are subject to approval, review, oversight and monitoring; and protecting health professionals and providers from civil and criminal liability.[14] Any legislation should include review mechanisms to ensure transparency and oversight of the regulatory regime following its implementation.

Problems with regulating restrictive practices through guardianship regimes

The appropriateness of guardianship legislation to regulate restrictive practices is explored comprehensively in Chandler, White and Willmott's forthcoming article in the *Monash Law Review*. Briefly, as discussed in that article, we consider guardianship legislation is a problematic mechanism for the regulation of restrictive practices for the following reasons:

i. ***Guardianship as a default home for restrictive practices is a modern assumption***

Though guardianship has been considered in Australia 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), historically the detention or restraint of people with mental illness or intellectual impairment was facilitated or authorised by the *parens patriae* jurisdiction or a committee of the person.[15] The modern tendency to utilise guardianship to authorise detention and restraint of people with intellectual impairment in community settings is a new development

[13] Chandler, White and Willmott, n 3, 26.
[14] Kim Chandler, Lindy Willmott and Ben White, 'Rethinking restrictive practices: a comparative analysis' (2014) *QUT Law Review* 90-122.
[15] See detailed discussion of this issue in Chandler, White and Willmott, n 3, 27-28.

and invites us to reconsider the assumption made by some that guardianship is an appropriate vehicle for regulating restrictive practices.[16]

ii. *Restrictive practices risk losing the adult focus of guardianship systems*[17]

An important 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. At the centre of guardianship systems are adults with impaired capacity. 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.

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 (inappropriately, in our view) 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. 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.

Continued regulation of restrictive practices therefore reduces the focus of guardianship systems on the rights and interests of vulnerable adults.

iii. *Guardianship systems as currently designed lack sufficient safeguards*

In stark contrast to other regimes that deprive people of liberty and security such as the involuntary treatment frameworks under mental health legislation, there are not sufficient safeguards for decisions about restrictive practices in the guardianship system (for example, 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). Though some tribunals do attempt to impose safeguards when making their orders, where there is no legislative framework, these safeguards remain on a weaker footing. More importantly, tribunals are only involved in a small number of restrictive practices cases.

While there are some legislative safeguards in Queensland and Tasmania (which have specific provisions in guardianship legislation authorising guardians to consent to restrictive practices), the reliance on guardians as the primary decision-maker for restrictive practices is insufficient, for a number of reasons:

- 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.[18] Of course, a guardian will often know

[16] Ibid.

[17] Ibid, 28-30.

[18] Michael Williams, John Chesterman and Richard Laufer, 'Consent versus scrutiny: Restricting liberties in post-Bournewood Victoria' (2014) 21 *Journal of Law and Medicine* 641, 656; Australian Law Reform Commission, *Equality, Capacity and Disability in Commonwealth Laws*, Report No 124 (2013), 245 [8.12], 252-3 [8.45]-[8.46]; Australian Government, *National Framework for Reducing and Eliminating the Use of Restrictive Practices in the Disability Service Sector* (2014) <https://www.dss.gov.au/our-responsibilities/disability-and-carers/publications-articles/policy-

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 can arise and require specialist health or medical expertise.[19] Given guardians will generally not have such expertise, there is a risk that they will be 'rubber stamping' poor practices in disability 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. [20]

- 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. For example, 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.

- 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 they that 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.

Given the significant problems identified above, we submit that restrictive practices should not be regulated under the New South Wales Guardianship Act, and that options other than guardianship legislation should be considered to regulate restrictive practices in New South Wales.

Legislating restrictive practices in New South Wales

We recommend that consideration be given to introducing a legislative administrative model, such as those currently in place in Victoria and the Northern Territory, to regulate restrictive practices in New South Wales, but with the following additions:

- further procedural safeguards; and
- mechanisms to address fundamental inequalities that lead to over-reliance on restrictive practices.

An administrative model of restrictive practices

The current administrative models rely on an existing administrative decision-maker such as the secretary or chief executive officer of the department in which the services are provided or funded to approve or authorise the use of restrictive practices. Within the context of the current restrictive

research/national-framework-for-reducing-and-eliminating-the-use-of-restrictive-practices-in-the-disability-service-sector>.

[19] Williams et al, above n 20, 654.

[20] See also Williams et al, above n 20, 655, which describes the risk of a 'mechanistic' use of guardianship just to authorise existing practice. See also John Chesterman, 'Restrictions on the Liberty of People with Disabilities: The View from the Office of the Public Advocate' in B Naylor, J Debeljak, I Dussuyer and S Thomas (eds), *Monitoring and Oversight of Human Rights in Closed Environments* (Melbourne University Law Chambers, 2010) 75.

practices regimes, most restrictive practices are approved by an administrative decision-maker, such as the secretary or chief executive office of the relevant state's human services department or a senior officer in a disability service.[21]

In one sense the administrative model fits well with the overall objective of the regulatory regimes that are aimed at regulating the standards of care provided in state-funded disability services in that it enables the respective human services departments to maintain greater control over the delivery of support services in state-funded or provided disability services. These models however, the authors believe, offer insufficient safeguards. In particular there is not sufficient independence of the entities that consent to the use of restrictive practices from the entities that are seeking to use the restrictive practices.

Further discussion about the models currently in place in Victoria, Tasmania and the Northern Territory are detailed in Chandler, White and Willmott's article in the *QUT Law Review*.[22]

Further procedural safeguards for the use of restrictive practices

Regardless of the legislative model adopted in New South Wales, any legislation adopted must include robust safeguards for decision-making about restrictive practices.[23] These safeguards are needed not only to ensure good decision-making for individuals but to drive changes to practice to reduce reliance on restrictive practices at a systems level.[24]

Restrictive practices such as detention, seclusion and physical, chemical and mechanical restraint constitute serious infringements on a person's human rights. We consider any restrictive practices framework introduced in NSW (or nationally) must:

- Provide appropriate safeguards to protect the vulnerable cohort subject to restrictive practices from abuse, neglect and exploitation.

- Ensure the scope of any regulatory framework encompasses both the public and private sectors and all settings where restrictive practices are used on people with impaired capacity.

- Contain 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.[25] Examples include review mechanisms to ensure transparency and oversight of the regulatory regime following its implementation; ongoing oversight and monitoring of practices; regulation of minimum standards of care and support; and protecting health professionals and providers from civil and criminal liability.

A regime which enforces and maintains safeguards is particularly important given the rollout of the National Disability Insurance Scheme is likely to result in state governments increasingly stepping back from the role of providing disability services, and funding non-government organisations to provide these services.

[21] Chandler, Willmott and White, above n 17, 98.
[22] Ibid, 98-100.
[23] Allen and Tulich, above n 14, 22.
[24] Australian Government, above n 20.
[25] Chandler, White and Willmott, above n 3, 33.

Provisions in New South Wales legislation for restrictive practices

With respect to questions 7.3 to 7.6 in Question Paper 5 concerning the details of any restrictive practices regulatory framework the authors offer the following submissions:

i. ***Restrictive practices regulated***

Restrictive practices regulated should include:

- detention/ containment,
- seclusion,
- chemical, physical and mechanical restraint,
- environmental restraints, and
- restricting access to objects.

The regulatory framework must have a 'sliding scale' of procedural safeguards depending on the nature of the practices being authorised. Arguably practices such as detention/containment should have greater procedural safeguards than the use of, say, restricting access to objects. Any restrictive practices that have a 'punitive' element, such as certain psycho-social restraints and consequence given practices, should never be utilised given the potentially demeaning impact on people with disability.

ii. ***What sectors should be regulated***

The authors do not see any justification for regulating the use of restrictive practices in government-funded disability services, but not in other facilities, for example aged care facilities or other health facilities (such as rehabilitation services for people with acquired brain injury). Regardless of the environment in which they are utilised restrictive practices are unlawful (unless authorised, justified or excused by law); represent a significant infringement on the right to equality and security for people with disability; and have a negative impact on the well-being of people with disability.

iii. ***Criteria for the use of restrictive practices***

While the authors do not offer an extensive list of criteria for the use of restrictive practices (guidance can be found from many existing restrictive practices regulatory frameworks) there should be a prohibition on utilising such practices for certain purposes including:

- the convenience of staff;
- as punishment for 'bad' or 'challenging' behaviors'; or
- in lieu of appropriate support services; environment or accommodation.

The use of such practices would never be tolerated for these reasons on other members of the population, so should not be tolerated for vulnerable people with disability. As discussed above, these reasons are also antithetical to the fiduciary nature of guardianship.

Further, the entity providing criteria must be required to seek and take into account the views, wishes and preferences of:

- the person subject to restrictive practices; and
- the person's guardian or other members of the person's supportive network.

iv. *Consent/authorisation*

While the authors prefer the use of an 'administrative' model to regulate restrictive practices, as opposed to a guardianship model, there must be further safeguards than those currently in, for example, the Victorian model, where the service provider seeking to use the restrictive practice authorises the practice, albeit with oversight by the Senior Practitioner.

Authorisation, particularly for those practices that impact significantly on a person's right to liberty and security (detention/ containment and seclusion); as well as physical, chemical and mechanical restraint must be given by an independent entity (that is, not the service provider seeking to use the practice, or the department that funds that service provider). In the case of practices such as detention, there is a strong argument that, to be consistent with other regulatory regimes for involuntary detention or civil commitment, there should also be a right to review by an independent tribunal or court.

v. *Oversight/systemic advocacy*

Because of the extreme vulnerability of those persons subject to restrictive practices, including significant barriers to complaining about the use of such practices, there must be independent oversight and monitoring of facilities which use restrictive practices. The extreme risks faced by those who live in 'closed environments' to abuse, neglect and exploitation are amplified in the case of people with intellectual and cognitive impairments.

vi. *Addressing fundamental inequalities*

The authors also argue that any approach to the regulation of restrictive practices must go beyond the provision of appropriate procedural safeguards, such as reviews by independent courts or tribunals; clear and objective criteria for treatment/ detention; and independent oversight (although those safeguards remain very important). What is also needed is an approach to the regulation of restrictive practices that aims to realise the rights to liberty and security for people with disability on an equal basis with others - that is, an approach to equality that is not dependent on a certain physical, intellectual or cognitive status; that recognises that people with disability are holders of rights, not simply subjects of welfare; and that recognises that people start from certain points of structural disadvantage. This approach is reflected in the *Convention on the Rights of Persons with Disabilities* ('the CPRD').[26]

The CPRD represents a significant paradigm change[27], one that must be integrated into any contemporary regulatory framework for restrictive practices that is aimed at ensuring equality for people with disability.

First, the CRPD challenges the medical idea of disability, that is, that disability is defined by a person's impairment, including mental impairment, and is based on what is known as the social model of disability. The social model of disability locates a person's disadvantage or discrimination in

[26] Theresia Degener, 'Disability in a Human Rights Context' (2016) 5 *Laws*, 35.

[27] Rosemary Kayess and Philip French 'Out of Darkness Into Light? Introducing the Convention on the Rights of Persons with Disabilities' (2008) 8 (1) *Human Rights Law Review*, 3. Kayess and French point out that it was Ambassador Mackay, Chairman of the Ad Hoc Committee that developed the Convention on the Rights of Persons with Disabilities that characterized the Convention as embodying a 'paradigm shift'. Whereas Glen points out that it was Thomas Kuhn who first coined the actual expression 'paradigm shift' in his book The Structure of Scientific Revolution (1962) Kristen Booth Glen, 'Changing Paradigms: Mental Capacity, Legal Capacity, Guardianship, and Beyond' (2012-13) 44 *Columbia Human Rights Law Review*, 93, 96.

the social environment, rather than the person's impairment.[28] The definition of disability in Article one of the CPRD emphasises interaction between impairment and social and structural barriers to equality.[29]

The CPRD also has foundations in a human rights model that recognises the inherent and intrinsic dignity of human beings, regardless of differences, including impairments. Importantly, the CPRD also introduces a new definition of discrimination. Article two defines discrimination on the basis of disability that, not only encompasses direct and indirect indiscrimination, but also the denial of 'reasonable accommodations.'[30] 'Reasonable accommodation' is defined as:

> 'necessary and appropriate modifications and adjustments not imposing a disproportionate or undue burden, where needed in a particular case, to ensure to persons with disabilities the enjoyment or exercise on an equal basis with others of all human rights and fundamental freedoms.'[31]

Article 14 states that state parties must ensure that people with disabilities enjoy liberty and security on the same basis as others. It also states that in no case should having a disability be justification for a being deprived of liberty or security. Read with the overarching responsibility of non-discrimination, or the obligation to make reasonable accommodations in article 5, this could involve for example providing for habiliation and rehabilitation (as demanded by article 26 that obliges state parties to 'enable persons with disabilities to obtain their maximum independence, full physical, mental, social and vocational ability, and full inclusion and participation in all aspects of life') to ensure people with disability have an equal opportunity to realise their rights to liberty and security.

French, Chan and Carracher indicate for example that for people with cognitive impairment who engage in 'behaviours of concern', realising the right to liberty and security may also include the availability of skilled support staff 'to assist the person to realise their positive developmental potential.'[32] Therefore, while laws that authorise the curtailment of liberty and security of people with intellectual and cognitive impairments may contain certain safeguards, they will not be consistent with an approach that recognises that people with disability have human rights on an equal basis with others if they do not also address underlying inequality that impact on the ability of people with disability to realise these rights.

Legislation that restricts the rights to liberty and security of people with intellectual and cognitive impairments should also place an obligation on the state to ensure that people with disability have access to appropriate support services; to services for rehabilitation and habilitation; support to access the community and to be included in the community, to name but a few. These obligations must be part of the criteria for the use of restrictive practices. Without such obligations there is a real risk that any regulatory regime for restrictive practices becomes a rubber stamp which simply authorises these practices but does not improve the quality of service provision provided to people with disability.

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[28] Kayess and French, above n 28, 6.

[29] *Convention on the Rights of Persons with Disabilities*, opened for signature 30 March 2007 [2008] ATS12 (entered into force 3 May 2008) article 1; Sandra Fredman, 'Emerging from the Shadows: Substantive equality and Article 14 of the European Convention on Human Rights' (2016) 16 *Human Rights Law Review*, 273, 279.

[30] *Convention on the Rights of Persons with Disabilities*, opened for signature 30 March 2007 [2008] ATS12 (entered into force 3 May 2008) article 2.

[31] *Convention on the Rights of Persons with Disabilities*, opened for signature 30 March 2007 [2008] ATS12 (entered into force 3 May 2008) article 2.

[32] Phillip French, Jeffrey Chan and Rod Carracher, 'Realizing Human Rights in Clinical Practice and Service Delivery to Persons with Cognitive Impairment who Engage in Behaviours of Concern' (2010) 17(2) *Psychiatry, Psychology and the Law*, 245, 265.

Thank you for the opportunity to contribute to this review. We would be pleased to assist the Commission further if additional information is required.

Yours sincerely

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