HUMAN RIGHTS COMMISSION

The Secretariat
Review of ACT Mental Health Act

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Dear Sir/Madam

Thank you for the opportunity to comment on the 'The Review of the ACT Mental Health (Treatment and Care) Act 1994' Options Papers on both the 'Framework of Mental Health and Related Legislation' and 'Forensic Mental Health' papers.

OVERALL IMPRESSIONS

The Commission appreciates the detailed discussion in the Options Paper of the current system and options for reform, including the human rights implications of each option. In this paper, rather than favouring one option over another, the Commission instead seeks to offer some key considerations in assessing the various options. While there are issues with the status quo, the Commission is mindful any reform may potentially raise new human rights and other issues.

In particular, the Commission recommends that any change to the current system should be supported by additional research and documentation. For example:

- Flowcharts detailing the practical experience or journey of a consumer through a new system, whichever option is chosen, for example using a number of different 'consumer-types'. This might illustrate any pitfalls and potential for consumers to 'slip through the cracks', or for people not currently subject to mental health legislation to be covered in revised scheme. We note the Framework or Non-Forensic options paper includes a beginning of such a chart on page 26, but suggest one that provides a similar snapshot utilising different situations consumers may find themselves in, would aid understanding of any change to the system.

- As noted in our previous submission provided in February 2008, statistical and generalised information about the 14 or so members of the ACT community who have been subjected to Community Care Orders over four years to the end of fiscal 2006-2007 have been provided to the Purpose and Principles Working Group of the RAC. Perhaps the Care Coordinator could seek the consent of those individuals or their guardians to present detailed, but de-identified if possible, case studies to the RAC. Alternatively, similar information could be considered for the most recent financial year. Without an understanding of the situations that the legislative provisions dealing with mental dysfunction seek to address, and identifying any actual problems with the scheme, it is difficult to make convincing arguments that they should be removed.

We note the Framework Options paper provides some of this information including that in 2007-08 there were only 11 medical applications in the whole year for a Community Care Order. We also note that the paper suggests a range of clients with dual diagnosis (that is not mental dysfunction alone) may now be receiving PTOs.

- Similarly, the Commission is aware that the ACT Civil and Administrative Tribunal (ACAT) has introduced a practice of noting in its mental health orders whether a person retains or lacks the requisite capacity to consent to treatment. Given the focus of Option C on capacity, it would be advantageous to have some de-identified data on the numbers of mental health consumers subject to Tribunal orders that have or have not retained capacity.

Human Rights

As the Options Paper notes, there are many human rights implications arising from the current system, and the reforms proposed. In assessing these, the Commission is mindful that section 28 of the *Human Rights Act 2004* ('the HR Act') provides that rights under the Act may only be limited by Territory laws where such limitations are reasonable and can be demonstrably justified in a free and democratic society. Section 28(2) provides criteria for making this assessment of proportionality. In deciding whether a limitation is reasonable, all relevant factors must be considered including:

(a) the nature of the right affected;
(b) the importance of the purpose of the limitation;
(c) the nature and extent of the limitation;
(d) the relationship between the limitation and its purpose;
(e) any less restrictive means reasonably available to achieve the purpose the limitation seeks to achieve.

The Commission agrees that the legislation should at least reflect the UN Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care[1]. The Commission would argue that the UN Principles are more relevant than the ten WHO Principles of Mental Health Law, also noted in the paper, and as a Resolution of the UN General Assembly would satisfy the definition of 'international law' under s.31 of the HR Act. We note that the UN Principles are baselines rather than a ceiling for human rights compliance. For example, in the 'Application of Rights Analysis Instrument to Australian Mental Health Legislation' (2000)[2] for the Australian Health Ministers' Advisory Council (AHMAC) it was noted that some Australian jurisdictions were:

> *'…concerned that voluntary patients in facilities also approved to detain involuntary patients, could be subject to the overt or covert threat of being made an involuntary patient. The UN Principles do not adequately address this issue, except to provide for an active right of discharge, and preference for voluntary admission.'*

[1] GA Resolution 46/119 of 17 December 1991.
[2] Prepared by Dr Helen Watchirs

The Commission is also mindful of the new obligations under the recent *Convention on the Rights of People with a Disability* which is identified by the Options Paper as a key instrument. As discussed below, Australia's likely ratification to the Optional Protocol Against Torture may also have a bearing on these issues.

Consistent with these obligations, and as recommended by the Australian Human Rights Commission (then the Human Rights and Equal Opportunity Commission) in its 1993 'National Inquiry into the Human rights of People with Mental Illness' ('the Burdekin Report'), legislative criteria for involuntary admission should be specific and should include the requirement that there is no less restrictive form of appropriate treatment available.[3]

Finally, the Commission notes the recent announcement by the Northern Ireland Executive to introduce a new Bill covering both mental health and capacity issues by 2011. This may prove a useful model for any changes contemplated in the ACT.

Advance Directives

Whichever Option is favoured, the Commission supports the proposal to make provision for advance directives in the legislation. As Professor Rees notes, key considerations in determining how advance directives will operate in any mental health system include:

> *'…. the test for capacity at the time an 'advance directive' is made, the identity of the person or persons who must attest to the person's capacity at the time an advance directive is made, the means by which an 'advance directive' is drawn to the attention of relevant clinicians, the scope of an advance direction, the circumstances (if any) in which a person's clearly expressed wishes in an 'advance directive' may be overridden, and the identify of the person (or body) who (or which) may be invested with the power to override an 'advance directive'.*[4]

In particular, clinical decision makers should not have unfettered power to override the advance directives of consumers. This situation was criticised by the UK Joint Parliamentary Human Rights Committee in relation to the 2002 draft UK Mental Health Bill, as it would not be consistent with the European Convention on Human Rights (ECHR):

> *"The draft Bill does oblige the clinical supervisor and others to consult (in various situations) the patient, and the patient's carer and the patient's nominated person (who may be obliged to give information about the patient's wishes) before making decisions about treatment, but it will be for the decision-maker then to decide what weight to attach to their views. We have doubts about whether it should be possible to override the wishes of the patient, expressed when capable of making a decision, about treatment. The ECHR permits treatment (including forced feeding through a naso-gastric tube) to keep a person alive against his or her will, if he or she is suffering from a mental disorder at the time, because the state can rely on its positive obligation to preserve life.*

[3] HREOC, Report of the National Inquiry into the Human rights of People with Mental Illness, 1993, http://www.humanrights.gov.au/disability_rights/inquiries/mii.htm

[4] Neil Rees, 'Learning from the Past, Looking to the Future: Is Victorian Mental Health Law Ripe for Reform', Mental health Review Board of Victoria's 20th Anniversary Conference, 6 December 2007.

> *The same duty would justify the state in compulsorily providing treatment to someone who would otherwise be likely to cause death or serious harm to others. But we have doubts as to whether the same principle would justify overriding a direction given with proper capacity where the patient later became ill, but not a threat to himself or others.*[5]

The Commission would support a degree of oversight similar to that currently attached to the making of a Psychiatric Treatment Order, being included in the process of overriding of a future care statement. That would better ensure that any limitation on rights is proportionate, particularly in relation to the rights to privacy (s.12) and liberty (s.18).

Children and Young People

The Commission notes that the Framework Options Papers does not go into detail in relation to how children and young people are to be treated in relation to any new mental health legislative regime (those aged 12-18 years in this context). The Forensic Options Paper also briefly discusses children and young people in relation to information sharing. A lack of detailed discussion at this point is probably appropriate, given there are still fundamental issues outstanding at a general (adult) level about what tests will be used in relation to involuntary treatment.

Nonetheless, the Commission is mindful of the special protection provided to children under the HR Act (s.11) and the obligations contained in international instruments relevant to children and young people, most particularly the United Nations Convention on the Rights of the Child.

We do not propose to go into detail in this submission on these issues, but mindful of these obligations, consideration will be necessary into how any new system treats children and young people, particularly those without capacity (or competence depending on the particular concepts used). Such considerations should also inform the development and construction of the new Adolescent Mental Health Unit.

OPCAT

The Australian Government is expected to ratify the Optional Protocol Against Torture (OPCAT), in the coming months. This Protocol requires independent oversight and reporting of places of detention, including prisons and mental health facilities. New Zealand has already ratified OPCAT and released two reports detailing the monitoring of such facilities. The most recent report, released in December 2009, includes a list of relevant international instruments dealing with the treatment of detainees (Appendix 2) and details a monitoring standards framework with reference to relevant considerations and instruments (Appendix 3). This report would be useful in further refining any new legislative regime.[6]

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[5] House of Lords and House of Commons Joint Committee on Human Rights, 'Draft Mental Health Bill', 25th Report of Session 2001-02.

[6] A copy of the New Zealand OPCAT report is available at http://www.hrc.co.nz/hrc_new/hrc/cms/files/documents/18-Dec-2009_14-23-46_Opcat_2009_final-web.pdf

In particular, the Optional Protocol should be considered along with the other international instruments listed in the two papers, particularly those listed on page 16 of the Forensic Paper.

FRAMEWORK OPTIONS PAPER

Option A

The Commission agrees that the current arrangements contained in the *Mental Health (Treatment and Care) Act 1994* raise human rights issues, particularly in relation to involuntary treatment.

Principle 4(1) of the 'UN Principles on the Protection of Persons with Mental Illness and the Improvement of Mental Health Care' states that 'a determination that a person has a mental illness shall be made in accordance with internationally accepted medical standards.' As such, questions have been asked about whether the coverage of the ACT's existing legislation is consistent with the Principles, given it contains the broader concept of 'mental dysfunction'.[7]

The UK Joint Committee on Human Rights made similar criticisms of the UK's draft Mental Health Bill in 2002, which included coverage of the mental health regime to those with mental dysfunction, including those with addiction and learning disorders. The Committee concluded that such inclusion limited the 'fundamental aspect of the right to personal autonomy and physical integrity which arises at both common law and under Articles 3 and 8 of the ECHR [equivalent to sections 10 and 12 of the HR Act]' [8] While the Bill went through many iterations, ultimately the UK Mental Health Act was amended to essentially exclude those with learning disorders or addiction to drug or alcohol from the definition of mental disorder.[9]

The ACT legislation does not seek to cover conditions not included in the Fourth Edition of the Diagnostic and Statistical Manual (DSM-IV). While the existing broad coverage may be an issue, it is also subject to the current tests of involuntary treatment including risks of harm to self and others. Arguably, the most fundamental question of this review is whether and in what form individuals should be subjected to involuntary treatment.

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[7] The ACT was criticized in the AHMAC 'Application of Rights Analysis Instrument to Australian Mental Health Legislation'

[8] House of Lords and House of Commons Joint Committee on Human Rights, 'Draft Mental Health Bill', 25th Report of Session 2001-02.

[9] Subsection 1(2A) states – 'But a person with learning disability shall not be considered by reason of that disability to be –
(a) suffering from mental disorder for the purposes of the provisions mentioned in subsection (2B) below; or
(b) requiring treatment in hospital for mental disorder for the purposes of sections 17E and 50 to 53 below,
unless that disability is associated with abnormally aggressive or seriously irresponsible conduct on his part.
Subsection 1(4) states Dependence on alcohol or drugs is not considered to be a disorder or disability of the mind for the purposes of subsection (2) above.

The UN Principles make clear that whatever illness is covered by mental health law, any involuntary treatment should be appropriate to the patient's health needs. Principle 9 states:

> *'Every patient shall have the right to be treated in the least restrictive environment and with the least restrictive treatment to the patient's health needs and the need to protect the physical safety of others.'*

Similarly, Principle 10 states:

> '*Medication shall meet the basic health needs of the patient, shall be given to a patient only for therapeutic or diagnostic purposes and shall never be administered as a punishment or for the convenience of others.'*

As such, a key consideration of any new regime will be how it ensures that consumers receive treatment appropriate for their condition (whatever that might be).

In other jurisdictions, the question of whether involuntary treatment is the most appropriate for the individual's particular mental dysfunction or illness has been to some extent waived for patients in the criminal justice system. Principle 9 does appear to contemplate the involuntary detention or treatment of someone with a mental illness where such 'treatment' is for the protection of others. This is discussed below in relation to the Forensic Options Paper.

In relation to non-forensic consumers, the separate assessment of people with mental illness for involuntary treatment has been criticised on the basis it is discriminatory and breaches the right to equality under the International Covenant on Civil and Political Rights (as adopted by s.8 of the HR Act). The Options paper notes the decision of *Herczegfalvy v Austria*,[10] which set out general rules on forced medical treatment (including forced feeding) of a person who lacked capacity and was imprisoned by the State.

It is worth noting these issues were touched upon in the recent ACT Supreme Court case of *Australian Capital Territory v JT*[11], in which Chief Justice Higgins ruled a person with a long psychiatric history of paranoid schizophrenia who was refusing naso-gastric forced feeding, should be forced fed by the state, on the basis he was not of sound mind and not capable of informed consent. He therefore could not be regarded as having agreed to withdrawal of or refusal to apply available medical treatment.

As discussed further below, many commentators have suggested it is these general principles of forced medical treatment that should be applied in all cases where capacity is at question.

This argument is strengthened by the provisions of the Convention on the Rights of Persons with Disabilities (CRPD), recently ratified by Australia. Arguably the CRPD does not set out any new rights, but clarifies existing rights to ensure that persons with disabilities are

[10] 24 September 1992 (No.15) EHRR 437 (1993)
[11] [2009] ACTSC 105

treated equally and actively participate in decision making.

Article 1 of the CRPD notes that persons with disabilities include 'those who have long-term physical, mental, intellectual or sensory impairments which various barriers may hinder their full and effective participation in society on an equal basis with others.'

Article 12 of CRPD in particular recognises the full legal capacity of all people with disability. It has been suggested by some commentators that the effect of Article 12 is to prevent involuntary psychiatric treatment in any situation.[12] However, the growing consensus in Australia appears to be that Article 12(4) does provide the basis for lawful involuntary treatment and substitute decision making, provided it is only used as a last resort:

> *'States Parties shall 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.'*

This interpretation is supported by the Victorian Public Advocate[13] and the Human Rights Law Resource Centre.[14]

Mindful of these limitations, the Commission agrees that limitations on key rights protected in the HR Act should be addressed through a reform of the current system.

Option B

As detailed above, the Commission notes the potential human rights issues in treating those with 'mental disorders' under the current mental health system. Option B therefore offers a solution to this issue by removing this group from the current Mental Health (Treatment and Care) Act.

The Commission is, however, concerned to see how such a change would work in practice, dealing with individual consumers. As the Options Paper notes, there may still be considerable human rights implications arising from operation of substituted decision making, particularly where substituted decision makers authorise involuntary treatment.

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[12] See for example comments by Australian Federation of Disability Organisations.
[13] Victorian Public Advocate, 'Australia's ratification of the UN Convention on the Rights of Persons with Disabilities', March 2008, http://www.publicadvocate.vic.gov.au/file/file/Research/Submissions/2008/Sub_to_UN_Convention_08.pdf?phpMyAdmin=fe8bb73b8ddef429ba268102bddcf16c.
[14] Human Rights Law Resource Centre, Submission to Possible Ratification of Convention, February 2008, http://www.hrlrc.org.au/files/X34WOWUHWQ/Letter%20re%20Ratification%20of%20Disability%20Convention.pdf

Professor Rees, chair of the Victorian Law Reform Commission has moved away opposing the use of guardianship to authorise coercive treatment, if strict safeguards are incorporated

> *'In the past I have argued that there are a number of reasons why guardianship laws should not be used in this fashion. Those reasons include the potential for conflict between the guardian and the person under guardianship, especially when the guardian may be a friend or family member, and the need for transparent and 'arm's length' decision-making when the loss of important liberties, such as liberty and bodily integrity, is at stake. While these considerations continue to be important, there are other steps that may be taken such as permitted external review of individual decisions made by guardians, which may cause the balance to tilt in favour of using guardianship rather than mental legislation in some instances when formal legal power is needed to direct where a person should live or whether they must accept treatment.'*

Such safeguards would reduce limitations on the rights to privacy (s.12), fair trial (s.21) and liberty and security of the person (s.18) in the HR Act.

As the Options Paper notes, some analysis is required of how consumers of this type would navigate through any new system, and the resource implications. The failure to provide proper resources could result in a breach of the prohibition against inhumane treatment (s.10 of the HR Act). As Rosenthal and Sundram have noted:

> *'Often neglect may be due to a lack of resources or staff. The linkage between the protection of individuals in medical research and the protections against torture and inhumane treatment in the language of the ICCPR is an indication that this protection was not intended to be limited to politically-motivated actions by government authorities but is also applicable to medical or scientific practices.'*[15]

Further, the Commission is conscious of the references in the Discussion Paper to 'restrictive practices' occurring in mental health facilities, disability homes, aged care and nursing homes, respite facilities, hospitals and private homes which may not have a sound legal basis. Such action by an ACT Public Authority would be contrary to obligations under s.40B of the HR Act in respect of the right to liberty and security of the person under (s.18). Similar issues were considered in the House of Lords in the case of *R v Bournewood Community and Mental Health NHS Trust, ex parte L. (Secretary of State for Health and other intervening).* [16] In that case, a 'compliant patient' was not capable of consenting to treatment, but was nonetheless detained under the British common law doctrine of necessity. It is this common law doctrine that the Discussion Paper suggests current ACT services providers would also be relying upon in many restrictive practices. The House of Lords found it was lawful to treat the patient as a voluntary patient, thereby denying him the protection afforded to those held compulsorily or involuntarily. In response, the British Government made changes to its mental health and capacity legislation. This situation under ACT law is unclear. This is

[15] Sundram, Clarence and Rosenthal, Eric, 'International Human Rights in Mental Health Legislation', New York Law School Journal of International and Comparative Law, 2002
[16] [1999] 1 AC 458, HL

discussed further below in terms of principles that may be drawn for the purposes of the Review.

The Commission is also mindful of existing limitations of the guardianship system, whereby substituted decision makers and treating health professionals are left in a legal uncertainty when those without capacity nonetheless strongly physically oppose any treatment.

As such, it might be argued that Option B does not make all necessary reforms to deal with the human rights (and other) issues identified.

Option C

Option C does appear to address some of the above issues in advocating for a single piece of capacity legislation for all those requiring involuntary treatment. Richardson questions in relation to the European Convention on Human Rights 'why should the forcible medication of a competent adult simply to preserve her mental health be permitted under article 8.2 if forcible medication in the interests of her physical health would not be'. [17] The recent announcement of the Northern Ireland Executive to create a single piece of law covering both issues of mental health and capacity has been motivated by these concerns.

As Dawson and Szmukler have similarly noted:

> "*One major aim of bringing all involuntary treatment under a single legislative scheme is to avoid discrimination against people with mental disorders (and, perhaps, against mental health professions) by not making psychiatric treatment unnecessarily the subject of special legislation. Using a single scheme acknowledges the problematic character of the distinction between 'mental' and 'physical' illness….under a comprehensive statute, the decision-making incapacity of the patient would be the central criterion for involuntary treatment in all medical contexts.'*[18]

They advocate that the test for involuntary treatment should shift away from potential 'risk of harm' as the central ground upon which psychiatric treatment should be imposed. This would permit earlier intervention and would ensure uniform application of the criminal law. The authors note that any new criteria would need to comply with the European Convention on Human Rights' protection from unlawful detention (similar to the protection provided by s.18 in the HR Act). While noting that the Convention does not expressly provide for involuntary treatment or detention based on general incapacity criteria, they argue that the European Court of Human Rights decision in *HL v United Kingdom* does offer a precedent that 'persons of unsound mind' may be detained. This decision was made following an appeal from *L* in the House of Lords decision in *Bournewood* discussed above.

[17] G Richardson, 'The European convention and mental health law in England and wales: Moving beyond process?', International Journal of Law and Psychiatry 28 (2005) 127
[18] John Dawson and George Szmukler, 'Fusion of Mental Health and incapacity legislation', British Journal of Psychiatry (2006).

> *'Following the decision of the European Court of Human Rights in HL v the United Kingdom (2004), the legislation should also provide some procedural safeguards for non-objecting but incapacitated patients, when restrictions on their liberty, exercised during their care, are of such a 'degree and intensity' as to constitute 'deprivation of liberty'…that is likely to be the case whenever public sector health professionals exercise 'complete and effective control' over the patient's care and movement….In our view, the scope of such extra protections should depend largely on the incapacity and vulnerability of the persons concerned, not on the distinction between psychiatric and general medical care.'*

It would seem this description would include those elderly patients who anecdotally, as referred to above, are detained without a proper legal basis. The UK's response to the *Bournewood* issue is discussed below.

However, the Commission is mindful that the current inclusion of principles based on harm or deterioration in the ACT legislation is largely consistent with the criteria set out in Principle 16 of the UN Principles. Principle 16 requires, among other things, a diagnosis by a qualified mental health practitioner that a person has a mental illness and that he or she considers:

> (a) That, because of that mental illness, there is a serious likelihood of immediate or imminent harm to that person or to other persons; or
> (b) That, in the case of a person whose mental illness is severe *and whose judgement is impaired*, failure to admit or retain that person is likely to lead to a serious deterioration in his or condition or *will prevent the giving of appropriate treatment* that can only be given by admission to a mental health facility in accordance with the principle of the least restrictive alternative. [emphasis added]

On the other hand, the emphasised text suggests that there is a case for including criteria of lack of capacity combined with specified need for treatment.

The Commission is aware of the submission to the RAC by Ryan, Large Nielssen and Hayes, that capacity alone should be the test for involuntary treatment. This submission notes research suggesting that the assessment of consumers for admission shows 'only very modest agreement' amongst doctors on the risk of danger to self or danger to others. Similarly, the submission refers to research findings that predictions of violence and predictions of self-harm are also poor. The submission also proposes that a change to an assessment based on capacity would lead to earlier inventions in consumers with psychosis.

Nonetheless, a capacity test alone as suggested by Ryan, Large, Nielsen and Hayes may not be consistent with the United Nations Principles. While the Principles are not binding, given the uncertainty over the CRPD impact on involuntary treatment, they remain the clearest

statement in international law on how involuntary treatment should be applied to those with mental illness. As Dr Watchirs has noted previously:

> *'These Principles have some legal weight as a UN General Assembly Resolution, but are not formally binding, except to the extent that they reinforce general human rights treaty obligations in the International Bill of Rights through the specific guidance they provide'*[19]

Rosenthal and Sundram suggest former UN Special Rapporteur on Disabiilty Bengt Lindqvist had concerns with Principle 11 and its potential discriminatory focus. They point to a conference of disability rights experts in November 2000 which resolved that any law is 'inherently suspect as a form of discrimination' if it permits coercive treatment for individuals with disabilities, but not for other people.[20] However, the Commission has been unable to find any further consideration of these issues in relation to Principle 11 and it appears it remains the most specific United Nations statement on these issues.

In advocating for a capacity-only test, Richardson admits the Canadian Supreme Court case of *Starson v Swayze*[21] does show how difficult a capacity test in the context of mental disorder can be. The case concerned a university academic suffering bi-polar who declined drug treatment as he believed it affected his capacity to think. The Consent and Capacity Board imposed involuntary drug treatment on the basis that he did not recognize that he was ill and that he needed treatment, that he was not able to understand the consequences to consent and he failed to appreciate the risks and the benefits. On this basis, he lacked the requisite capacity to refuse treatment.

The majority of the Supreme Court found the Board had erroneously based its ruling on "the best interests" of the patient when its sole determining factor was supposed to be the patient's capacity:

> "*Capacity involves two criteria: first, a person must be able to understand the information that is relevant to making a treatment decision and second, a person must be able to appreciate the reasonably foreseeable consequences of the decision or lack of one. The legislative mandate of the Consent and Capacity Board is to adjudicate solely upon a patient's capacity and the Board's conception of the patient's best interests is irrelevant to that determination."*

The Commission's research Starson's further appeals against subsequent findings of lack of capacity by the Board have failed.[22]

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[19] Dr Watchirs, 'Human rights audit of mental health legislation – results of an Australian pilot', International Journal of Law and Psychiatry 28 (2005) 99-125.
[20] Sundram, Clarence and Rosenthal, Eric, 'International Human Rights in Mental Health Legislation', New York Law School Journal of International and Comparative Law, 2002
[21] 2003 SCC 32, [2003] 1 S.C.R. 722
[22] http://www.canada.com/ottawa/ottawacitizen/news/story.html?id=b5bd867f-db9e-40e2-a52b-013173bd39a8

Any reform of the test for involuntary treatment based on capacity needs a detailed examination of what the test for capacity will be. There would also be questions as to what would happen to particular individuals navigating through the new system.

Section 26 of the existing *Mental Health (Treatment and Care) Act 1994* does include capacity in the list of matters the Tribunal must consider generally, but it is not specifically referred to in s.28 (governing psychiatric treatment orders). It might be that one improvement would be to give capacity greater prominence in the Tribunal's assessment of involuntary orders.

Option C would also appear to require a new level of practical support through ACT Government agencies, which should be properly resourced by Government before any change occurs. As was noted by the UK Joint Human Rights Committee in 2002, insufficient resources, particularly where such insufficient resources result in people being detained involuntarily for longer periods, will breach human rights obligations such as Article 5 of the European Convention on Human Rights (the equivalent s.18 in the HR Act)

> *"…detention initiated lawfully and for a lawful purpose may become unlawful under Article 5 on account of the suitability of the resources which are available for a patient's treatment.'*

The Commission would also strongly advocate that consistent with the rights to privacy (s.12), fair trial (s.21) and right to liberty and security of the person (s.18) any extension of guardianship powers to encompass some form of coercive power would have to be sanctioned through a court or tribunal on a case by case (and likely specific action) basis.

Bournewood Patients

Whatever option is chosen, consideration will be needed into how 'Bournewood' patients, or those dubbed 'compliant' and unable to express their consent (or otherwise) to treatment should be considered. These are described in the Discussion Paper as patients subject to 'restrictive practices' in the ACT. Such patients, at least in the UK, were at risk of receiving treatment that might not be necessary or in their best interests. On appeal, the European Court of Human Rights in *HL v United Kingdom* noted the lack of procedural rules under British law for admission and detention of 'compliant incapacitated persons' compared to the extensive network of safeguards applicable to those treated involuntarily under the mental health regime. The European Court found key ingredients were necessary and missing from the UK law:

1) Formalised admission procedures indicating who can propose admission, for what reasons and on the basis of what kind of medical and other assessments;
2) The exact purpose of admission and limits in terms of time, treatment or care must be attached to admission
3) There must be continuing clinical assessment of the disorder warranting detention
4) The appointment of a representative of a patient who could make certain objections and applications on his or her behalf.

The Government made subsequent amendments to the UK *Mental Health Capacity Act 2005* which gained general support from the joint Parliamentary Committee on Human Rights initially, although the Committee did suggest subsequent amendments.[23] The Commission submits that whatever options are chosen, such considerations are also given to how to deal with similar compliant patients in the ACT.

Conclusions

As detailed above, there are human rights implications to all three Options proposed in the Paper. While the details of each Option and its application require further consideration, in our view it is arguable that human rights principles, international instruments and jurisprudence do require a greater emphasis on capacity than that provided for in the current Mental Health (Treatment and Care) Act. However, consistent with the UN's Mental Health Principles, it seems any test for involuntary treatment must also take into account issues of serious harm to the individual or others.

[23] See 2001-02 report vs 2006-07 reports

FORENSIC PAPER

Introduction

The Commission is mindful that whatever decisions are made in relation to the non-forensic system, these decisions will impact on the forensic mental health system ultimately adopted by the Government.[24] As such, we make only general comments on the forensic system at this stage, and will provide more detailed comments as those decisions are made.

The reference to the four sources of International law relevant to the interpretation of the HR Act is incorrect, as the reference to the Australian National Statement of Principles for Forensic Mental Health would not satisfy the definition of 'international law' under the HR Act.

Please note, the Paper includes a slight error in that it refers to the sections of the HR Act coming into effect (sections 40B and 40C). These new sections had already commenced when the paper was released.

As way of furthering the discussions around a forensic system generally, the Commission notes that Dawson and Szmukler have offered an approach for a forensic system where the non-forensic system uses capacity as the model of care involving:

a. Any prisoner or forensic patient with capacity who consents to treatment may be treated voluntarily in an appropriate facility, during which sentence would continue to run.
b. When forensic patients lack the capacity to make treatment decisions, their treatment without consent would be justified on the same basis as other non-forensic incapacitated patients.
c. When prisoners lack the capacity to consent to treatment, their transfer to hospital and treatment without consent would be authorised [presumably by an independent adjudicator such as a court or tribunal]. If they regain capacity, treatment could continue only with their consent with return to prison if they refused.
d. In the case of those found not guilty by reason of insanity or unfit to stand trial, who cannot be sent to prison, their treatment without consent might be unlawful even if they retained capacity. This is because they have been shown, on reliable evidence, to have committed the acts or omissions necessary to constitute a serious offence; they are suffering from a serious mental disorder that contributed significantly to their conduct; and an effective treatment can be offered that could reasonably be expected to reduce the risk of recurrence. This could be the limited exception to pure incapacity principles, necessary to reduce the risk of harm to others.
e. Upon a person's conviction for a serious criminal offence, an appropriate prison sentence would be imposed. Offenders who were found to lack capacity to consent to treatment at that time could still be directed to hospital for treatment, and during their time in hospital, their prison sentence would continue to run. If they regained

[24] Notwithstanding that the World Health Organisation's 'Resource Book on Mental Health, Human Rights and Legislation', 2005, suggests it is possible to interpret 'mental illness' or 'mental dysfunction' narrowly in relation to punitive purposes, but more widely for beneficial purposes.

capacity and refused treatment, however, they would be transferred to prison to continue their sentence. At the end of their sentence, if capacity was not regained, their involuntary treatment could continue as a civil patient.

Alternatively, a criminal court imposing a hospital order for treatment following a person's conviction could set a limiting term, proportionate to the seriousness of the offence, during which the involuntary treatment would be lawful despite that person having capacity, on the same conditions as those stated above for those found not guilty by reason of insanity.'[25]

Item D above, along with the 'alternative scenario' proposed seems broadly similar to that proposed in the discussion paper in relation to Special Hearings regime.

Role of the Commission

We note the discussion of oversight bodies on page 11 of the Forensic Paper. TIt might be noted that the Human Rights Commissioner also has a systemic audit role under the HR Act, as well as an inspection role under s.56(1)(d) of the *Corrections Management Act 2007,* and that the Children and Young People Commissioner and Disability and Community Services Commissioner can take complaints in relation to services provided for those client groups or conduct a commission-initiated consideration into those services.

Special Hearings – Options 1,2 and 3.

The Commission is supportive of victims being made aware of decisions not to prosecute, and indeed general notifications about the release of alleged offenders. However, we remain confused about why it is proposed that the Director of Public Prosecutions (DPP) will *consult* with a victim when the DPP decides to take no further action against an accused who is a forensic patient. In particular, this raises the question as to whether the DPP currently consults with all victims before making a decision not to prosecute. If not, such consultation would appear discriminatory against those accused of a criminal offence that suffer from a mental illness or dysfunction and may unreasonably limit the right to equality (s.8). Further, it is unclear how this consultation would bring matters to the attention of the Tribunal as the Paper suggests, and for what purpose?

Criminal responsibility and mental impairment – Options 4, 5 and 6.

The Commission is unclear on the reason to mandate the Court referring those found not guilty by reason of mental impairment to the Tribunal. The current system, whereby the Court can take this action, or make another appropriate order would seem more flexible and preferable, as it gives the Court the discretion to refer the matter to the Tribunal or take other appropriate action. It is unclear why this flexibility should be removed.

[25] John Dawson and George Szmukler, 'Fusion of Mental Health and incapacity legislation', British Journal of Psychiatry (2006).

Information Sharing – Options 7, 8 and 9

As noted in the paper, the sharing of an individual's health information would limit the right to privacy in the HR Act (s.12). Nonetheless, such limitation may be proportionate and reasonable in circumstances where it is intended to assist in the care of the person. However, such sharing of information would have to be limited in its coverage and in clearly defined circumstances in order to be proportionate. In particular, there are also safeguards and procedures for the transfer of information governed in legislation, for example the ACT *Health Records (Privacy and Access Act) 1997,* under which the Health Services Commission may handle complaints.

Victim's Rights – Options 9, 10 and 11

The Commission wishes to clarify whether the proposal for victim impact statements in relation to special hearings would only be provided in circumstances of non-acquittal? Consideration of a victim impact statement before a determination had been made could be discriminatory against those with a mental illness or disorder (on the basis such statements are not considered during criminal trials before a determination of guilt has been made). This appears to be the option proposed, but is made unclear in the paper by the following:

> *'The VoCC and others have reported to JACS that there have been a series of recent instances in the Territory where victims have been unable to satisfactorily put forward their views, or to have their needs addressed, in relation to court matters dealing with an accused's fitness to plead.'*

It is unclear in what circumstances a victim would be providing evidence or putting forward opinions on an accused's fitness to plead. These are questions of clinical judgment and legal thresholds. It is difficult to imagine a scenario where a victim's evidence could have probative value. Section 137 of the Commonwealth *Evidence Act 1995*, which applies in the ACT, prevents evidence in criminal proceedings being adduced by the prosecutor if its probative value is outweighed by the danger of unfair prejudice to the defendant. This could be the case in relation to such evidence by victims and could raise issues in relation to the right to fair trial (s.21) and equality (s.8) of the HR Act.

In relation to question 13, the Commission also assumes that it is the practice of courts now to note how they have taken into account Victim Impact Statements in relation to criminal trials. Otherwise again, the proposed in question 13 would appear to discriminate against those with mental illness or impairment.

Options in Relation to Decision Making – Questions 18-25

The Commission submits there are some issues with the current 'nominal sentence' regime, particularly in relation to the right to liberty of the person (s.18). That is, under the current system it appears the Court is sentencing a person as though they have been found guilty of an offence. That is not the case, particularly as the person has been found explicitly not to have the requisite fault element to have committed a criminal act.

Further, they have not had the opportunity to have the sentence discounted in any way, for example by pleading guilty. There is therefore a risk those with mental illness of dysfunction spend greater time being potentially subject to detention than those found guilty of criminal conduct.

The setting of such a nominal imprisonment term can also unfairly imply to the Tribunal that this is the minimum (and maximum) time a person should be detained.

Nonetheless, the Commission accepts the intention of the current scheme is to avoid indefinite or longer detention for those found unfit to plead, as is the case in other jurisdictions.

The suitability of the person for treatment is also not one of the considerations of the Tribunal in ordering treatment. The Commission notes the proposal to transfer decision-making to the Court would enable the Court to obtain expert advice on which facility and services can meet the psychiatric needs of the person. The Commission submits that whichever body is making these decisions, consideration should be given to including the suitability of treatment in the factors considered in mandating treatment.

The Commission is mindful that some have argued that the 'treatability' of a person found not guilty by reason of mental impairment may not be a primary consideration of involuntary 'treatment' or detention, on the basis of their risk of serious harm to themselves or others, and lack of capacity may render the limitation on their rights reasonable. Arguably, in any new system, consistent with the international jurisprudence discussed in relation to the non-forensic options paper, capacity should also be a major consideration of any involuntary 'treatment' or detention.

The Commission also submits further information is required to explain, as the Forensic Paper proposes, when 'a person would be found not fit to plead by a Court, but would also not be suitable for civil orders.' There appears to be a preventive detention element to the orders contemplated, which is concerning:

> *The Tribunal's role in civil matters is to provide treatment and care for mentally ill and mentally dysfunctional persons in a manner that is least restrictive of their human rights.*
> *In a forensic matter, the primary focus of the Tribunal is the need to provide for the treatment and care for mentally ill or mentally dysfunctional persons who have come to the attention of the justice system in order to protect the community from harm.*

The ACT Civil and Administrative Tribunal (ACT) is a public authority under the HR Act. Section 40(2)(b) suggests that such obligations will only flow to courts when they are acting in an administrative capacity. However, the Victorian Civil and Administrative Tribunal decision in *Kracke v Mental Health Review Board*[26] is precedent for the proposition that the 'administrative' coverage is narrow in relation to Tribunals.

[26] [2009] VCAT 646 (23 April 2009)

That is, if the Kracke decision were applied in the ACT, the ACAT would be subject to the obligations placed on all ACT public authorities in exercising its decision making powers.

Further, the HR Act requires that all ACT laws must be interpreted consistently with human rights (s.30) and that such rights can only be limited by ACT law in certain circumstances (s.28).

As such, the Tribunal's role at all times is to authority involuntary treatment for clients in a manner least restrictive of their human rights, whether they are considering such issues in the civil or forensic jurisdiction. This is reflected in the Victorian legislation which as the Forensic Paper notes, provides that in making decisions the court must apply the overarching principle that restrictions on a person's freedom and personal autonomy should be kept to the minimum consistent with the safety of the community.

Such limitation on freedom is arguably justified in circumstances where a person has been found not guilty of a criminal offence on the basis of some mental impairment. While the Commission has not had an opportunity to consider the Victorian legislation in detail, it seems a sensible way of dealing with such matters. However, the proportionality of such legislation in the ACT would have to be considered in detail once it was drafted, to take into account issues such as the 'treatability' of the dysfunction or illness concerned, the capacity of the individual and the particular risks they posed to themselves or the community.

Preventative Detention?

The Commission is concerned that progressing some of the options canvassed in this section of the paper may lead to 'preventative detention' type orders, for example at page 13 of the definition of forensic patients as those 'people with a mental illness in mainstream mental health services who are a significant danger to their carers and/or the community and who require specialist forensic mental health services.' Even individuals who have not been charged with any criminal offence and are suffering mental illness (as opposed to mental dysfunction?) may be included under this definition of 'forensic patients'.

This is briefly discussed in the Non-Forensic Paper. The Commission notes that three views are put forward – that the same protections against incarceration apply in both the Forensic and non-Forensic spheres. Secondly, that the state retain the power to detain those who are 'dangerous to their families, carers or society at large', provided that their disorder is 'treatable'. Finally, the test of 'best interests' of the person is used. The Commission welcomes the reference to a 'robust review mechanism' being used. From a human rights perspective, the first of these options would appear to be the least restrictive on rights. Nonetheless, there is some jurisprudence to support other options being considered including those based on serious harm to others.

However, as noted above, predictions of violence have been shown to be unreliable. The 2002 UK draft Mental Health Bill sought to permit the indefinite detention of people with a mental disorder who were presumed dangerous, had committed no criminal offence, and may have a condition that was not considered treatable. This was found to raise human rights issues by the Joint Human Rights Committee as the law was:

> "…to permit the compulsory detention and care of people for the protection of others when the people detained have never been charged with any criminal offence and nothing can be done to alleviate the mental disorder from which they are suffering. This raises human rights issues, flowing mainly from the breadth of the circumstances in which a patient could be subjected to compulsory, non-consensual treatment.'[27]

Ultimately, such detention was found to be proportionate by the Joint Human Rights Committee, but only where such mental health disorder impacted on capacity.

> 'Where a patient is suffering from a condition which seriously impairs his or her mental capacity to choose whether to accept treatment, there seems to us to be a rational and objective justification for treating that person differently, in relation to decisions about treatment, from someone whose mental capacity for decision-making is not so seriously impaired. This consideration seems to use to justify the liability of mentally disordered patients to non-consensual medical intervention where other patients would not be so liable, avoiding a violation of ICCPR Article 26 [equivalent to s.8 of the ACT HR]'

This was on the basis that compulsory detention was only authorised where either:

(a) a person at substantial risk of causing serious harm to others, whom it is necessary to treat for the protection of such people; or
(b) a person to whom it is necessary to provide medical treatment for his or her own health or safety or to protect others, and to whom treatment could not be provided unless the compulsory provisions were applied.

This is broadly consistent with the tests contained in Article 16 of the UN Principles.

The European Court of Human Rights held in *Hutchinson Reid v UK* that a person may be detained if it is properly established they are of 'unsound mind' (as per Article 5 of the European Convention) and there is a danger of harm to others, even where the patient is suffering from a psychopathic disorder that cannot be treated in hospital.[28] The twin requirements that the person is of unsound mind and a risk of harm to others also appears consistent with UN Principles, although the terminology is more dated.

Nonetheless, caution must be taken on embarking on any such a legislative regime without ensuring such limitations on human rights are the absolute minimal required. The UK's Joint Parliamentary Committee on Human Rights is only one source of authority on this issue and it also raised concerns about the reliability of 'risk factors' in predicting serious harm to others. The European Court of Human Rights decision in *Hutchinson Reid v UK* also pre-dated the United Nations' adoption of the International Convention on the Rights of People with Disability. The human rights proportionally depends on the specific protections and

[27] House of Lords and House of Commons Joint Committee on Human Rights, 'Draft Mental Health Bill', 25th Report of Session 2001-02.
[28] *Hutchinson Reid v UK* (2003) ECHR 94

drafting contained in such law, regarding the individual's capacity and the particular threshold of harm (likely serious harm).

Attorney-General's Right of Appearance

The need for a right of appearance for the Attorney-General to deal with matters of 'public safety' is unclear. It would be highly unusual for the Attorney-General, as a member of the Executive, to intervene in any criminal trial. The interests of the community are represented by the state through the independent office of the Director of Public Prosecutions. It is unclear why there should be any special attention given to matters involving the consideration of suitable treatment orders for individuals with mental illness or dysfunction. The Attorney-General already has power to intervene in any court or tribunal matter under s.35 of the HR Act, whereas the Human Rights Commissioner must seek leave to intervene.

Children and Young People – Questions 32-33

Again, any restrictions on the right to privacy, particularly in relation to children and young people, will need careful scrutiny to determine if it provides the minimal limitation possible for the legitimate purpose of providing the best care for that child or young person.

Thank you for the opportunity to comment on these matters.

Yours sincerely

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Human Rights and
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Children and Young People
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Mary Durkin
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Disability and Community
Services Commissioner

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