Victorian Equal Opportunity and Human Rights Commission

Comments on the Department of Health's Mental Health Bill 2010 Exposure Draft

15 March 2011

(Amended 24 March 2011)

Victorian Equal Opportunity
& Human Rights Commission

ABOUT THE COMMISSION

The Victorian Equal Opportunity and Human Rights Commission is an independent statutory body with responsibilities under three laws:

- Equal Opportunity Act 1995
- Racial and Religious Tolerance Act 2001
- Charter of Human Rights and Responsibilities Act 2006

The Equal Opportunity Act makes it against the law to discriminate against people on the basis of a number of different personal characteristics.

The Racial and Religious Tolerance Act makes it against the law to vilify people because of their race or religion.

Under the Equal Opportunity Act and the Racial and Religious Tolerance Act, the Commission helps people resolve complaints of discrimination, sexual harassment and racial or religious vilification through a free and impartial complaint resolution service with the aim of reaching a mutual agreement.

The Charter of Human Rights and Responsibilities means that government and public bodies must comply with human rights and must consider relevant human rights when making decision. The Commission's role is to educate people about the rights and responsibilities contained in the Charter and to report annually to the Victorian Government about the operation of the Charter. The Commission does not handle complaints related to the Charter.

Services provided by the Commission include:

- a free telephone enquiry line
- a free and impartial dispute resolution service
- information and education about equal opportunity, racial and religious vilification and the Charter of Human Rights and Responsibilities
- education, training and consultancy services.

INTRODUCTION

1.1 Overview

The Commission welcomes the opportunity to comment on the Exposure Draft of the Mental Health Bill ('the Exposure Draft').

A review of the *Mental Health Act 1986* (Vic) is a unique opportunity to address serious human rights issues in mental health treatment and care, making this endeavour one of the most important legislative reviews within Victoria in recent times.

The Review of the Mental Health Act is a significant process of law reform. It seeks to tackle one of the oldest mental health laws in Australia and to look at it through a human rights lens. It seeks to grapple with behaviours and treatments that are stigmatised. It raises questions about whether this is an area that should be regulated separately to existing laws on health and guardianship. It sends a message about how people with mental illness are viewed in our community.

This submission addresses the following key issues from the Exposure Draft:

- Human rights and the legislative review process
- Involuntary treatment
- Protections around the use of electro-convulsive therapy and psychosurgery
- Advanced directives
- How capacity is assessed
- Treatment of children
- Timeliness of reviews and second opinions
- Role of family and carers, information sharing and relationship to the Guardianship Act
- Operation of the Mental Health Tribunal
- Legal representation and the role of review officers
- Respecting cultural rights, and
- Implementing a human rights culture.

1.2 Background

1.2.1 Charter obligations

Domestically, the Victorian Parliament has adopted human rights legislation that enshrines and protects certain human rights in the *Charter of Human Rights and Responsibilities Act 2006* ('the Charter').

The Charter promotes human rights dialogue between the executive, the legislature, the judiciary and the community.

Section 28 of the Charter requires the legislature, when enacting legislation, to consider the consistency of proposed legislation with human rights protected under the Charter.[1] The Charter also directs the Courts to consider whether mental health laws are consistent with human rights principles under section 32 when they are considering relevant cases.

Under section 38 of the Charter, public authorities must act in a way that is compatible with human rights, and give proper consideration to Charter rights when making decisions.

1.2.2 Equal Opportunity

In April 2010 the Victorian Parliament passed the *Equal Opportunity Act 2010* ('the EOA 2010'). The objectives of the EOA 2010 are to encourage the identification and elimination of discrimination, sexual harassment and victimisation and their causes, and to promote and facilitate the progressive realisation of equality. The new provisions of the EOA 2010 take effect from 1 August 2011 and include a legal obligation for service providers to comply with a 'positive duty' to take reasonable and proportionate measures to eliminate discrimination, sexual harassment and victimisation as far as possible. Mental illness is a protected attribute under the definition of 'impairment' under the Equal Opportunity Act.

This has relevance for the exposure draft in two key ways. Firstly, the legal obligation of the new positive duty will be a relevant consideration for providers of mental health services and will need to be taken into account in the operationalisation of the Mental Health Act. Secondly, the amendments to the Equal Opportunity Act in 2010 were the result of an important recognition of the need to address systemic discrimination.

The Commission is disappointed to see a policy approach in the Exposure Draft that actively works against this by entrenching discrimination. Aspects of the current Draft will have the effect of continuing to make lawful discrimination against persons with mental illness. This is particularly concerning where the proposed legislation provides insufficient support or safeguard for people with a mental illness who will, at critical times, find it difficult to advocate for themselves.

1.2.3 International human rights law

Human rights protections also exist in relevant international conventions to which Australia is therefore a party. These include:

- the International Covenant on Civil and Political Rights (ICCPR);[2]
- the International Covenant on Economic, Social and Cultural Rights (ICESCR); [3]
- the International Convention on the Rights of Persons with Disabilities (CRPD);[4]
- the Convention on the Rights of the Child (CRC);[5]

[1] Under section 29 of the Charter, a failure to comply with section 28 of the Charter does not render the law invalid if it is inconsistent with human rights principles.
[2] *International Covenant on Civil and Political Rights,* opened for signature on 19 December 1966, 999 UNTS 171, entered into force 23 March 1976.
[3] *International Covenant on Economic, Social and Cultural Rights,* opened for signature on 19 December 1966, 999 UNTS 3, entered into force 3 January 1976.
[4] *International Convention on the Rights of Persons with Disabilities*, opened for signature on 30 March 2007, 611 UNTS 66, entered into force 3 May 2008.

- the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW);[6] and
- the Convention Against Torture and other Cruel, Inhuman and Degrading Treatment or Punishment (CAT).[7]

The CRPD is the most recent of the UN conventions on human rights and Australia has accepted international legal obligations under this instrument.

Any reform in Victorian mental health law should be consistent with the human rights principles articulated in the Charter and in the CRPD. Notably, section 32(2) of the Charter requires that international law, including the CRPD is to be considered in interpreting the Charter provisions.

1.2.4 Human rights may be limited

In recognising that human rights protections are vital in mental health, the Commission also notes the Siracusa principles[8] and the general limitation clause contained in section 7(2) of the Charter, which is modelled on these principles. These provisions mean that the protection of and adherence to human rights does not automatically preclude any limitation on rights. However, section 7(2) of the Charter provides that such limits on human rights must be reasonable and demonstrably justified in a free, democratic society based on human dignity, equality and freedom depending on the nature of the right and the importance of the limitation.

This provides an important legal framework within which to assess limitations on the rights of Victorians.

DEFINITIONS

Terms used in this submission are consistent with the definitions provided to those terms in the Exposure Draft.

SCOPE OF THE SUBMISSION

1.3 Access

The Commission recognises that there is a distinction between involuntary treatment and access to mental health services. This submission addresses the legislative aspects of the Exposure Draft.

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[5] *International Convention on the Rights of the Child*, opened for signature on 20 November 1989, 1577 UNTS, 3, entered into force 2 September 1990.
[6] *Convention on the Elimination of All Forms of discrimination against Women*, opened for signature on 18 December 1979, 1249 UNTS 13, entered into force 3 September 1981.
[7] *International Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, opened for signature on 10 December 1984, 1465 UNTS 85, entered into force 26 June 1987.
[8] United Nations, Economic and Social Council, 'U.N. Sub-Commission on prevention of discrimination and protection of minorities, Siracusa Principles on the limitation and derogation of provisions in the International Covenant on Civil and Political Rights,' Annex, UN Doc E/CN.4/1984/4 (1984).

A more in depth discussion of access to mental health services and the mental health service system is beyond the scope of this submission. However, the Commission acknowledges that a large number of people with mental illness (for example, documented in the *Not for Service* Report[9] and in the Senate Committee report[10]) wish to access mental health services in Victoria, but cannot do so due to a lack of resources in the service system.

This has implications for involuntary treatment truly being an option of last resort or people having a true ability to consent to treatment. There is a risk that due to lack of services, either involuntary treatment occurs or a person consents to treatment she or he does not really want, simply because there is a lack of choice or it is perceived to be the only option by which to access a mental health service.

The Commission recognises that lack of access to mental health services is inconsistent with human rights and requires redress.

1.4 Women on involuntary treatment orders

Further, the Commission has also identified that women with mental illness may be especially vulnerable to human rights abuses in the context of in-patient and closed environments.[11]

The Commission urges the Government to give specific consideration to according human rights protections to women with mental illness who are on involuntary treatment orders in an in-patient environment, when considering the content of the Exposure Draft.

1.5 Key principles informing this submission

The Commission submits that involuntary treatment of illness (while detained in a mental health service or in the community)[12] in Victoria should only be authorised in a manner that is consistent with human rights principles.

Human rights law provides the necessary legal framework to eliminate arbitrariness and unreasonableness in clinical decision-making. It provides the basis for maximising opportunities for people with mental illness to reach their full potential and to achieve full participation and inclusion in society. This is particularly important when compulsory treatment is imposed.

Relevant human rights principles include taking measures to promote the autonomy of the person subject to involuntary treatment and ensuring that the treatment is subject to strict

[9] Human Rights and Equal Opportunity Commission, *Not For Service Report* (2005).
[10] The Senate Select Committee on Mental Health, *A National Approach to Mental Health –From Crisis to Community –First Report*, March 2006.
[11] Heather Clarke, Victorian Women and Mental Health Network, *Women at Risk of Abuse in Mixed Sex Psychiatric Wards*, 2008.
[12] The Commission notes the comparatively high rate of CTOs in Victoria as compared with other jurisdictions in Australia. The Commission emphasises that CTOs authorise involuntary treatment for mental illness and therefore limit rights in a manner similar to people who receive involuntary treatment while detained in a mental health service.

safeguards. They also include ensuring that any limit on the person's right to privacy and right to liberty and security of person (ie the general right to be free from medical treatment without consent only be limited when reasonable and no less restrictive alternative is available), and ensuring that the treatment is subject to timely, regular and independent review.

The Commission does not have the expertise to comment on the detailed aspects of clinical and procedural matters that the new Act will necessarily address.

1.6 Disability Reference Group member views

In preparing this submission, the Commission consulted with members of the Commission's Disability Reference Group ('DRG'). The DRG members meet quarterly with the Commission. The aims of the Group include assisting the Commission to identify human rights priorities affecting people with disabilities and providing advice to the Commission on the development of policies and procedures.[13]

This is the Commission's submission, but it is informed by discussion with the DRG and key concerns of DRG members are noted in relevant areas. The Commission notes that members of the DRG expressed differing views about what should be included in the review of the Mental Health Act. General community views about mental health treatment and care are not included in this submission.

DRG members expressed views in relation to the following issues, which will be discussed in more detail throughout this submission:

- involuntary treatment;
- advanced directives; and
- the use of electroconvulsive therapy ('ECT') for treatment of mental illness, in particular with respect to treatment of children and adolescents.

HUMAN RIGHTS AND THE LEGISLATIVE REVIEW PROCESS

One of the objectives of the review of the Mental Health Act is for a new Act to be developed that will appropriately protect 'human rights in light of the Charter and Australia's international human rights obligations'.[14] The resulting Exposure Draft has sought to 'promote a contemporary rights-based approach to the regulation of mental health treatment and care'.[15] The Commission welcomes this approach, particularly as mental health laws have such a significant impact on the human rights of vulnerable people.

The Commission appreciates that the Department of Health has sought to take a human rights based approach to the Review process. The Commission has advocated using the PANEL approach (**P**articipation, **A**ccountability, **N**on-discrimination and attention to vulnerable groups, **E**mpowerment and **L**inking planning policies and practice to human

[13] Victorian Equal Opportunity and Human Rights Commission, *Disability Terms of Reference* (August 2007).
[14] Department of Health, Review of the Mental Health Act 1986: Consultation Paper, p 13.
[15] Department of Health, *Exposure Draft Mental Health Bill 210: Explanatory Guide*, p vi.

rights principles and standards) as a way of ensuring that a human rights based approach to policy and decision-making has been achieved. The PANEL approach is derived from United Nations development work, and is consistent with the Commission's aim to encourage participation and empowerment in individuals and organisations[16].

There has been an opportunity for community input into the Review and the production of an Exposure Draft is a positive step. Human rights considerations have also been incorporated into the general principles of the Exposure Draft. However, the human rights dialogue in the Exposure Draft and accompanying information materials are at a high-level and in general terms. They do not appropriately inform the community about the way in which Charter rights will be engaged and limited by the proposed legislation.

A number of old paradigms and discretions have also been left in place when it comes to the detail of the drafting. The approach taken in the Exposure Draft to issues like involuntary treatment (which is discussed in more detail below) continues to entrench discrimination against people with a mental illness in breach of the right to equality under the Charter (section 8). The materials also fail to provide an evidence-base to justify limitations that are proposed on a person's right not to be subjected to medical treatment without his or her full, free and informed consent (a right under section 10(c) of the Charter). They also fail to address how the best interests of the child will be taken into account in the treatment of minors (a right under section 17(2) of the Charter).

In its current form, the Exposure Draft risks capturing human rights as general principles that are not applied practically. Human rights fundamentally ensure people have the dignity and respect they need to thrive.

More attention needs to be paid to how human rights engage with practical outcomes for people under the Mental Health Act.

The Department of Health has noted that the Exposure Draft 'engages a number of rights which are specifically protected and promoted by the Charter' and then goes on to say that a Statement of Compatibility will be delivered when the Bill is tabled in Parliament.[17] The Statement of Compatibility is an important tool for informing Parliamentary debate, but given the significance of this legislation, it is appropriate that Parliament ensures that it is transparent, accountable to and seeks input from the community. If a new Mental Health Bill is introduced into Parliament in 2011 it will have been through around three years of review and community consultation without government authorities publicly assessing or providing commentary about the Bill's compatibility with the Charter.

Recommendation 1: That a human rights analysis of the Bill be undertaken and provided to the public given the complexity of the subject matter, the significance of the human rights issues involved, and the investment of the community in the Review process. This would facilitate the preparation of the Statement of Compatibility and would ensure that the community is able to provide informed opinion on any

[16] Details of the PANEL approach can be found at the Commission's website: humanrightscommisson.vic.gov.au

[17] Department of Health, *Exposure Draft Mental Health Bill 210: Explanatory Guide*, p vii.

proposed limitation of human rights within the Exposure Draft. The Commission would be happy to provide advice to the Department to assist with this process.

INVOLUNTARY TREATMENT

1.7 Background

If treatment for mental illness is authorised against the will of an individual, that treatment should only be authorised and administered in a manner that is consistent with human rights law. Human rights provide a legal and policy framework that maximises the capabilities of all people to reach their potential and participate fully in society. In particular, international human rights law recognises the need to respect individual autonomy, including 'the freedom to make one's own choices' (CRPD, Article 3(a)).

The administration of involuntary treatment under the Mental Health Act also engages the following Charter rights:

- the right not to be subject to medical treatment without full, free and informed consent (section 10(c))
- the right to freedom of movement (section 12)
- the right to liberty and security of person (section 21(1)(7))
- the right to privacy and reputation (section 13), and in some cases
- the protection from cruel, inhuman or degrading treatment (section 10).

The way that treatment is administered and decisions are made can also raise questions about:

- the right to recognition and equality before the law (section 8), and
- the right to a fair hearing (section 24).

The decision of Justice Bell in *Kracke*[18] highlights that these rights must be interpreted broadly, particularly in the protection of the human rights of vulnerable people. Justice Bell noted that the involuntary treatment of mentally ill patients is a classic example of where the need to protect the human rights of vulnerable people arises.

1.8 Involuntary treatment and the Exposure Draft

To support a human rights based approach, the Exposure Draft seeks to move to supported rather than substituted decision-making. The Explanatory Guide to the Exposure Draft says that:

> The principles reflect a supported decision-making model. Currently the MHA reflects a substituted decision-making model: psychiatrists provide substituted consent to treatment if a person who is subject to an order is unable or refusing to consent. In contrast, supported decision making is based on a presumption that

[18] *Kracke v Mental Health Review Board* [2009] VCAT 646 (23 April 2009).

people subject to compulsory orders have the capacity to make their own decisions unless it is determined otherwise.[19]

The general principles set out in clause 7 of the Exposure Draft also recognise that:

(1) Persons with a mental illness have the same rights and responsibilities as other members of the community and should be empowered to exercise those rights and responsibilities.
(2) A person with a mental illness is presumed to have the capacity to make decisions about matters relating to their mental illness if the person appears to be capable of doing the things specified in section 3(2)…
(4) A person with a mental illness must as far as is reasonably possible in the circumstances … be supported to enable the person to make his or her own decisions
(5) Treatment services should -
(a) be provided for the benefit of the person and only for therapeutic or diagnostic purposes and never be administered as a punishment or for the convenience of others.

The Commission strongly supports this approach. However, it is not an approach that is adopted consistently in the substance of the Exposure Draft. For example, clause 125 of the Draft provides for involuntary treatment not only if the patient is incapable of giving consent, but also if the patient is capable of giving consent and does not do so. It states that:

(1) This section applies if a patient –
(a) has the capacity to consent to the administration of treatment for mental illness and does not give consent; or
(b) does not have the capacity to consent to the administration of treatment for mental illness.
(2) If this section applies, the authorised psychiatrist may authorise the administration to the patient of treatment for mental illness without consent if the authorised psychiatrist is satisfied that –
(a) the patient requires treatment for the mental illness;
(b) there is a risk that the patient may harm themselves or another person or suffer serious physical or mental deterioration;
(c) the risk specified in paragraph (b) is most appropriately managed by the administration of treatment for mental illness;
(d) the administration of treatment for mental illness without consent is a necessary and proportionate response to the risk specified in paragraph (b).

This clause continues and provides that the treating psychiatrist must 'have regard to' (as point (h) in a list of other considerations) 'whether the treatment is likely to promote and maintain the health and wellbeing of the patient'.

This type of provision is not applied to any other sector of the community. Victorian law more generally protects the right of people to refuse medical treatment.[20] For example, the right of Jehovah's Witnesses to refuse blood transfusions and other blood products is legally protected, even where this would involve a life-saving treatment. Where an adult has capacity to make the decision, their right to do is respected, even though other people may disagree with their choice or the reason for it. The law supports a person's autonomy,

[19] Department of Health, *Exposure Draft Mental Health Bill 210: Explanatory Guide*, p 2.
[20] See the *Guardianship and Administration Act 1986*; *Medical Treatment Act 1988*; *Human Tissue Act 1982*.

bodily integrity and belief. Indeed, the Office of the Public Advocate warns people in its guidance material that:

> Where a person provides medical treatment (such as a blood transfusion) against the decision of an adult with capacity, that person has committed assault. The assault may give rise to either criminal charges or to a civil action for battery.[21]

The way the Exposure Draft is currently framed, these protections apply unless you are a person who has, or appears to have, a mental illness. The approach of the Exposure Draft to involuntary treatment is discriminatory and incompatible with human rights. It perpetuates the view that people with a mental illness are more dangerous than others in the community, that their opinions matter less and that they are not able to make informed decisions. There has been no justification in the Exposure Draft or supporting materials as to why this approach is a reasonable, objective and proportionate limitation of rights (as allowed for in section 7(2) of the Charter).

The test should be one of capacity. The human rights implications of using a test other than one based on capacity are significant and the Department should be transparent about this.

1.9 Restrictive Interventions and Involuntary Treatment 'as a last resort'

Where a person lacks the capacity to make a decision about their assessment and treatment making an involuntary order should be an option of last resort only (under a supported decision-making model). The principle of 'last resort' has not been included effectively and consistently within the Exposure Draft. Currently, the principle of last resort is included in Part 8 of the Exposure Draft only. Clause 136 of Part 8 of the Exposure Draft states:

> **PART 8—RESTRICTIVE INTERVENTIONS**
> **136 Principles**
> (1) Restrictive interventions must only be used on a person in an approved mental health service as a last resort for safety reasons.
> (2) If it is necessary to use restrictive interventions on a person in an approved mental health service, the restrictive intervention used must be the restrictive intervention which is the least restrictive in the circumstances and maintains the safety and dignity of the person.

The Commission is concerned that Part 5 does not comply with section 7 of the Charter (ie being a reasonable limitation on rights) because:

- no reference to the principle 'of last resort' is made in Part 5 of the Exposure Draft that deals with Involuntary Treatment; and
- Part 5, and specifically clause 125 within Part 5, does not require that an involuntary treatment order only be used when it can be shown to be in the best interests of the patient, when it is justified through the application of an analysis that ensures that any limitation on human rights be reasonable and when no less restrictive alternative is available.

Under clause 125 of the Exposure Draft, an authorised psychiatrist may authorise the administration of involuntary treatment to a patient, without their consent, where:

[21] Office of the Public Advocate, *Jehovah's Witnesses and Blood Transfusions,* Information Sheet, August 2007.

- the psychiatrist is satisfied that the patient requires treatment for the mental illness; and
- there is a 'risk' that the patient may harm themselves or suffer serious physical or mental deterioration.

The Oxford English Dictionaries Online defines the term risk as:

> *a situation involving exposure to danger;*
>
> *the possibility that something unpleasant or unwelcome will happen*[22]

The threshold of a 'risk' that a patient may harm himself or herself or suffer serious physical or mental deterioration falls well short of the analysis that an authorised psychiatrist would be required to apply in order to comply with section 7 of the Charter, as set out above. The current Exposure Draft would allow the administration of involuntary treatment where there is the mere 'possibility' that a patient will cause harm to him or herself or suffer serious physical or mental deterioration.

Clause 125 is also inconsistent with clause 64(c) of the Exposure Draft, which provides more stringent criteria for the making of an assessment order where a person is not detained, than clause 125 that provides for the administration of involuntary treatment.

Clause 64(c) of the Exposure Draft requires that there be 'imminent and significant risk' that a person may cause serious harm to himself or herself, or that there is 'significant' risk that the person will suffer physical or mental deterioration. The explanatory materials do not provide any rationale or evidence as to why different thresholds are provided in each of clause 64(c) and clause 125 of the Exposure Draft.

The Commission submits that clause 125 of the Exposure Draft should be amended to ensure that where the Bill provides for the administration of involuntary treatment it only does so where a patient requires treatment for a mental illness and poses a very significant and likely risk of harm to themselves, or is likely to suffer serious physical or mental deterioration. Authorisation and administration of involuntary treatment and the associated limitation of human rights must be considered reasonable, proportionate and necessary in the particular and individual circumstances of a patient. In the context of a supported decision-making model for the care and treatment of individuals with a mental illness, the threshold for determining whether a limitation on human rights can be justified will be high.

The Commission submits that clauses 125(c) and (d) be retained to ensure that any probable risk of harm under clause 125 is most appropriately managed by the administration of treatment for mental illness, and that the administration of treatment for mental illness without consent is necessary and proportionate to that probable risk.

The nature of any probable risk identified for the purpose of determining whether involuntary treatment is required under clause 125 should be clearly documented. The circumstances in which involuntary treatment may be authorised should be well defined, on the basis of agreed clinical criteria that accords with best practice standards. The Commission submits that standards, including the National Standards for Mental Health

[22] http://oxforddictionaries.com

Services[23] and World Health Organization standards should be used to determine where authorisation and administration of involuntary treatment, and the associated limitation of human rights might be considered reasonable, proportionate and necessary in the particular and individual circumstances of a patient.

If a medical practitioner forms a view that involuntary treatment of an individual is required, inconsistent with the terms of any advanced directive provided by that individual, an independent and expedient second psychiatric opinion should be provided as soon as is reasonably practical to assist to determine whether the involuntary treatment is required. The Commission's submissions with respect to advanced directives commence at paragraph 6 of this submission. The importance of ensuring a timely process for review and the provision of a second psychiatric opinion is also dealt with in this submission, commencing at paragraph 10.

Other jurisdictions provide different examples of how this may be achieved.

1.10 Administering involuntary treatment in other jurisdictions

1.10.1 Australia: ACT and Tasmania

Section 27 of the *Mental Health (Treatment and Care) Act 1994* (ACT) permits the Mental Health Tribunal to make an involuntary psychiatric order for a person who has a mental illness, if it has reasonable grounds to consider there to be likelihood of 'serious harm' to self or others, or 'serious' mental or physical deterioration.

In addition, in the ACT, it is only the Tribunal that is authorised to make such a decision for treatment to be administered, not an authorised psychiatrist. The ACT does however allow for emergency detention and treatment on the decision of a doctor or mental health officer under section 37(2) of the Act which states that:

> Where a doctor or mental health officer believes on reasonable grounds that
> (a) a person is mentally dysfunctional or mentally ill and
> (i) as a consequence, requires immediate treatment or care; or
> (ii) in the opinion of the doctor or mental health officer, the person's condition will deteriorate within 3 days to such an extent that the person would require immediate treatment or care;
> (b) the person has refused to receive that treatment or care; and
> (c) detention is necessary for the person's own health or safety, social or financial wellbeing, or for the protection of members of the public; and
> (d) adequate treatment or care cannot be provided in a less restrictive environment;
> (e) the doctor or mental health officer may apprehend the person and take him or her to an approved health facility.

In Tasmania, medical treatment under section 32 of the *Mental Health Act 1996* (Tas) for patients who refuse consent may only be given with the authorisation of the Guardianship and Administrative Board, after there has been a hearing in accordance with Part 10 of the

[23] The National Standards for Mental Health Services 2010 are available from the Federal Government, Department of Health and Ageing website: http://www.health.gov.au/internet/main/publishing.nsf/content/mental-pubs-n-servst10

Guardianship and Administration Act 1995 (Tas). Otherwise, all treatment must be with the informed consent.

1.10.2 The Scottish Example

The Mental Health (Care and Treatment) (Scotland) Act 2003 recognises the importance of capacity in determining whether or not substituted decision-making is appropriate, and non-consensual treatment is only available where the criteria of impaired decision-making capacity or judgement is apparent. The Scottish Act is based on a set of guiding principles, which any person taking action under the Act must consider, including non-discrimination, least restrictive alternative, participation in one's own assessment, treatment and care, and benefit (that any intervention must be likely to produce a benefit for the service user that cannot reasonably be achieved otherwise). The Act provides a link between principles and lived experiences and is supplemented by policy guidelines.

Under the Scottish Act, voluntary patients must consent to any treatment. Patients that refuse treatment or cannot consent, may be administered compulsory treatment, if they are under one of the following orders:

- Emergency detention certificate, granted by a medical practitioner with the consent of a mental health officer, which enables a patient to be detained in hospital for a maximum of 3 days, where:[24]
  - it is necessary 'as a matter of urgency' to detain the patient for the purpose of assessing what treatment is required; and
  - there is a 'significant risk' to the health, safety or welfare of the patient, or to the safety of others if they were not detained.
- Short-term detention granted by a medical practitioner with the consent of a mental health officer, which enables a patient to be detained in hospital for a maximum of 28 days, where:[25]
  - it is necessary to detain the patient to determine the best treatment, or to administer them necessary treatment; and
  - there is a 'significant risk' to the health, safety or welfare of the patient, or to the safety of others if they were not detained.
- Compulsory treatment order, made by order of the Mental Health Tribunal on application by a mental health officer, a patient can be given involuntary treatment where:[26]
  - there is medical treatment available that is likely to prevent the worsening, or alleviate the symptoms or effects of the patient's disorder;
  - if they were not to receive the treatment there is a there is a 'significant risk' to the health, safety or welfare of the patient, or to the safety of others.

In Scotland, a Compulsory Treatment Order can be based in hospital or in the community, and the Tribunal will only grant one where the application includes two medical recommendations and a plan of care detailing the care and treatment proposed for the patient. The patient is entitled to free legal representation for the hearing, and the orders are 'tailored to the personal needs of each patient,' which was a significant shift from the

[24] Ibid s 36.
[25] Ibid s 44.
[26] Ibid s 57.

preceding Scottish Act.[27] The capacity threshold for each of the above three orders is that, due to their mental disorder, 'the patient's ability to make decisions about the provision of medical treatment is significantly impaired.'

1.11 Disability Reference Group Member Views

The Commission's DRG members had a range of views as to whether involuntary treatment is consistent with human rights principles. One view sees all involuntary treatment as inconsistent with human rights principles and another regards involuntary treatment involving reasonable limitations on rights so long as it is subject to stringent safeguards, as acceptable.

Some DRG members concurred with the views of Tina Minkowitz (a leading commentator in the area of mental illness and human rights). These views are shared by the International Disability Alliance (IDA), a peak body representing disability organisations. This view is based on an interpretation of Article 12 (2) of the CRPD,[28] that non-consensual psychiatric and medical interventions are contemplated as torture, or cruel, inhuman or degrading treatment.

Minkowitz also says that the principle of non-discrimination and the obligation under Article 15(2) in the CRPD, should prevent torture and cruel, inhuman or degrading treatment or punishment from being inflicted on persons with disabilities on an equal basis with others. She comments that this requires a re-consideration of the circumstances in which non-consensual psychiatric interventions (or involuntary treatment) can amount to torture under definitions in international law.

The position of DRG members that regard involuntary treatment as involving reasonable limitations on rights, so long as it is subject to stringent safeguards, have a position that aligns closely with the Charter's definition of what human rights are and when they may be limited. That is, that involuntary treatment must not be used unless it can be shown to be in the best interests of the person and when it is justified through the application of an analysis that ensures that any limitation on human rights is reasonable, in accordance with section 7 of the Charter.

DRG members also told the Commission that it was critical that a new Bill consider the unique position of people that suffer from multiple disabilities. By way of example, a DRG member highlighted a situation where a person may have a mental illness on top of a pre-diagnosed cognitive impairment. Group members commented that additional safeguards needed to be included within the legislation to ensure that all relevant considerations were taken into account by an authorised psychiatrist prior to the making of an involuntary treatment order where a person has multiple disabilities. These additional 'safeguards' could include:

- a requirement to consult with and be guided by the medical practitioner that is responsible for any current treatment being received by the patient; and/or
- ensuring that a nominated person that is aware of the relevant history of the patient's disabilities may be consulted and make decisions (where a person does not

[27] Laura Pirnie 'Mental Health Act: Care and Treatment' (2003) 48(11) *The Journal* 50, 51.
[28] Article 12 (2) of the CRPD provides that people with disabilities enjoy legal capacity on an equal basis with others.

have capacity) with respect to further treatment of the patient. Where a person has not provided a nominated person to make these decisions, or the nominated person is not aware of the medical history of a person with multiple disabilities, it may be appropriate to consult a family member or primary carer of the patient.

Recommendation 2: That Part 5 of the Exposure Draft be amended to ensure that it is clear from reading that Part of the Bill alone that Involuntary Treatment only be administered to a patient as an option of last resort.

Recommendation 3: The Bill should not make provision for involuntary treatment where a person has capacity to consent to, or to refuse treatment.

Recommendation 4: Determination of both capacity and consent should take into account the human rights of the person concerned and should be based on the principle of supported decision-making.

Recommendation 5: Clearly defined standards should be incorporated in the Exposure Draft to guide mental health practitioners in determining where authorisation and administration of involuntary treatment, and the associated limitation of human rights, is reasonable, proportionate and necessary in the particular and individual circumstances of a patient. These standards should be based on the National Standards for Mental Health Services[29] and World Health Organization standards.

Recommendation 6: The Exposure Draft should be amended to ensure that where a medical practitioner forms a view that involuntary treatment of an individual is required, that an independent and expedient second psychiatric opinion should be provided as soon as is reasonably practical. We deal below with the situation where an advanced directive is in place.

Recommendation 7: The Commission submits that clauses 125(c) and (d) of the Exposure Draft be retained to ensure that any probable risk of harm under clause 125 is most appropriately managed by the administration of treatment for mental illness, and that the administration of treatment for mental illness without consent is necessary and proportionate to that probable risk.

ADVANCED DIRECTIVES

1.12 Background

[29] The National Standards for Mental Health Services 2010 are available from the Federal Government, Department of Health and Ageing website: http://www.health.gov.au/internet/main/publishing.nsf/content/mental-pubs-n-servst10

The following rights identified in the Charter and in the CRPD, enhance the right to autonomy.

Charter

- Section 8 recognition and equality before the law
- Section 10 protection from torture and cruel, inhuman or degrading treatment
- Section 12 freedom of movement
- Section 23 Privacy and reputation
- Section 14 freedom of thought, conscience, religion and belief
- Section 15 freedom of expression
- Section 17 protection of families and children
- Section 18 taking part in public life
- Section 21 right to liberty and security of person
- Section 22 humane treatment when deprived of liberty

CRPD

- Article 12 equal recognition before the law
- Article 17 protecting the integrity of the person
- Article 19 living independently and being included in the community
- Article 21 freedom of expression and opinion and access to information
- Article 22 respect for privacy
- Article 23 respect for the family
- Article 25 health
- Article 29 participation in political and public life
- Article 30 participation in cultural life, recreation, leisure and sport

Importantly, the first guiding principle of the CRPD, contained within Article 3(a) confirms that respect for autonomy is central to the objectives and operations of the CRPD:

> **Article 3 General Principles**
> The principles of the present convention shall be:
> (a) Respect for inherent dignity, individual autonomy including the freedom to make one's own choices, and independence of person.

1.13 Advanced directives and the Exposure Draft

The adoption of advanced directives in the Exposure Draft enhances compliance with the Charter and international human rights law. Mental health legislation that provides for advanced directives from persons with a mental illness is necessary as a mechanism to ensure protection from medical treatment without consent. The content of any advanced directive provided by an individual should be taken into account when determining whether the administration of involuntary treatment on a patient, where that patient does not have capacity to provide consent is 'reasonable, proportionate and necessary' in the circumstances. A scheme that was implemented in this manner would ensure consistency with section 7 of the Charter, and would represent a commitment to uphold the human rights of individual patients to the fullest extent possible.

In Victoria, it is timely and appropriate that advanced directives have been incorporated into the Exposure Draft. Part 10 Division 1 of the Exposure Draft clearly stipulates what

may be included in the content of an advanced directive and what constitutes a valid advanced directive.

Advanced directives, where properly made, should be enforceable and adhered to at all times, in accordance with providing mentally ill patients with an express right of autonomy. However, clause 154(4) of the Exposure Draft allows for the Mental Health Tribunal or any other body required to make a decision in relation to the treatment of a patient to depart from the wishes and preferences of the patient expressed in the advanced directive. Clause 154(4) states that:

> If a person, the Mental Health Tribunal or any other body required to make a decision in relation to the treatment of a patient makes a decision which is inconsistent with the wishes and preferences of the patient expressed in their advance statement, the person, the mental health service provider must—
> (a) record the circumstances and the reasons for doing so;
> (b) maintain a copy of that record;
> (c) give written advice specifying the circumstances and reasons—
> (i) to the patient;
> (ii) in accordance with section 9(2);
> (iii) to the Mental Health Commissioner;
> (iv) if the decision has not been made by the authorised psychiatrist, to the authorised psychiatrist.

It has been reported that people in Australia who have made advanced directives and who have negotiated their treatment options with clinicians expect that these directives will be honoured, despite there being no current legal requirement to do so.[30] As discussed above, similar directions about health care given by people without a mental illness are protected by the law (even where the choice places their lives at risk) and must be respected by medical professionals. The difference in approach here when someone has equally made an informed choice when they had capacity to do so, is discriminatory.

The Commission considers that advanced directives should be adhered to and that they should be adhered to in a way that is proportionate and tailored to an individual's need during a period of acute illness. This is consistent with the application of reasonable limits as per section 7(2) of the Charter.

1.14 Disability Reference Group Member Views

The Commission notes that DRG members supported the notion of implementing advanced directives in the revised Act. Some members of the DRG viewed advanced directives as crucial in promoting autonomy in decision making by a person with mental illness. DRG members highlighted the importance of the advanced directive being made by the person when they have capacity. Some felt that advanced directives should be legally binding.

Recommendation 8: There should be a legal regime for the making of advanced directives, including an assessment of the person's capacity to make a legally binding directive and a mechanism to ensure that the directive is an informed choice. With these protections in place, capacity exercised through an advanced directive should be respected.

[30] Mental Health Legal Centre, *Lacking Insight*, 2008, 42.

ASSESSING CAPACITY

1.15 Background

Consistent with Article 12 of the CRPD, the assessment of capacity should not be recognised as an 'all or nothing concept' [31] but rather, it should be assessed as proportionate to the needs of the individual concerned. This is especially relevant to mental illness as it is often episodic and therefore, capacity may fluctuate from time to time.[32]

The World Health Organization adopts a similar view that there should be a presumption of capacity and consequently of competence, in a person with mental illness. In addition, the World Health Organization adopts the view that despite the presence of a mental illness that may affect capacity, a person with a mental illness may still have the capacity to carry out some decision-making functions.[33]

1.16 Assessing capacity and the Exposure Draft

The Commission welcomes the general principle relating to capacity that is set out in Clause 7(2) of the Exposure Draft:

> 'A person with a mental illness is presumed to have the capacity to make decisions about matters relating to their mental illness if the person appears to be capable of doing the things specified in section 3(2).'

Clause 3(2) of the Exposure Draft states that:

> A person has capacity to make a decision for the purposes of this Act if the person is capable of—
> (b) understanding the nature and effect of the decision; and
> (c) making the decision freely and voluntarily; and
> (d) communicating the decision in a manner such that another person can understand what the decision is.

We note that making a determination that a person does not have the capacity to make decisions in relation to their assessment or treatment engages the following rights:

(e) the right to not be subject to medical treatment without full, free and informed consent (s10(2) of the Charter)
(f) the right to freedom from unlawful or arbitrary interference with privacy (s13(a) and (b) of the Charter)
(g) the right to equality and non-discrimination (the right to equality and non-discrimination (s8 of the Charter)
(h) the right to respect for physical and mental integrity (article 17 of the CRPD); and

[31] Aaron Dhir, 'Human Rights Treaty Drafting Through the Lens of Mental Disability: The Proposed International Convention on Protection and Promotion of the Rights and Dignity of Persons with Disabilities, (2005) 41 *Stanford Journal of International Law*, 181.
[32] World Health Organisation, *WHO Resource Book on Mental Health, Human Rights and Legislation*, 2005.
[33] World Health Organisation, *WHO Resource Book on Mental Health, Human Rights and Legislation*, 2005.

(i) depending on the specific circumstances of an individual, rights that related to the liberty and security of the person (as reflected in the principles set out in s21 of the Charter and article 14 of the CPRD).

As noted in the submission on the Exposure Draft of the Human Rights Law Resource Centre, Article 12(4) of the CPRD requires parties to ensure that 'all measures that related to the exercise of legal capacity provide for appropriate and effective safeguards'[34]. Any limitation of these rights must be reasonable, necessary and proportionate. Specifically, any limitation of the rights set out in the Charter must be in accordance with section 7(2) of the Charter.

The Commission is concerned that there are two different tests for capacity contained within the Exposure Draft. In addition to the test set out in clause 3(2) of the Exposure Draft (above), the Exposure Draft contains a definition of capacity relating in clauses 64(d), 70(d) and 71(d), that applies when giving consideration to an Assessment Order, Compulsory Treatment Order and Community Treatment Order respectively. This definition provides that:

> A person has capacity to make a decision for the purposes of this Act if the person is capable of—
> (a) understanding the nature and effect of the decision; and
> (b) making the decision freely and voluntarily; and
> (c) communicating the decision in a manner such that another person can understand what the decision is.

The Commission is concerned that the Exposure Draft does not provide mental health practitioners and patients clarity as to the circumstances in which each definition will apply. The explanatory materials do not provide any guidance to practitioners and patients as to why it is necessary for the Exposure Draft to contain what are essentially two different thresholds for determining consent.

Both definitions of capacity within the Exposure Draft appear to be a marked improvement from the definition in section 8(1)(d) of the current Act. However, the Commission believes that the potential for confusion in the application of each of the definitions may result in a contravention of the Charter, as well as Australia's obligations under Article 12(4) of the CPRD. The Exposure Draft should contain one consistent method for assessing the capacity of an individual.

1.17 Assessing capacity in Nova Scotia, Canada

The Involuntary Psychiatric Treatment Act NS 2005 of Nova Scotia, Canada, implements a more considered and balanced approach to assessing the capacity of a patient in a manner that is consistent with recognising the patient's human rights. Under that Act, treatment is only permitted where a person has been involuntarily admitted, which includes an assessment of whether, as a result of the mental disorder, the person 'does not have the capacity to make admission and treatment decisions' (section 17). Section 18 of the Act sets out the test for determining capacity as follows:

[34] Human Rights Law Resource Centre, 'Mental Health: Submission on Mental Health Bill Exposure Draft (Vic) (17 Dec 2010)', at Paragraph 24

18 (1) In determining a patient's capacity to make a treatment decision pursuant to clause 17(e), the psychiatrist shall consider whether the patient fully understands and appreciates

(a) the nature of the condition for which the specific treatment is proposed;
(b) the nature and purpose of the specific treatment;
(c) the risks and benefits involved in undergoing the specific treatment; and
(d) the risks and benefits involved in not undergoing the specific treatment;

Recommendation 9: That the rationale for the adoption of a particular test to determine whether a person has capacity to make a decision under the Bill is justified by reference to an analysis in accordance with section 7 of the Charter. This approach would require the Bill to adopt a test for capacity that is the least restrictive on the rights engaged by the process of making a determination of capacity.

Recommendation 10: That information that sets out the rationale and analysis of compliance with section 7 of the Charter for the adoption of a particular test to determine capacity is made available to the public.

ELECTROCONVULSIVE THERAPY AND PSYCHOSURGERY

1.18 Background

Electroconvulsive therapy (ECT) and psychosurgery are controversial treatments. Many of the public submissions to the Mental Health Review revealed strong negative views about the use of these procedures, particularly in the absence of informed consent or for the treatment of minors. The Commission also wishes to draw the Department's attention to the recent (January 2011) United States Food and Drug Administration hearings in relation to the safety and effectiveness of ECT, and to a new scientific review that sets out significant risks to which ECT recipients have been exposed.[35]

1.19 Electroconvulsive therapy and psychosurgery in the Exposure Draft

In the absence of informed consent, the provision of ECT and psychosurgery engages the issues discussed above in relation to involuntary treatment, including the right to protection against medical treatment without informed consent.[36] The provision of such treatment by public authorities in the absence of full, free and informed consent, is unlawful under the Charter unless the breach of the right can be demonstrated to be justified under section 7(2).

In addition, we note that the Exposure Draft requires 'informed consent' (as defined in clause 129) for the administration of non-psychiatric treatment and psychosurgery, but sets a lower threshold of 'consent' only for the administration of treatment (Part 7, Division 1), electroconvulsive therapy and with respect to determining whether to make a transfer order (interstate or to other mental health facility). For electroconvulsive therapy, whilst consent is required to be in writing, there is no requirement that this consent is 'informed consent'. There has been no justification in the Exposure Draft or supporting materials why informed

[35] http://www.medicalnewstoday.com/articles/214539.php
[36] Charter s10(c) states: 'A person must not be subjected to medical or scientific experimentation of treatment without his or her full, free and informed consent.'

consent is not required or why a lower threshold is a reasonable, objective and proportionate limitation of rights.

Recommendation 11: Electroconvulsive therapy should generally only be permissible with the full, free and informed consent of the person.

Recommendation 12: Psychosurgery should only be permissible with full, free and informed consent of the person.

Recommendation 13: The Exposure Draft should be reviewed to ensure that the threshold of consent for the administration of all kinds of treatment under the legislation is 'informed consent', as defined in clause 129 of the Exposure Draft.

TREATMENT OF CHILDREN

1.20 Incorporation of the 'best interests' principle into the Exposure Draft

The Exposure Draft deals with the treatment of children at a number of different points. Under section 17(2) of the Charter, children are to be afforded additional human rights protection as needed in their best interests and as needed by reason of being a child. Those with responsibilities to make decisions about the care and psychiatric treatment of children have a duty to ensure that decisions about children are made in conjunction with a 'best interests' analysis.

The Exposure Draft requires incorporation of a 'best interests' test to ensure that the best interests of the child is a primary consideration. This approach is also consistent with the Convention on the Rights of the Child[37] and the practice that has been adopted more generally under legislation in Victoria which aims to protect and promote the rights of children.[38]

The Commission also notes that consent to medical treatment is generally more appropriately considered with reference to a person's capacity rather than their age. This approach is consistent with the principle that capacity to consent to medical treatment varies according to a young person's level of maturity and the complexity of the procedure to be performed. Respect for the evolving capacities of children with disabilities is also one of the general principles of the CRPD (Article 3(h)). By adopting a capacity-based approach to consent, the proposed Bill would avoid issues of age discrimination and a breach of the equality rights under the Charter (section 8), against young persons who have capacity to decide about treatment.

As with adults, circumstances in which involuntary treatment for children might be authorised should be well defined on the basis of agreed clinical criteria that accords with best practice standards. The Commission submits that standards, including the National

[37] Article 3(1) of the Convention provides that: 'In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration'.
[38] For example, the *Children, Youth and Families Act 2005* (Vic),

Standards for Mental Health Services[39] and World Health Organization standards should be used to determine where authorisation and administration of involuntary treatment, and the associated limitation of human rights might be ever considered reasonable, proportionate and necessary for the treatment of a mentally ill child.

Consistent with considering what is in the best interest of the child, the Commission is concerned that the Exposure Draft does not require a treating psychiatrist to obtain fully informed parental consent (or consent from a child's legal guardian) prior to the administration of involuntary treatment or assessment of a child of 18 years or younger. The best interest of the child should always be given primary consideration. In circumstances where all reasonable efforts have been made to locate the parent or guardian, and involuntary treatment of a child is considered to be absolutely urgent, a treating psychiatrist should be required to adequately inform a parent or guardian of the nature of the treatment, risks associated with the treatment and why the treatment or assessment was justified in these extremely urgent circumstances.

1.21 The use of electroconvulsive therapy and psychosurgery on children

The use of ECT and psychosurgery in children is of particular concern in the community. The Exposure Draft limits the administration of ECT and psychosurgery in relation to children. It prohibits the use of these treatments in people under the age of 13 years, but permits ECT and psychosurgery for the treatment of people between the ages 13 and 18 years in certain circumstances. Given the issues associated with both of these treatment options, the question is not only one of capacity to consent in determining the age at which it is available. The possible impact of the treatment on a developing brain also needs to be considered.

The World Health Organization believes ECT should be prohibited in children and young persons under the age of 18 years,[40] and there is a lack of data supporting the safety and need for these forms of treatment in minors. Given this, the Commission has concerns about the use of these treatments on minors and would like to see the right of every child in Victoria under the Charter to 'such protection as is in his or her best interests and is needed by him or her by reason of being a child' (section 17(2)) expressly taken into account.

1.22 Disability Reference Group Member Views

The Commission notes the views of many members of the DRG that the Act should provide that ECT should *not* be used in the treatment of mental illness for children and adolescents.

The views of some members of the DRG state that ECT usage is contrary to the best interests of the child under Article 3 of the Convention on the Rights of the Child. They further argue that use of ECT on children and young people is inconsistent with the notion of the evolving capacities of the child articulated in the CRPD. The Commission believes that this is an issue that the review should examine closely.

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[39] The National Standards for Mental Health Services 2010 are available from the Federal Government, Department of Health and Ageing website:
http://www.health.gov.au/internet/main/publishing.nsf/content/mental-pubs-n-servst10

[40] World Health Organisation. *Resource Book on Mental Health, Human Rights and Legislation*, World Health Organisation 2005, Geneva, p 64.

Recommendation 14: Any decision concerning children under the Act must consider the best interests of the child.

Recommendation 15: The ability of minors to consent to medical treatment should be based on an assessment of capacity and the principles of supported decision-making.

Recommendation 16: The Exposure Draft should align its approach to the use of electroconvulsive therapy and psychosurgery in minors with the international standards established by the World Health Organization.

TIMELIENESS OF REVIEWS AND SECOND OPINIONS

The Commission strongly supports the establishment of a number of new mechanisms to facilitate review and accountability under the Act. The Exposure Draft is a significant improvement on the current Act. However, the timeliness of these functions will continue to be an issue. This requires both legislative direction, flexibility to take into account the needs of individuals, and adequate resourcing.

1.23 Background

Principle 17 of the United Nations Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care states that review 'of a decision to admit or retain a person as an involuntary patient shall take place as soon as possible after that decision and shall be conducted in accordance with simple and expeditious procedures as specified by domestic law.' While these principles are not binding, they provide useful guidance on what is appropriate to fulfil the international human rights standards upon which the Charter is based. This includes section 21 of the Charter which contains the right to liberty and security of person.

Article 12 of the CPRD requires that safeguards should ensure that measures relating to the exercise of legal capacity be proportional and tailored to the person's circumstances, and apply for the shortest time possible.

The importance of ensuring an expedient and independent review of a medical decision to retain a person as an involuntary patient becomes particularly clear when considering the findings within each the Burdekin Report[41] and the Chelmsford Royal Commission,[42] that medical opinion on the nature of a psychiatric illness and the necessity of administering treatment is not always accurate.

1.24 Reviews and second opinions in the Exposure Draft

[41] Burdekin Report, Human Rights and Equal Opportunity Commission, Human rights and mental illness - Report of the National Inquiry into the human rights of people with mental illness, 2 volumes. Canberra: AGPS, 1993. Parliamentary Paper: Vol 1 185/1993 (Aust.); Vol 2 186/1993 (Aust.)

[42] Chelmsford Royal Commission, New South Wales Royal Commission into Deep Sleep Therapy. Report. 1990. Chair: J.P. Slattery, Commissioner. Parliamentary Paper: 304/1990-1991 (NSW)

The Exposure Draft provides for a visit from a review officer within seven days and review by the Tribunal with 10 days notice or a hearing from the Tribunal within 10 days of an application being lodged. When someone is being involuntarily treated and possibly detained, the system needs to be more responsive than this in order to ensure that any limitation on human rights is reasonable, necessary and proportionate, and in accordance with section 7(2) of the Charter.

In *Kracke*, Bell J stated that: 'the law must provide a measure of legal protection…against arbitrary interference by public authorities with the rights safeguarded.[43]' This protection must be timely if it is to be meaningful.

In addition, the Mental Health Tribunal also lacks the jurisdiction to review assessment orders. This gives rise to a situation where a patient who 'appears to have mental illness' and meets the criteria in clause 64 could theoretically be held for up to six days without any ability to challenge the detention. Presumably, drafters consider that the addition of review officers will fill this gap, although we note that the submission of the Law Institute of Victoria on the Exposure Draft casts doubt as to the effectiveness of this as a safeguard[44].

In another area where timeliness is an issue, the Exposure Draft would allow involuntary treatment to be continued for three months before a second opinion is required (clause 126). This is an extensive period of time when someone is being treated either without consent or capacity and in an area where there can be significant debate about diagnosis and treatment.

1.25 A comparison: automatic and independent second psychiatric opinion in other jurisdictions

The review mechanism set out in clause 126 of the Exposure Draft provides for an automatic, independent second psychiatric opinion where a patient does not consent to treatment after a continuous period of three months. The Commission is of the opinion that the three-month time is excessive and does not comply with section 7 of the Charter. Detention of a person without their consent is a severe restriction on human rights that should require a second opinion review to be provided to a patient as a matter of right and as a matter of urgency in order to determine that detention of that person is reasonable, proportionate and necessary in the circumstances.

In New South Wales, the period for review is substantially shorter than that in the Victorian Exposure Draft. In the United Kingdom, a three-month time until the provision of a second opinion has proven to be ineffective. These examples are set out in further detail below.

The New South Wales Act

In order for a person to be involuntarily admitted under the *Mental Health Act 2007* (NSW), detained and treated, an authorised medical officer must be of the opinion that:[45]

- the person is mentally ill, or mentally disordered; and
- there is no less restrictive care that is appropriate and reasonably available.

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[43] *Kracke V Mental Health Review Board* & Ors (General) [2009] VCAT 646 (23 April 2009) at 179

[44] Law Institute of Victoria, 'MentalHealth Bill Exposure Draft Submission', 10 December 2010, at Page 14, http://www.health.vic.gov.au/mentalhealth/mhactreview/ed_submissions/eds75.pdf

[45] Section 12(1) *Mental Health Act 2007* (NSW)

Under section 27 of the Act, initial assessments regarding whether to detain or treat a person as an involuntarily patient must made by at least two medical practitioners. The initial medical assessment must occur as soon as practical, but no later than 12 hours following the arrival of an individual at a mental health facility, by an authorised medical officer. The authorised medical officer must cause the person to be examined by another medical practitioner as soon as possible after coming to their initial decision. The second examiner must notify the authorised medical officer in the form prescribed by the regulations if he or she is of the opinion that the person is a mentally ill person or a mentally disordered person that is required to be detained and treated. A third medical officer will be required if there is a difference of opinion between the first and second examinations.

If a decision is made to detain a person as an involuntary patient, the person must be brought before the Tribunal for an initial inquiry as to whether they are a mentally ill or disordered person 'as soon as practicable' after admission. Prior to 2008, this inquiry was held by a magistrate, and 'as soon as practicable' had been consistently interpreted by the courts as "within 7-10 days".46 Since the 2008 amendments 'as soon as practicable' still applies. However, the Tribunal operates under a policy whereby inquiries are not held until at least three to four weeks after detention has commenced. At the time of the amendments, the potential for delay in review was subject to criticism amongst both mental health consumer advocacy groups and psychiatrists, as significantly diminishing patients' rights to independent review of treatment.

It should be noted that this system of follow-up and review is still much quicker than that applied and proposed for Victoria, and that it applies in a State with significantly greater geographical challenges (such as distance from a major centre).

The experience in the United Kingdom

Practitioners in Victoria have indicated (in the context of reviewing community treatment orders) that availability of psychiatrists to review prior to three months may be an issue, 47 however this should not be a reason to deny patients access to safeguards.

The 'second psychiatric opinion' in the Exposure Draft Bill (s 126) appears to be modelled on the United Kingdom legislative scheme. Under section 58 of the *Mental Health Act 1983* (UK) detained patients who do not or cannot consent to medication must, after an initial three months of such treatment, receive a visit from a Second Opinion Appointed Doctor. But research from the UK suggests that under their Mental Health Act, the majority of detained patients never receive a second opinion, as they are often erroneously deemed to given consent after such a period and therefore the operation of the automatic review is never activated[48] (pursuant to section 58(3)(a), to which the Draft Bill's clause 126(1)(a)) is equivalent).

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[46] Christopher James Ryan, Sascha Callaghan and Matthew Large 'Long time no see: Australians with mental illness wait too long before independent review of detention' (2010) 35(3) *Alternative Law Journal*, 128.
[47] University of Melbourne Department of Psychiatry, *Submissions on the Exposure Draft Mental Health Bill* (24 November 2010) Department of Health, http://www.health.vic.gov.au/mentalhealth/mhactreview/ed_submissions/eds23.pdf
[48] Mental Health Act Commission (UK), 13th Biannual Report (2009) 'Coercion and Consent: Monitoring the Mental Health Act 2007-2009' 139.

1.26 The nature of the 'second psychiatric opinion safeguard'

Further, the Commission has some concerns about the nature of the 'second psychiatric opinion safeguard' that clause 126 attempts to provide. The Exposure Draft permits the mental health service provider to select and appoint a psychiatrist from an approved panel. The Commission is concerned that this method of appointment for a second opinion is problematic because of the potential for perceptions of bias to arise if the second psychiatrist is sourced from a related service provider. In the alternative, the Commission suggests that the patient, consistent with the principles of supported decision-making, be provided with the right to nominate a preferred psychiatrist, which may need to be approved or confirmed by the Mental Health Tribunal.

1.27 The requirement for a review to be effective

In conjunction with being timely and independent, the review of the second opinion psychiatrist must also be effective. Although treatment cannot continue after three months unless there is either the patient's consent or review by a second opinion psychiatrist, where the second opinion psychiatrist does not confirm the treatment, it can still be continued if the initial authorised psychiatrist then 'reviews the treatment plan and confirms the continued administration of treatment' (clause 126(1)(b)(ii)). The Commission suggests that in the alternative, where there is a conflict between views of the authorised psychiatrist and second opinion psychiatrist, that matter automatically be referred to the Mental Health Tribunal or Chief Psychiatrist.

1.28 Reviews and second opinions in England and Scotland

In Scotland, amendments to mental health legislation in 2004 reduced the period between commencement of treatment and a second psychiatric opinion to two months from what had previously been a three-month period. Under the Scottish Act, a person who is unable or refusing to consent to treatment can only continue to receive medication after two months if an independent, designated psychiatrist provides a second opinion that the proposed treatment is in accordance with the Act, and in the person's best interests. The reason for refusal of consent must also be taken into account.

Recommendation 17: Review of a decision to admit or retain a person as an involuntary patient should be independent to avoid real or perceptions of bias, and incorporate the opinion of the patient where possible, in accordance with a supported decision-making framework.

Recommendation 18: Review of a decision to admit or retain a person as an involuntary patient should take place as soon as possible. The Department should re-examine and explain how the need for the timeliness and flexibility in review and other accountability procedures will be addressed under the proposed Bill. Charter rights are a relevant consideration in the exercise of these functions.

THE ROLE OF FAMILY AND CARERS

1.29 Background

The following rights in the Charter and in the CRPD are engaged in relation to a person receiving involuntary treatment for mental illness and access to information about their treatment by a family member or carer:

Charter

- Section 13 privacy and reputation
- Section 17 protection of families and children
- Section 19 cultural rights
- Section 22 humane treatment when deprived of liberty
- Section 24 fair hearing

CRPD

- Article 22 respect for privacy
- Article 23 respect for family
- Article 21 freedom of expression and opinion and access to information
- Article 30 participation in cultural life, recreation, leisure and sport

The current Act provides minimal guidance in relation to the role of family and carers. At present, the Act only permits disclosure of information to families and carers where they are involved in providing *ongoing care* to a person with mental illness.

The Commission welcomed the Minister's comment that supported decision-making needs to strike the appropriate balance between respecting the privacy of the individual who is receiving treatment for mental illness and the requirement of family or a carer to receive adequate information about treatment in order to properly fulfil the role of caregiver.

In determining where the balance lays between the right to privacy of the patient, and the needs of *unnamed* carers or family members to access information that will help them to care for the person, the new Act should limit any infringement on privacy rights only to the extent permissible in accordance with section 7 of the Charter. The same balance and application of section 7 of the Charter must also be applied when considering the need of family members or other individuals that are in the care of the patient to know relevant information concerning the patient's mental health that may impact on the ability of them to receive the care from the patient that they require.

1.30 Principles relating to information in the Exposure Draft

Clause 9 of the Exposure Draft sets out principles in relation to information that apply to providing information to a person other than a person who is a mentally ill patient:

> **9 Principles relating to information**
> (3) The contents of any advice, notice, order or other information given or provided to a person with a mental illness under this Act must be explained by the person giving the advice, notice or information to the maximum extent possible to the person with a mental illness in the language, mode of communication and terms which that person is most likely to understand.
> (4) If a provision of this Act provides that a copy of any advice, notice, order or other information must be provided in accordance with this subsection, the copy of any advice, notice, order or other information must be provided as soon as is reasonably practicable—
> (f) to the nominated person;
> (g) if there is no nominated person or the nominated person cannot be found or located, to a family member, guardian, carer, advocate or other person to which the person with a mental illness has consented should be provided a copy of any advice, notice, order or other information;
> (h) if the person with a mental illness is under 18 years of age, to their parent or guardian if the parent or guardian is not otherwise the person to whom the copy of any advice, notice, order or other information is provided under paragraph (a) or (b).

1.31 Locating a 'nominated person'

The inclusion of the principles contained within clause 9 in the Exposure Draft is positive as it permits a person who is receiving involuntary treatment to stipulate a 'named person or guardian' who can access information relevant to treatment and care and who can be notified at all stages of the treatment process. However, the Commission submits that the Exposure Draft requires further clarification to strike a balance that appropriately protects the privacy rights of individuals.

Clause 9 states that 'advice, notice, order or other information' must be provided as soon as is reasonably practical to the nominated person. If there is no nominated person, then an alternative person will be provided with the relevant information in accordance with clause 9(2)(b). This clause should include a requirement to ensure that all reasonable steps are taken by a medical practitioner or mental health service provider to determine whether the patient has nominated a person to whom information can be provided.

The Commission is also concerned about the need to provide information to a nominated person or an alternative 'as soon as reasonably practical'. This drafting is potentially inconsistent with the Charter and the nominated person's scheme, as it does not require a mental health service provider or medical practitioner to consider or limit the restriction that the requirement to provide information 'as soon as reasonably practical' may have on privacy rights of the individual. Mental health practitioners and service providers should ensure that a reasonable time is taken to locate the nominated person, proportionate to the purpose and urgency of providing the information to an alternate person (ie other than a nominated person).

1.32 Nomination of 'named persons' in other jurisdictions

A leading practice example of a jurisdiction which has attempted to balance the patient's right to privacy with the family (or carer's) need to access information to provide adequate care is the *Mental Health (Care and Treatment) Act 2003* (Scotland). Part 17 of the Act is similar to the current Exposure Draft as it allows for the nomination of a named person to whom a mental health officer may provide certain kinds of information to throughout all stages of the treatment process. However, the Scottish legislation goes further to protect the privacy and autonomy of patients by:

- requiring mental health officers to take such steps as are reasonably practical to establish whether the patient has a named person, and if so, to ascertain who that named person is;
- providing a default position in the event that a named person cannot be reasonably located, or has not been nominated, for the primary carer of the patient to become the named person; and
- if the primary carer has not attained the age of 16, by ensuring that the patient's nearest willing adult relative becomes the named person.

The Scottish legislation contains detailed and stringent processes to ensure that named persons are nominated either with the informed consent of the patient, or that all reasonably necessary steps are taken to ensure that the correct individual that provides the closest support to the patient only is provided with information of a private nature.

1.33 Culturally appropriate regulation of family and carer roles

The Commission submits that in the Victorian context any legislation or policy regulating family and or carers roles in the Act needs to be culturally appropriate and respectful of diverse family types/kinship relationships.[49]

In New Zealand, for example, under the *Mental Health (Compulsory Assessment and Treatment) Amendment Act 1999* (NZ), Section 2:

> Legislative powers must be exercised or the proceedings conducted:
> (a) with proper recognition of the importance and significance to the person of the person's ties with his or her family, whanau , hapu, iwi,1 and family group;
> (b) with proper recognition of the contributions those ties make to the person's well-being; and
> (c) with proper respect for the person's cultural and ethnic identity, language, and religious or ethical beliefs."

Recommendation 19: In determining where the balance lays between the right to privacy of the patient, and the needs of unnamed carers of family members to access information that will help them to care for the person, the relevant provisions of the new Act should limit any infringement on privacy rights only to the extent permissible in accordance with section 7 of the Charter.

[49] Consistent with cultural rights under the *Charter of Human Rights and Responsibilities Act 2006*, s19.

Recommendation 20: Consistent with recommendation 19, the requirement to notify a nominated person or alternative 'as soon as reasonably practical' should be complemented with a requirement to ensure that reasonable time is taken to locate the nominated person, proportionate to the purpose and urgency of providing the information to a person other than a nominated person.

1.34 Relationship with the Guardian and Administration Act 1986 (Vic)

Clause 9(2)(b) intimates that a 'nominated person' for the purposes of the Exposure Draft is not necessarily a person that has been appointed by the patient as a guardian in accordance with the Guardian and Administration Act 1986 (Vic). This is so because clause 9(2)(b) provides for a patient's guardian to be provided with information in the event that the patient has not nominated an individual to be provided with relevant information, or the nominated person cannot be located.

Recommendation 21: The Exposure Draft should be amended to clarify the relationship that the nominated persons scheme is intended to have with the Guardianship and Administration Act 1986 (Vic).

1.35 Children of parents with a mental illness

The Commission is concerned that neither the Exposure Draft nor supporting materials address the rights of children whose parents have a mental illness. We believe that consideration of the rights of children of parents with a mental illness will be a critical element of any legislative scheme that wishes to take a holistic, human rights based approach to decision-making and mental health service delivery. The necessity to the development of a human rights culture in Victoria is discussed further below in this submission at paragraph 14.

In circumstances of voluntary and involuntary assessment and treatment of parents with a mental illness, questions will arise that concern the best interests of the child, protection of families and children generally, privacy and reputation (s13 of the Charter) and cultural rights (s19 of the Charter). These concerns may include, but will not be limited to:

- the rights of parents and children to reside together, or have adequate access with one another;
- the rights and ability of parents to participate in decision-making concerning a child's well-being; and
- the provision of adequate support services to children in the care of mentally ill patients.

Recommendation 22: That the Department of Health conduct appropriate consultation to determine how the rights of children of parents with a mental illness may be protected and promoted by the Exposure Draft.

MENTAL HEALTH TRIBUNAL

1.36 Background

The Commission welcomes the establishment of a Mental Health Tribunal as an important practical measure necessary to implement the obligation to promote the right to equal recognition before the law, in accordance with the Charter and Article 12(4) of the CRPD.

Article 12(4) of the CRPD provides an obligation on parties to ensure that:

> all measures that relate to the exercise of legal capacity provide for appropriate and effective safeguards to prevent abuse in accordance with international human rights law. Such safeguards shall ensure that measures relating to the exercise of legal capacity respect the rights, will and preferences of the person, are free of conflict of interest and undue influence, are proportional and tailored to the person's circumstances, apply for the shortest time possible and are subject to regular review by a competent, independent and impartial authority or judicial body. The safeguards shall be proportional to the degree to which such measures affect the person's rights and interests.

Compliance with Article 12(4) of the CRPD requires the Mental Health Review Tribunal to be a body that has the expertise and sufficient understanding of people with mental illness to enable them to make decisions that are independent, and in the best interests of the person that has that mental illness.

It is also critical that the Mental Health Tribunal operate consistently to ensure that rights contained within the Charter are protected. The following rights are particularly relevant:

- Section 8 recognition and equality before the law
- Section 10 protection from torture and cruel, inhuman or degrading treatment
- Section 13 right to privacy and reputation
- Section 14 freedom of thought, conscience, religion and belief
- Section 15 freedom of expression
- Section 21 right to liberty and security of person
- Section 24 fair hearing

The Mental Health Tribunal also has specific obligations under the Charter.

Section 38 of the Charter imposes duties on public authorities to act compatibly with human rights and to give proper consideration to relevant human rights when making a decision. The Charter clearly excludes courts and tribunals from the definition of a public authority, except when they are acting in an administrative, as opposed to judicial, capacity.

When acting judicially, courts and tribunals are not required to comply with section 38 of the Charter. However the Charter does apply by virtue of section 6(2)(b) to courts and tribunals when acting judicially ‘to the extent that they have functions under Part 2 and Division 3 of Part 3’ of the Charter. In the decision of *Kracke*, the human rights in Part 2 that were held to potentially apply to courts and tribunals under section 6(2)(b) are those specified in sections 10(b) (in its reference to punishment), and the fair trial and criminal

procedure rights set out in 21(5)(c), 21(6), 21(7), 21(8), 23(2), 23(3), 24(1), 24(2), 24(3), 25, 26 and 27 of the Charter.

1.37 A Mental Health Tribunal in the Exposure Draft

The Commission welcomes inclusion of provisions in the Exposure Draft that seek to ensure that the Mental Health Tribunal is a 'competent, independent and impartial authority'. We support the inclusion of the principles and procedural requirements contained in the following clauses:

- Clause 25: the Tribunal's ability to review an Inpatient Treatment Order and Community Treatment order on its own motion;

- Clause 27: ensures the Tribunal's independence and confirms that the Tribunal acts without the control or direction of any organisation or person, including the Minister;

- Schedule 2, Clause 4: states that the Tribunal must act in accordance with the rules of natural justice; and

- Clause 90 and Schedule 2, Clauses 5(b) and (c): these clauses confirm the principles to which the Tribunal must have regard, as well as the obligation on the Tribunal to conduct proceedings in a way that recognises and accounts for the needs of any person involved in a proceedings, having regard to their age, any disability and their gender, sexuality, religion, culture (including Aboriginal culture), language and other communication needs.

The Commission submits that despite the inclusion of the above principles and procedures for the Mental Health Tribunal, that the Exposure Draft does not contain enough safeguards to comply with the standards required by the CRPD and the Charter. The remainder of this section of the submission discusses amendments that the Commission suggest be made to the Exposure Draft to ensure timely, effective review and fair conduct of review proceedings by the Mental Health Tribunal.

1.38 Timeliness of Review

Clauses 79(2), 80(2) and 117(2) of the Exposure Draft provide that if a mental health service applies to the Tribunal to consider an application to make an Extended Inpatient Order, Extended Community Treatment Order or Extended Secure Treatment Order, the Tribunal must hear and determine the application before expiry of the existing Order.

Clauses 79(4), 80(4) 117(4) of the Exposure Draft give the Tribunal an opportunity to extend this timeframe for up to 10 days if the Tribunal determines that it cannot hear and determine the application before the expiry of the existing order.

The Exposure Draft does not explain or create a threshold for a 'reasonable justification' where it might determine that it cannot hear or make a decision with respect to an application before the expiry of an order.

The Commission believes that it is essential that the Mental Health Tribunal, wherever possible, review an application to extend an existing order as soon as reasonably possible and prior to the expiry of the order. Any application to the Mental Health Tribunal for the review of an involuntary order should be made no later than 10 business days after the application is lodged.

The Exposure Draft should be amended to ensure that the Mental Health Tribunal is only permitted to extend the time period for the hearing and determination of an application for review, or in any other way delay proceedings, where that delay is necessary, reasonable, proportionate and justifiable in the circumstances. This amendment is required to ensure compliance with obligations under the CRPD and under the Charter.

The Mental Health Tribunal must be sufficiently resourced to meet these obligations, and to ensure that the Tribunal is able to operate with flexibility to hear matters on an ad hoc basis.

Recommendation 23: The Exposure Draft be amended to ensure that the Mental Health Tribunal is only permitted to extend the time period for the hearing and determination of an application for review, or in any other way delay proceedings, where that delay is necessary, reasonable, proportionate and justifiable in the circumstances. The Mental Health Tribunal should be required to demonstrate its reasons for any decision to extend the time period for the hearing and determination of an application for review.

1.39 Legal Representation

The Commission welcomes provisions in the Exposure Draft to permit individuals that appear before the Mental Health Tribunal to receive legal advice and be legally represented. However the Exposure Draft does not go far enough to safeguard the human rights of mentally ill people in that it provides formal, instead of substantive access to legal representation. Given the possible circumstances of the individuals concerns, failure for an individual that is mentally ill to be provided with legal representation would raise concerns as to whether the right to a fair hearing has been accorded with.

The Exposure Draft should be amended to provide for a mechanism by which the Mental Health Tribunal is able to order that an individual be legally represented. An example of where this kind of provision has been incorporated into Victorian legislation that aims to protect the rights of vulnerable people can be seen in section 71 of the *Family Violence Protection Act 2008*, which allows the Court to order that a legal aid lawyer be appointed to appear on behalf of a respondent to an intervention order application to cross examine a protected person under that Act.

Recommendation 24: The Exposure Draft be amended to provide the Mental Health Tribunal with the ability to order that a legal representative be appointed to represent an individual for the purpose of making a review application.

Recommendation 25: An involuntary patient should have the option of being provided with an independent legal advisor to ensure that all relevant considerations and wishes of the involuntary patient are taken into account in the review process.

1.40 Review Officers

The Exposure Draft establishes a role for Review Officers to meet with patients subject to compulsory orders to ensure that the processes and procedures relating to the making of an order have been followed, in compliance with the legislation. Review Officers also have an obligation to provide a patient with advice concerning their rights under the legislation. Clause 88 of the Exposure Draft allows a Review Officer to make an application to the Mental Health Tribunal if they believe that there is a mistake or error in the process for the making of an Assessment or Compulsory Order. A Review Officer may not act as an advocate for a patient.

The Commission welcomes an automatic administrative review on process and procedure where an Assessment or Compulsory Order is made. However the Commission considers that appointment of a Review Officer who is not able to provide legal advice or act as an advocate for a patient does not adequately protect individuals from an abuse of process. Providing automatic administrative review for patients subject to Assessment or Compulsory Orders in the absence of the opportunity to be provided with legal advice and assistance may breach the rights contained in section 8 (recognition and equality before the law) and section 24 (the right to a fair hearing) of the Charter.

The Commission recommends that the role of Review Officers be implemented in addition to a scheme that ensures that individuals who have been made subject to an Assessment or Compulsory Order have substantive access to legal advice and representation, as soon as practical after the making of the order. This is particularly pertinent given the nature of the Assessment and Compulsory Orders, and the ability of these orders to considerably limit the human rights of an individual.

Recommendation 26: The role of Review Officers be supplemented by a scheme that ensures that individuals that have been made subject to an Assessment or Compulsory Order have substantive access to legal advice and representation, as soon as practical after the making of the order.

1.41 Preserving the principle of natural justice

Clause 4(1) of Schedule 2 of the Exposure Draft states:

> **4 General procedure**
> (1) The Mental Health Tribunal—
> (a) is bound by the rules of natural justice;
> (b) is not bound by the rules of evidence or any practices or procedures applicable to courts of record, except to the extent that it adopts those rules, practices or procedures;
> (c) may inform itself on any matter as it sees fit;
> (d) must conduct each proceeding with as little formality and technicality, and determine each proceeding with as much speed, as the requirements of this Act and the regulations and a proper consideration of the matters before it permit.

Clause 4(4) of Schedule 2 of the Exposure Draft goes on to state that:

> Subclause (1)(a) does not apply to the extent that this Act authorises, whether expressly or by implication, a departure from the rules of natural justice.

The Mental Health Tribunal should be bound by the rules of natural justice at all times.

The current Exposure Draft and explanatory materials do not clarify where the proposed legislation intends to expressly or implicitly authorise departure from the rules of natural justice. Any departure from the rules of natural justice will be a limitation on the right to a fair hearing, which is protected in the common law as well by human rights law.
No evidence has been provided to justify how any limitation on the application of the rules of natural justice.

In addition, it has long been established in Australian law that where a Tribunal has the capacity to make a finding that may adversely affect the person or parties to whom the decision pertains, that the decision-making Tribunal will be bound by the rules of natural justice.[50] Failure for the Mental Health Tribunal to afford natural justice to persons or parties at all times could result in a decision of the Mental Health Tribunal being void because the rules of natural justice have not been applied. In addition, it may be considered discriminatory for the rules of natural justice not to be deemed to apply in certain circumstances before the Mental Health Tribunal, where the rules of natural justice are held to apply generally in all other Tribunals.

Recommendation 27: The Commission recommends that subsection 4(4) of Schedule 2 of the Exposure Draft is deleted and that the Mental Health Tribunal remains bound by the rules of natural justice at all times.

RESPECTING THE CULTURAL RIGHTS OF PEOPLE WITH MENTAL ILLNESS

The following rights are specifically engaged in the Charter and in the CRPD in respect of Indigenous Australians and people from culturally and linguistically diverse (CALD) communities who receive involuntary treatment for mental illness:

Charter

- Section 14 freedom of thought, conscience, religion and belief
- Section 15 freedom of expression, including the freedom to receive information
- Section 19 cultural rights

CRPD

- Article 21 freedom of expression and opinion and access to information
- Article 30 participation in cultural life, recreation, leisure and sport

Section 19 of the Charter protects the rights of Victorians to enjoy their culture and identity. Article 30(4) of the CRPD explicitly protects the right of people with disabilities to recognition and support of specific cultural and linguistic identities on an equal basis with others.

[50] See the High Court decision of *Kioa v West* [1985] HCA 81; (1985) 159 CLR 550

The Commission welcomes the inclusion within the exposure draft of Clause 8, which sets out the principle of responsiveness that is required for specific needs and rights as an extremely positive measure:

> **8 Principle of responsiveness to specific needs and Rights**
> (1) In making decisions and providing treatment under this Act, appropriate regard is to be had to any specific needs of a person with a mental illness, including as a result of their age, gender, disability, sexuality, religion, culture, language or other communication needs.
> (2) Without limiting the generality of subsection (1), Aboriginal persons hold distinct cultural rights which must be taken into account.

The Commission welcomes this provision in the Exposure Draft to ensure that the cultural rights of Indigenous Victorians and people from CALD backgrounds must be adequately protected and respected. This should occur in respect of all aspects of mental heath treatment and care and in all contacts with the mental health system.

Promotion of the right to life and equal treatment is particularly required for Indigenous Australians with mental illness. This is especially in light of empirical evidence reported in the Senate Select Committee's report on Mental Health that the Indigenous Australian population has a much higher rate of suicide compared with the general population.[51]

The report also found that there was a gap in mental health service delivery in respect of culturally appropriate mental health services for CALD and Indigenous Australians. The latter who can experience extreme isolation, trauma and stigma.[52]

The Commission considers that the cultural rights of CALD persons and Indigenous Australians with mental illness should also be respected in clinical practice. This goes beyond the provision of interpreters and could be achieved through the promulgation of guidelines so that clinical decisions in respect of CALD and Indigenous Australians with psychosocial disabilities are consistent with the cultural rights protected in the Charter and the CRPD.

Examples where clinical guidelines can arguably promote and respect the cultural rights of people with mental illness in mental health practice include:

- guidance to treating teams during the diagnosis and assessment of mental illness which take into account cultural behaviours, attitudes and beliefs of the particular person;
- incorporating cultural and religious observances into treatment plans;
- recognising diverse family and kinship relations in treatment planning; and
- guiding treatment teams about the significance of a diagnosis of mental illness in different CALD communities and the impact this has on the person who is diagnosed with mental illness in the context of treatment planning and discharge.

[51] The Senate Select Committee on Mental Health, *A National Approach to Mental Health –From Crisis to Community –First Report*, March 2006.
[52] Ibid.

Recommendation 28: That implementation of new legislation be complemented with the development of clinical guidelines that promote the cultural rights of people with mental illness in mental health practice.

IMPLEMENTING A HUMAN RIGHTS CULTURE IN A MENTAL HEALTH SERVICE SYSTEM

Clinical practice in mental health treatment and care that lacks a human rights oriented culture, potentially engages Charter and CPRD rights including:

Charter

- Section 8 recognition and equality before the law
- Section 10 protection from torture and cruel, inhuman or degrading treatment
- Section 12 freedom of movement
- Section 13 Privacy and reputation
- Section 14 freedom of thought, conscience, religion and belief
- Section 15 freedom of expression
- Section 17 protection of families and children
- Section 18 taking part in public life
- Section 21 right to liberty and security of person
- Section 22 humane treatment when deprived of liberty

CRPD

- Article 12 Equal recognition before the law
- Article 17 Protecting the integrity of the person
- Article 19 Living independently and being included in the community
- Article 21 Freedom of expression and opinion and access to information
- Article 22 Respect for privacy
- Article 23 Respect for the family
- Article 29 Participation in political and public life
- Article 30 participation in cultural life, recreation, leisure and sport

Key issues

The *Not for Service* Report,[53] the Senate Committee Inquiry on Mental Health [54] and more recently, the *Lacking Insight* Report,[55] have revealed that there is an appreciable gap between human rights theory and the realisation of human rights in clinical practice and associated processes.

The former UN Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Paul Hunt[56] commented that while a vast

[53] Human Rights and Equal Opportunity Commission, *Not For Service Report* (2005).
[54] The Senate Select Committee on Mental Health, 'A National Approach to Mental Health –From Crisis to Community –First Report,' March 2006.
[55] n 28.
[56] The current UN Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health is Mr Anand Grover, appointed August 2008.

majority of health professionals have contributed to human rights, some have unwittingly or because of political, legal, economic, social or cultural pressures, made decisions with profound human rights implications.

The Commission acknowledges that human rights training targeted at mental health professionals was provided by the Department of Health and Department of Human Services as part of the implementation of the Charter. However, further ongoing, staged and integrated human rights training and education for mental health professionals should be provided to students (undertaking training with a mental health focus) and to clinicians in mental health services and in the community[57] to enable treating teams to make clinical decisions that are consistent with human rights. Training should have a particular focus on day-to-day operations and integration of human rights into decision-making.

A commitment to a human rights culture in mental health services and in the community requires strong leadership at the senior level, across mental health services, authorised psychiatrists, and permeating into treating teams.

To support that leadership, the Act should include a statement that clinical decision and practice making must be consistent the human rights principles entrenched in the Charter and the CRPD.

In the Commission's previous annual Reports on the Operation of the Charter, the Commission has noted that regular review of policies, procedures and guidelines is required in order to ensure continuing compatibility with human rights in a modern and democratic society. It is on this basis that the Commission has welcomed the current review of mental health legislation in Victoria to ensure that human rights deficiencies in the existing legislative scheme can be dealt with. The Commission believes that the current Exposure Draft should provide for regular and timely monitoring and evaluation of the impact that the new legislative scheme for the provision of mental health services in Victoria will have on human rights. Ensuring that the new legislative regime contains a 'built-in' process and period for review would provide a clear opportunity for health professionals, patients and the community to consider how the legislation operates in practice. A time clearly identified for review of the legislation would also ensure, as a safeguard, that there is an opportunity and commitment to make amendments to the legislation where it is determined that the legislation has had an unforseen impact on human right.

1.42 Disability Reference Group Member Views

The DRG has indicated to the Commission that it has serious concerns about how mental health legislation has been implemented in the past in challenging environments. Specifically DRG members raised concerns about existing difficulties concerning a lack of access to services for the proper assessment and treatment of mental illness where patients are living in closed environments. DRG members indicated that they would like the government to take into account how the delivery of mental health services can be improved in closed environments.

[57] John Dawson, 'Community Treatment Orders and Human Rights,' (2008), 26(2), *Law in Context.*

Recommendation 29: The Act should include a provision that clinical decision and practice making must be consistent with the human rights law in the Charter and the CRPD. Relevant principles arising out of human rights law include: respect for inherent dignity, individual autonomy, equality and non-discrimination, full and effective participation and inclusion in society, respect for difference of persons with disabilities, equality of opportunity, accessibility, and respect for the evolving capacities of children.

Recommendation 30: The Act should include a process and period for a review, within a reasonable time period after the enactment of the legislation, to ensure that the human rights impact is monitored and evaluated, and that there is a clear opportunity to amend the legislation where amendments are considered to be required.