Dignity, Equality, Freedom & Respect: A Human Rights-Based Approach to Mental Health

Submission to the

Review of the *Mental Health Act 1986*

February 2009

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About the Human Rights Law Resource Centre

The Human Rights Law Resource Centre (***HRLRC***) is an independent community legal centre that is a joint initiative of the Public Interest Law Clearing House (Vic) Inc and the Victorian Council for Civil Liberties Inc.

The HRLRC provides and supports human rights litigation, education, training, research and advocacy services to:

(a) contribute to the harmonisation of law, policy and practice in Victoria and Australia with international human rights norms and standards;

(b) support and enhance the capacity of the legal profession, judiciary, government and community sector to develop Australian law and policy consistently with international human rights standards; and

(c) empower people who are disadvantaged or living in poverty by operating within a human rights framework.

The four 'thematic priorities' for the work of the HRLRC are:

(a) the development, operation and entrenchment of Charters of Rights at a national, state and territory level;

(b) the treatment and conditions of detained persons, including prisoners, involuntary patients and persons deprived of liberty by operation of counter-terrorism laws and measures;

(c) the promotion, protection and entrenchment of economic, social and cultural rights, particularly the right to adequate health care; and

(d) the promotion of equality rights, particularly the rights of people with disabilities, people with mental illness and Indigenous peoples.

Acknowledgement

The HRLRC would like to acknowledge the assistance provided by Greg Oke in the preparation of this submission.

Contents

Acronyms

Convention on the Elimination of All Forms of Discrimination against Women	CEDAW
European Convention on Human Rights	ECHR
European Court of Human Rights	ECtHR
Human Rights Committee	HRC
Human Rights Law Resource Centre	HRLRC
International Convention on the Elimination of All Forms of Racial Discrimination	CERD
International Covenant on Civil and Political Rights	ICCPR
International Covenant on Economic, Social and Cultural Rights	ICESCR
Mental Health Act 1986 (Vic)	MHA
Mental Health Review Board	MHRB
Universal Declaration of Human Rights	UDHR
World Health Organization	WHO

1. Introduction

1.1 Scope of this Submission

1. On 8 May 2008 the Minister for Health announced a review of the *Mental Health Act 1986* (Vic) (**MHA**). In December 2008 a Consultation Paper designed to stimulate discussion and raise key issues was released.

2. This submission is made by the Human Rights Law Resource Centre (**HRLRC**) and focuses on the aim articulated in the Consultation Paper: 'that the new Act appropriately protects human rights in light of the Charter and Australia's international human rights obligations.'[1] The HRLRC considers that the best way to promote the effective, holistic treatment and care of people with mental illness in Victoria is through a human rights framework.[2]

3. The MHA is more than 20 years old and reflects an outdated and inappropriate approach to the care and treatment of people with mental illness. The legislation is currently inconsistent with the Government's human rights obligations and legalises and entrenches unacceptable discrimination against people with mental illness.

4. The HRLRC has expertise in the content and operation of the *Charter of Human Rights and Responsibilities 2006* (Vic) (**Charter**) and significant experience advocating for the harmonisation of domestic laws with international human rights standards. Our experience and expertise in these areas inform the scope and content of this submission.

5. This submission does not address each of the issues covered in the Consultation Paper. Instead, it focuses on those issues that are most comprehensively dealt with in international human rights law and jurisprudence, namely:

   (a) involuntary orders;

   (b) consumer participation;

   (c) restraint and seclusion;

   (d) external review;

[1] Review of the *Mental Health Act 1986*: Consultation Paper (**Consultation Paper**), p. 13.

[2] The HRLRC's acknowledges the continuing debate about the most acceptable terminology to describe people who have mental illness or receive involuntary treatment. For the purposes of our submission, we have chosen to reflect the terminology used in the Consultation Paper.

(e) monitoring consumer well-being; and

(f) confidentiality and information-sharing.

1.2 Threshold Issues

6. This submission generally confines itself to issues set out in the Consultation Paper. However, we note that the preliminary question of the appropriateness of stand-alone mental health legislation regulating involuntary treatment is not fully explored in the Consultation Paper, which states that 'it is intended that Victoria will maintain a scheme for involuntary treatment under separate mental health legislation and this consultation paper refects this position'.[3] The Consultation Paper states that a regulatory framework that creates a separate regime for people with mental illness is preferred on the basis that:[4]

> stand-alone mental health legislation currently provides the best means to articulate and protect patients' rights and maximise individual autonomy in Victoria. In an increasingly complex mental health service system, stand alone legislation will enable statutory safeguards that respond specifically to the identified needs of people with mental illness and those who support them.

7. The HRLRC considers that the two threshold issues (why an involuntary scheme should be maintained and, if so, whether it should be contained in stand-alone legislation) warrant further consideration.

8. The right to refuse medical treatment is listed as a fundamental right in several major international human rights treaties.[5] The Victorian Charter also contains the right not to be subjected to medical treatment without full, free and informed consent.[6] These standards will be explored in detail throughout this submission. However, an analysis of a regime built around the denial of the right to refuse treatment must ask *why* before considering *when* this right may be denied.

9. Such analysis is particularly important because no one else in the community is denied their right to refuse medical treatment in the same manner and to the same extent as people with

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[3] Consultation Paper, above n 1, p.13.

[4] Consultation Paper, above n 1, p.13.

[5] Including:*International Covenant on Civil and Political Right*s, opened for signature 16 December 1966, 999 UNTS 171 (entered into force on 23 March 1976) (**ICCPR)**; *Convention on the Rights of Persons with Disabilities*, opened for signature 30 March 2007, 993 UNTS 3 (entered into force 3 May 2008) (**CRPD**); *Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, opened for signature 10 December 1984, 1465 U.N.T.S. 85 (entered into force 26 June 1987) (**CAT**).

[6] *Charter of Human Rights and Responsibilities Act* 2006 (Vic) (**Charter**), section 10(c).

mental illness. International human rights law requires that differential treatment be reasonable, objective and proportionate.[7] The care and treatment of people with mental illness could potentially be regulated through guardianship and administration laws in addition to existing general health, housing, employment and criminal justice laws.[8] Ultimately what is required is an evidence-based articulation of why the MHA is needed.

10. The disjuncture between mental health laws and guardianship and administration laws is of particular concern. Guardianship laws in Australia emphasise autonomy to a much greater extent than mental health laws through, for example, limiting the scope and duration of legal interventions, providing substitute decision-makers who are independent of medical authorities and establishing independent agencies to act as 'watchdogs' over the operation of legislation.[9]

11. Of course, stand-alone mental health legislation regulating involuntary treatment is the norm both in Australia and internationally. However, history is replete with examples of deeply discriminatory acts enjoying widespread support and acceptance. The right to equality demands thorough and vigorous analysis and justification of differential treatment. That analysis is too often missing in discussions about mental health.

12. It has been suggested that the differential treatment of people with mental illness is based on two assumptions, namely:[10]

    (a) that mental illness is generally diagnosable and treatable; and

    (b) that people with mental illness are more dangerous than other sectors of the community.

13. These assumptions are not tested in the consultation paper, nor are they explored in detail in this submission. They are, however, appropriate subjects for further and detailed review. In the absence of such review, their status as assumptions should be recognised.

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[7] See, for example, Human Rights Committee (**HRC**), *General Comment 31: Nature of the General Legal Obligation Imposed on States Parties to the Covenant*, UN Doc. CCPR/C/21/Rev.1/Add.13 (2004); HRC, *General Comment 18: Non-Discrimination*, UN Doc HRI/GEN/1/Rev.1 at 26 (1994).

[8] World Health Organisation *Resource Book on Mental Health, Human Rights and Legislation – Stop exclusion, dare to care* (**WHO Legislative Handbook**), 2005, 24 (available http://www.who.int/mental_health/policy/who_rb_mnh_hr_leg_FINAL_11_07_05.pdf, accessed 19 January 2009). p.7. WHO has reported that "there is little evidence that one approach is better than the other."

[9] Terry Carney, David Tait and Fleur Beaupert, "Pushing the Boundaries: Realising Rights though Mental Health Tribunal Process?" *Sydney Law Review* 17 (2008).

[10] David Webb, "Is Involuntary Psyciatric Treatment 'Reasonable, Necessary, Justified and Proportionate'?" (2008) (copy on file with author at HRLRC).

1.3 Positive Obligations

14. The Consultation Paper focuses on people 'whose mental illness is severe and may necessitate involuntary treatment and care'.[11] The review does not purport to cover structural and service delivery issues affecting broader mental health service provision for the reason that:

> [t]hese problems are more effectively dealt with through the kinds of policy reforms proposed in the whole-of-government health strategy, *Because mental health matters*, or in a combined policy and legislative response.

15. While acknowledging that it is indeed the case that a whole-of-government strategy is required, we note that the regime focusing on people whose mental illness is severe must take into account the services available to people whose mental illness is less severe.

16. In this respect we note the Government's obligation under the *International Covenant on Economic, Social and Cultural Rights* (**ICESCR**) to allocate the maximum of its available resources to realise the rights of everyone to achieve the highest available standard of mental health.[12] In addition, article 25 of the *Convention on the Rights of Persons with Disabilities* (**CRPD**) recognises that:[13]

> Persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability.

17. This submission does not address the positive obligations of Government, but we note that the compliance of any involuntary treatment regime with international human rights standards will depend in part on the service available to voluntary consumers. For example, if the review of the MHA results in a legislative framework under which fewer consumers are made involuntary (in accordance with the rights to autonomy, non-discrimination and others), it is vital that those consumers have access to services which allow them to realise their right to the highest attainable standard of mental health.

1.4 Recommendations

18. The HRLRC makes the following recommendations:

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[11] Consultation Paper, above n 1, p.3.

[12] *International Covenant on Economic, Social and Cultural Rights* (**ICESCR**), 16 December 1966, 003 UNTS 3 (entered into force January 2, 1976); article 2 and article 12.

[13] CRPD, above n 5.

Recommendation 1:

The Government should consider conducting a review of

(a) whether an involuntary scheme should be maintained and;

(b) if so, whether it should be contained in stand-alone legislation.

If the Government determines that an involuntary scheme should be maintained in stand-alone legislation, it should publish the evidence and reasoning upon which this decision is based.

Recommendation 2:

The purpose of the new legislation should explicitly recognise those principles set out in Article 3 of the Disability Convention, namely:

(a) Respect for inherent dignity, individual autonomy including the freedom to make one's own choices, and independence of persons;

(b) Non-discrimination;

(c) Full and effective participation and inclusion in society;

(d) Respect for difference and acceptance of persons with disabilities as part of human diversity and humanity;

(e) Equality of opportunity;

(f) Accessibility;

(g) Equality between men and women;

(h) Respect for the evolving capacities of children with disabilities and respect for the right of children with disabilities to preserve their identities.

Recommendation 3:

Mental health laws, regulations and policies should recognise the diverse needs of groups including women, children, Indigenous and CALD populations and should ensure that additional and tailored support and independent advocacy services are provided to people with diverse needs.

Recommendation 4:

As a person must not be involuntarily detained if they retain capacity and refuse treatment, the appearance of mental illness should not be included as a criterion for involuntary treatment. Section 8(1)(d) should be repealed.

Recommendation 5:

Determinations of mental illness should be made by a qualified mental health practitioner on the basis of objective medical evidence.

Recommendation 6:

Where treatment is imposed on a person (and the other criteria outlined above are met), the treatment must be proportionate to the legitimate aim of achieving mental health for the consumer and no more intrusive than is required to meet that aim.

Recommendation 7:

Mental health legislation should provide for the making and legal recognition of advance directives.

Recommendation 8:

More resources should be directed towards infrastructure and resource development so that seclusion and restraint are not used due to resource deficiencies.[14]

Recommendation 9:

Mental Health legislation should provide that:

- Mechanical restraint is not to be applied unless the consumer (or his or her appointed carer/guardian where the consumer lacks capacity) has provided his or her full, free and informed consent to medical treatment where mechanical restraint is absolutely

[14] WHO Legislative Handbook, above n 8.

necessary for administering that consensual medical treatment.

- Mechanical restraint for the purposes of preventing a consumer from causing injury to themselves or others should only be applied in the most limited circumstances and should be strictly applied. For example, only if necessary to protect the consumer or any other person from an *immediate* or *imminent* risk to the consumer's or other person's health or safety.
- Where mechanical restraint is authorised, it must be strictly and continuously monitored and time bound. The new MHA should provide that mechanical restraint is to end immediately when a consumer ceases to meet the grounds for the mechanical restraint.
- Mechanical restraint may only be applied for the purposes of preventing a consumer from causing injury to themselves or others, after proper consideration of other less restrictive means which achieve the same aim, such as use of "break-out", relaxing or self-soothing rooms.
- Mechanical restraint is not permissible to prevent the person from destroying property.

Recommendation 10:

Mental Health legislation should introduce a prohibition against *physical restraint* except to prevent the person from causing *immediate* or *imminent* risk to the health or safety or himself, herself or other persons

Recommendation 11:

There is currently no prohibition against *'chemical restraint'*. 'Chemical restraint' should be defined and explicitly prohibited

Recommendation 12:

Mental Health legislation should require that any seclusion:

- Be strictly, actively and continuously monitored and time bound.
- Be authorised only after giving proper consideration to other less restrictive means which achieve the same aim of preventing physical harm to self/others or absconding - such as use of "break-out", relaxing or self-soothing rooms.
- cease immediately when a consumer ceases to meet the grounds for the seclusion

Recommendation 13:

All involuntary orders should be reviewed within 48 hours and then again after 6 months. Consumers should be entitled to request an additional review at any time and additional reviews should be listed within two weeks.

Recommendation 14:

All involuntary consumers should have effective access to legal representation and advocacy support.

Recommendation 15:

The MHRB (or other body responsible for review and appeals of involuntary orders) must be constituted and organised in such a way as to ensure a full and independent merits review of all involuntary orders.

Recommendation 16*:*

A body with the relative independence of a tribunal, as opposed to an office within the department responsible for provision of services, should be mandated to take on the role and fulfil the functions that are currently undertaken by the Chief Psychiatrist and CVs.

Recommendation 17:

A consumer's right to privacy needs to be respected. Wherever possible, confidential information should not be disclosed without the consumer's full, free and informed consent.

2. Framework for Reform

2.1 Introduction

19. The MHA emphasises a medical model of disability and facilitates treatment 'in the patient's best interests'.[15] This framework was consistent with the prevailing attitude when the MHA was introduced that 'in many circumstances the mentally ill should be denied freedom of choice, for their own good.'[16] However, the 'best interests' or involuntariness model is at odds with contemporary international human rights law and standards, which emphasise autonomy and non-discrimination.

20. The most authoritative articulation of a human rights approach to disability is contained in the CPRD. The UN High Commissioner for Human Rights characterised the CRPD as rejecting the 'view of persons with disabilities as objects of charity, medical treatment and social protection' and affirming persons with disability as 'subjects of rights, able to claim those rights as active members of society'.[17]

21. Signatories to the CRPD are obliged to 'ensure and promote the full realisation of all human rights and fundamental freedoms for all persons with disabilities without discrimination of any kind on the basis of disability.'[18]

22. If Victorian mental health legislation is to be consistent with human rights standards, a paradigm shift is required.[19] This section provides a broad overview of the relevant international human rights instruments and their application to mental health law in Victoria. Specific provisions within these instruments are considered in more detail in the following Chapters.

[15] Sophie Delaney, "Autonomy Denied: International Human Rights and the Mental Health Act 1986 (Vic)", 18 *Melbourne University Law Review*, (1991-1992) at p 569.

[16] Ibid at p 567.

[17] Statement by Louise Arbour UN High Commissioner for Human Rights on the Ad Hoc Committee's adoption of the International Convention on the Rights of Persons with Disabilities, 5 December 2006.

[18] CRPD, above n 5, article 4.

[19] For a discussion of the development of the human rights approach to people with disabilities see Rosemary Kayess and Phillip French, "Out of Darkness into Light? Introducing the Convention on Rights of Persons with DIsabilites", *Human Rights Law Review* 8 (2008).

2.2 The CRPD

23. The CRPD was adopted by the UN in New York on 13 December 2006 and was opened for signature on 30 March 2007. Australia played a central role in the negotiation of the CRPD and signed on the first day that the CRPD was open for signature. In November last year an Australian, Professor McCallum AO, was elected as one of 12 experts to the first monitoring committee for the CRPD. Clearly, Australia has made a robust and public commitment to implementing the rights set out in the CRPD.

24. The CRPD creates a detailed international framework of rights for persons with disabilities. It has been hailed as the first comprehensive declaration of rights in the 21st century and had the highest number of signatories and ratifications on its first day of any UN Convention in history.[20]

25. The purpose of the CRPD is:[21]

> …to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity.

26. The opening provisions set out the general obligations of States Parties,[22] followed by the declaration of specific rights for persons with disabilities and specific obligations of States Parties in relation to those rights.[23]

(a) Obligations under the CRPD

27. States parties obligations under the CRPD are set out in Article 4 and can be separated into the following categories:

(a) adoption of legislative and administrative measures, to modify current regimes that constitute discrimination, and to implement the principles of the Convention, especially with regards to non-discrimination;

(b) engagement in research and development of technologies, goods and services suitable for the specific needs of persons with disabilities, and to provide information about the availability of these services; and

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[20] There were 84 signatories to the CRPD and 44 signatories to the *Optional Protocol*. ENABLE UN at http://www.un.org/disabilities on 10 February 2009.

[21] CRPD, above n 5, article 1.

[22] CRPD, above n 5, articles 4-9.

[23] CRPD, above n 5, articles 10-30.

(a) allocation of resources for the implementation of the Convention's goals in consultation with interested groups and parties.

28. Article 4(5) states that the provisions of the CRPD extend to all parts of Federal states without any limitations or exceptions.

(b) General Principles

29. Article 3 sets out the general principles behind the framework created by the Convention, being:

(a) respect for the inherent dignity, individual autonomy and independence of persons;

(b) non-discrimination;

(c) respect for difference and acceptance of persons with disabilities;

(d) equality of opportunity;

(e) accessibility;

(f) equality between men and women; and

(g) respect for the abilities of children and their rights to preserve their identities.

30. These principles should form the basis of Mental Health legislation in Victoria.

2.3 MI Principles

31. Before the adoption of the CRPD, the most authoritative statement of the human rights of people with mental illness were the *Principles for the Protection of Persons with Mental Illness* (**MI Principles**).[24] Like the CRPD, the pervasive philosophy of the MI Principles is the maximisation of consumer autonomy and freedom of choice.[25]

32. The MI Principles are not formally binding, but are considered to be an influential aid in the interpretation of existing treaty obligations (under, for example, the *International Covenant on Civil and Political Rights* (**ICCPR**) and the *International Covenant on Economic, Social and Cultural Rights* (**ICESCR**)).[26]

[24] United Nations General Assembly *Principles on the protection of persons with mental illness and the improvement of mental health care* (**MI Principles**), 75th Plenary Meeting, A/RES/46/119 (1991).

[25] Lawrence Gostin & Lance Gabl, (2004) 'The Human Rights of Persons with Mental Disabilities: a Global Perspective on the Application of Human Rights to Principles of Mental Health' 63:20 *Maryland Law Review*, 20-121, pp 37-40.

[26] Ibid, p 24.

33. The MI Principles still constitute an authoritative articulation of relevant human rights standards, but have been superseded by the CRPD. To the extent that there is any conflict between the two instruments, the CRPD prevails.[27]

2.4 Other International Conventions

34. While the ICCPR and ICESCR do not refer explicitly to the rights pf persons with disabilities, the rights articulated in these conventions apply equally to persons with disabilities and many are relevant to the issues raised in the Consultation Paper.

35. The *Convention against Torture and Other Cruel, inhuman or Degrading Treatment or Punishment* (**CAT**) is also relevant. There is ample jurisprudential support for the proposition that, in certain circumstances, forced psychiatric interventions may constitute a form of torture or ill-treatment prohibited by CAT.[28]

36. Several other international human rights instruments protect the rights of specific groups. These are discussed in the section below.

2.5 Diverse Needs

37. The Consultation paper states that 'a primary consideration in this review involves exploring the ways in which diverse needs of individuals could be better recognised and respected in the Act'.[29] The preamble of the CRPD recognises:

> the difficult conditions faced by persons with disabilities who are subject to multiple or aggravated forms of discrimination on the basis or race, colour, sex, language, religion, political or other opinion, national, ethnic, indigenous or social origin, property, birth age or other status.

38. In addition to the special protections required under the CRPD,[30] the promotion and protection of the human rights of specific groups is recognised in several human rights instruments. Women, children, Indigenous people and culturally and linguistically diverse (**CALD**) groups may require additional or different care in order to realise their human rights. Mental health legislation should recognise and address the special needs of vulnerable groups and groups already subject to other forms of discrimination.

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[27] United Nations, *Enable Newsletter*, Issue N3 (March 2008).

[28] Manfred Nowak, *Interim report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment* (**Nowak's Report**), A/63/175 (28 July 2008); Tina Minkowitz, 'The United Nations Convention on the Rights of Persons with Disabilities and the Right to be Free from Non-consensual Psychiatric Interventions, *34 Syracuse Journal of International Law and Commerce* (2006-2007).

[29] Consultation Paper, above n 1, p 13.

[30] CRPD, above n 5, see article 6 on women with disabilities and article 7 on children with disabilities.

39. The Convention on the Rights of the Child (**CRC**) provides that 'in all actions concerning children… the best interests of the Child shall be a primary consideration.'[31] The Committee on the Rights of the Child has stated that:[32]

> the best interests of the child is of particular relevance in institutions and other facilities that provide services for children with disabilities as they are expected to conform to standards and regulations and should have the safety, protection and care of children as their primary consideration, and this consideration should outweigh any other and under all circumstances, for example, when allocating budgets.

40. The leading principle for the implementation of the CRC with respect to children with disabilities is article 23(1) which provides for:[33]

> The enjoyment of a full and decent life in conditions that ensure dignity, promote self reliance and facilitate active participation in the community… The core message of this paragraph is that children with disabilities should be included in society.

41. Of particular relevance to the current review is article 12 of the CRC which highlights the importance of respect for the views of the child. The Committee on the Rights of the Child considers that it 'is essential that children with disabilities be heard in all procedures affecting them and that their views be respected in accordance with their evolving capacities'.[34]

42. The *Convention on the Elimination of All Forms of Discrimination against Women* (**CEDAW**) recognises the need to address compounded discrimination against women with disabilities and the CEDAW Committee has stated that:[35]

> Certain groups of women, in addition to suffering from discrimination directed against them as women, may also suffer from multiple forms of discrimination based on additional grounds such as race, ethnic or religious identity, disability, age, class, caste or other factors. Such discrimination may affect these groups of women primarily, or to a different degree or in different ways than men. States parties may need to take specific temporary special measures to eliminate such multiple forms of discrimination against women and its compounded negative impact on them.

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[31] *Convention on the Rights of the Child*, opened for signature 20 November 1989, 1249 UNTS 13 (entered into force on 2 September 1990) (**CRC**), article 3.

[32] Committee on the Rights of the Child, *General Comment 9 on Children with Disabilities*, CRC/C/GC/9 (27 February 2006).

[33] Ibid [11].

[34] Ibid [32].

[35] Committee on the Elimination of Discrimination Against Women, *General Recommendation No. 25, on article 4, paragraph 1, of the Convention on the Elimination of All Forms of Discrimination against Women, on temporary special measures*, 30th Session, 2004 [12].

43. In its 2006 Concluding Observations on Australia, the CEDAW Committee specifically noted the compounded discrimination faced by women with disabilities.[36]

2.6 The Charter of Human Rights and Responsibilities

44. The Consultation Paper states that 'the Act should be compatible with the Charter'.[37] The Charter enshrines a number of the rights contained in the ICCPR. The normative content of these rights will be developed by reference to international, regional and comparative domestic human rights jurisprudence.[38]

45. The rights contained in the Charter are not absolute and section 7 provides that '[a] human right may be subject under law only to such reasonable limits as can be demonstrably justified in a free and democratic society based on human dignity, equality and freedom and taking into account all relevant factors'. According to the Explanatory Memorandum, the section 'reflects Parliament's intention that human rights are, in general, not absolute rights, but must be balanced against each other and against other competing public interests'.

46. Charter rights and the requirements that must be met in cases where these rights are limited should provide a framework for the development of mental health legislation.

47. The Charter is designed to ensure that Ministers or other Parliamentarians introducing Bills 'take responsibility for the human rights impact of their legislation.[39] A member introducing a new Bill into the House 'must cause a statement of compatibility to be prepared in respect of that Bill'.[40] The statement must specify:

    (a) whether, in the member's opinion, the Bill is compatible with human rights and, if so, how it is compatible;[41] and

    (b) if, in the member's opinion, any part of the Bill is incompatible with human rights, the nature and extent of the incompatibility.[42]

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[36] Committee on the Elimination of Discrimination against Women, *Concluding Comments of the Committee on the Elimination of Discrimination against Women: Australia*, Thirty-fourth Session, 16 January – 3 February 2006, CEDAW/C/AUL/CO/5.

[37] Consultation Paper, above n 1, p 11.

[38] Charter, above n 6, s 32(2).

[39] Simon Evans, *The Victorian Charter of Rights and Responsibilities and the ACT* Human Rights Act*: Four Key Differences and their Implications for Victoria* (Paper presented at the Australian Bills of Rights: The ACT and Beyond Conference, Australian National University, 21 June 2006) 4.

[40] Charter, above n 6, s28(1).

[41] Charter, above n 6, s 28(3)(a).

48. The second scrutiny mechanism introduced by the Charter is the requirement that the Scrutiny of Acts and Regulations Committee 'must consider any Bill introduced into Parliament and must report to the Parliament as to whether the Bill is incompatible with human rights'.

49. The Charter also imposes obligations on courts, tribunals and public authorities. Section 38 of the Charter requires public authorities to act compatibly with human rights and, in making decisions, give proper consideration to human rights. Mental health services, the Chief Psychiatrist, authorised psychiatrists, registered medical practitioners, the Mental Health Review Board and some hospitals and their staff are all likely to be considered public authorities.

50. In addition, the Mental Health Review Board (**MHRB**) is likely to be considered a Tribunal.

Recommendation 2:

The purpose of the new legislation should explicitly recognise those principles set out in Article 3 of the Disability Convention, namely:

(a) Respect for inherent dignity, individual autonomy including the freedom to make one's own choices, and independence of persons;

(b) Non-discrimination;

(c) Full and effective participation and inclusion in society;

(d) Respect for difference and acceptance of persons with disabilities as part of human diversity and humanity;

(e) Equality of opportunity;

(f) Accessibility;

(g) Equality between men and women;

(h) Respect for the evolving capacities of children with disabilities and respect for the right of children with disabilities to preserve their identities.

[42] Charter, above n 6, s 28(3)(b).

Recommendation 3:

Mental health laws, regulations and policies should recognise the diverse needs of groups including women, children, Indigenous and CALD populations and should ensure that additional and tailored support and independent advocacy services are provided to people with diverse needs.

3. Involuntary orders

3.1 Introduction

51. The consistency of involuntary treatment with international human rights law – particularly as articulated in the CRPD – is the subject of considerable and continuing debate and disagreement. However, the HRLRC considers that two points are significant:

    (a) the current involuntary treatment regime in the MHA is inconsistent with the Government's human rights obligations. As a result, some consumers are being made subject to involuntary orders in violation of their human rights; and

    (b) if the current criteria are amended, the new criteria must be made subject to a rigorous human rights 'limitations analysis'. That is, new criteria must be shown to be reasonable, justified, necessary and proportionate limitations on the human rights of involuntary consumers.

52. This section examines:

    (a) The human rights relevant to involuntary treatment;

    (b) the requirements that must be met where these rights are limited; and

    (c) the compatibility of the existing criteria with human rights standards.

    This section concludes with specific recommendations.

53. The HRLRC considers that, at a minimum, consumers must not be made subject to involuntary orders when they have legal capacity and choose to refuse treatment. Further, even when a consumer is determined not to be capable of exercising legal capacity, they should only be made subject to involuntary orders in extremely limited circumstances. These recommendations are discussed in greater detail in section 3.3(b) below.

3.2 Human Rights Relevant to Involuntary Treatment

54. There are a number of rights protected under the CRPD and the Victorian Charter relevant to ITOs and treatment choices:

    (a) respect for dignity and individual autonomy (preamble and Article 3 of the CRPD);

    (b) right to non-discrimination (Article 5 of the CRPD, Section 8 of the Charter);

    (c) right to protection of physical and mental integrity (Article 17 of the CRPD);

(d) right to equal standards of health care, including on a free and informed basis (Article 25 of the CRPD);

(e) right to life (Article 10 of the CRPD, Section 9 of the Charter);

(f) right to equal recognition before the law (Article 12 of the CRPD, Section 8 of the Charter);

(g) right to liberty and security of person (Article 14 of the CRPD, Section 21 of the Charter);

(h) right to freedom from torture or cruel, inhuman and degrading treatment or punishment (Article 15 of the CRPD, Section 10 of the Charter);

(i) freedom from medical experimentation (Article 15 of the CRPD) or treatment (Section 10 of the Charter) without consent;

(j) right to freedom from exploitation, violence and abuse (Article 16 of the CRPD);

(k) right to liberty of movement and nationality (Article 18 of the CRPD, Section 12 of the Charter);

(l) right to live in the community with choices equal to others (Article 19 of the CRPD);

(m) right to respect for privacy (Article 22 of the CRPD, Section 13 of the Charter);

(n) right to participate with others in cultural life on an equal basis (Article 30 of the CRPD, Section 19 of the Charter);

(o) freedom of expression (Section 15 of the Charter); and

(p) freedom of thought, conscience, religion and belief (Section 14 of the Charter).

55. Some of these rights are considered in more detail below.

(a) Autonomy and inherent dignity

56. Paragraph (n) of the Preamble to the CRPD specifically recognises the importance of individual autonomy and independence. To similar effect, the first general principle of the Convention as articulated in Article 3(a) is:

> Respect for inherent dignity, individual autonomy including the freedom to make one's own choices, and independence of persons;

(b) Equality and non-discrimination

57. Article 5 of the CRPD provides that all persons are equal before and under the law and are entitled without any discrimination to the equal protection and equal benefit of the law. State Parties must prohibit all discrimination on the basis of disability and guarantee that persons

with disabilities have equal and effective legal protection against discrimination on all grounds. The general principle of non-discrimination is also recognised by article 3(b).

58. This is supported by s 8 of the Charter which provides that every person:

(1) has the right to recognition as a person before the law;

(2) has the right to enjoy his or her human rights without discrimination; and

(3) is equal before the law, is entitled to the protection of the law without discrimination and has the right to equal and effective protection against discrimination.

(4) Measures taken for the purposes of assisting or advancing persons or groups of persons disadvantaged because of discrimination do not constitute discrimination.

59. The definition of 'discrimination' in the Charter has the same meaning as provided in the *Equal Opportunity Act 1995* (Vic).[43] This Act defines 'prohibited discrimination' as less favourable treatment on the grounds of a 'protected attribute', or the imposition of an unreasonable requirement, condition, or practice with which people with a particular attribute may have difficulty complying. 'Protected attributes' are defined in s 6 of the same Act and expressly include an 'impairment'.[44] Pursuant to s 4(1)(d)(i), impairment means 'a malfunction of a part of the body, including a mental or psychological disease or disorder'. The Charter therefore requires that all persons be able to enjoy all their human rights – which extend to all aspects of life falling within the ambit of such rights – without any differentiation on the basis of mental illness. It also requires that Victorian law provide equal and effective protection against all discrimination on the basis of mental illness.

60. The jurisprudence of the HRC is that the right to equality before the law and to the equal protection of the law does not make all differences of treatment discriminatory. If the differentiation is based on reasonable and objective criteria and is a proportionate response to a legitimate aim, it does not amount to prohibited discrimination.[45]

(c) Legal capacity

61. Article 12 of the CRPD provides, among other things, that persons with disabilities have the right to 'recognition everywhere as persons before the law' and to 'enjoy legal capacity on an equal basis with others in all aspects of life'. Article 12(3) provides that States Parties shall take appropriate measures to provide access by persons with disabilities to the support they

[43] Charter, above n 6, s 3(1).

[44] *Equal Opportunity Act 1995* (Vic) s 6(1)(b).

[45] *Broeks v The Netherlands* (172/1984), ICCPR, (9 April 2007); *Love et al v Australia* (983/2001), ICCPR, (25 March 2003).

may require in exercising their legal capacity. Article 12(4) relates to restrictions of legal capacity. It provides that:

> 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.

(d) Liberty and Security of the Person

62. Article 14 of the CRPD provides that persons with a disability have a right, on an equal basis with others, to enjoy the right to liberty and security of person and not to be deprived of their liberty unlawfully or arbitrarily. This includes a stipulation that the existence of a disability shall in no case justify the deprivation of liberty. The provision goes on to place an obligation on States Parties to ensure that if persons with a disability are deprived of their liberty, they are entitled to guarantees in accordance with international human rights law and are treated in accordance with the objectives of the CRPD.

63. Section 21 of the Charter provides for the right to liberty and security of person as follows:

> (1) Every person has the right to liberty and security.
>
> (2) A person must not be subjected to arbitrary arrest or detention.
>
> (3) A person must not be deprived of his or her liberty except on grounds, and in accordance with procedures, established by law.
>
> (4) A person who is arrested or detained must be informed at the time of arrest or detention of the reason for the arrest or detention and must be promptly informed about any proceeding to be brought against him or her…
>
> (7) Any person deprived of liberty by… detention is entitled to apply to a court for a declaration or order regarding the lawfulness of his or her detention, and the court must –
>
> (a) make a decision without delay; and
>
> (b) order the release of the person if it finds that the detention is unlawful.

This provision is modelled on Articles 9 and 11 of the ICCPR.[46] Under the ICCPR, the right to liberty and security is an absolute right.

[46] Explanatory Memorandum, Charter of Human Rights and Responsibilities Bill 2006 (Vic), p 16.

(e) Freedom from torture or cruel, inhuman or degrading treatment or punishment

64. Article 15 of the CRPD provides that no one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment. In particular, no one shall be subjected, without his or her free consent, to medical or scientific experimentation. This right is protected in s 10 of the Charter, which includes protection from medical treatment or experimentation without consent. This is considered below.

(f) Humane treatment while deprived of liberty

65. The right to be treated humanely when deprived of liberty is recognised in s 22 of the *Charter* and establishing the right of all persons deprived of liberty to be treated with humanity and with respect for the inherent dignity of the human person. This section is modelled on article 10 of the *ICCPR*, but has a wider scope in that it specifically refers to the right of persons who are detained but have not been convicted to humane treatment.[47] Article 10 imposes a positive obligation on the state towards persons who are particularly vulnerable because of their status as persons deprived of liberty. In accordance with this article, persons deprived of their liberty may not be:

> subjected to any hardship or constraint other than that resulting from the deprivation of liberty; respect for the dignity of such persons must be guaranteed under the same conditions as for that of free persons. Persons deprived of their liberty enjoy all the rights set forth in the *Covenant*, subject to the restrictions that are unavoidable in a closed environment.[48]

66. Importantly, the implementation of the right is not dependent on the material resources available to the state and the right must be enjoyed by all persons without any kind of distinction as to race, sex, etc.[49]

(g) Physical and mental integrity

67. Article 17 of the CRPD provides that '[e]very person with disabilities has a right to respect for his or her physical and mental integrity on an equal basis with others'. Similarly to Article 12, this does not establish an 'absolute' right, but rather a right that may only be limited in circumstances where the right of a person without a disability would also be limited'.

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[47] There are broadly equivalent provisions in the *Human Rights Act 2004* (ACT) (s 19), *New Zealand Bill of Rights Act 1990* (s 22) and *South African Constitution* (s 35(2)(e)).

[48] HRC, *General Comment No 21 (Replaces General Comment 9) concerning Humane Treatment of Persons Deprived of Liberty* (1992) [2], available from http://www.ohchr.org/english/bodies/hrc/comments.htm, [3].

[49] Ibid [4].

(h) Living independently and being included in the community

68. Article 19 of the CRPD recognises the equal right of all persons with disabilities to live in the community, with choices equal to others. In particular, it requires States to ensure that persons with disabilities are not obliged to live in a particular living arrangement. Persons with disabilities, like any one else, must be able to choose where and with whom they live. They should have access to a range of in-home, residential and other community support services, including the personal assistance necessary to support living and inclusion in the community and to prevent social exclusion.

(i) Privacy

69. Article 22 of the CRPD provides that no person with disabilities shall be subjected to arbitrary or unlawful interference with their privacy. This right is protected in s 13 of the Charter. In *Pretty v United Kingdom*[50], the European Court stated that, the concept of 'private life' is a broad term not susceptible to exhaustive definition. It covers the physical and psychological integrity of a person. It can sometimes embrace aspects of an individual's physical and social identity.

(j) MI Principles

70. The MI Principles adopt a set of legal standards and procedures for involuntary admission to hospital. These are discussed below in relation to the right to liberty. While the MI Principles comprise a direct expression of the human rights relevant to mental health, they offer less robust protection against involuntary treatment than is articulated in the CRPD. In particular, principle 11 on consent to treatment represents a 'complex and detailed political compromise between autonomy and paternalism.'[51]

71. The MI Principles relevant to the Review include:

(a) least restrictive or intrusive treatment (Principle 9(1));

(b) treatment to preserve and enhance personal autonomy (Principle 9(4)); and

(c) privacy (Principle 13(1)).

[50] (2002) 35 EHRR 1, [61].

[51] Gostin & Gabl, above n 24, p 39.

72. As noted in section 2, above, the MI Principles must now be read in light of recent international mental health law developments, most significantly the CRPD. [52]

(k) Limitations on Human Rights

73. Section 7(2) of the *Charter* provides that:

> A human right may be subject under law only to such reasonable limits as can be demonstrably justified in a free and democratic society[53] based on human dignity, equality and freedom and taking into account all relevant factors.

74. Section 7(2) also sets out an inclusive list of factors to be considered, namely:

(a) *the nature of the right* - while there is no 'hierarchy' of rights as such, human rights that are considered absolute and non-derogable under international law, such as the prohibition on torture, would require a much higher level of justification so far as limitations are concerned than, say, the right to freedom of expression;

(b) *the importance of the purpose of the limitation*

1. a limitation on rights must fulfil a pressing need and pursue a legitimate aim. In this submission, the HRLRC submits the principal aim of involuntary detention must be the health of the consumer, rather than risk to others or management of behaviour (this is considered below in relation to s 8(1)(b) of the MHA);[54]

2. the aim sought to be achieved should be 'specific' and not merely general and must be compelling and important, not 'trivial'.[55] This Submission considers the necessity of involuntary treatment and provides guidance to ensure the aim of the limitation meets this requirement; and

[52] UN Enable Website, UN Secretariat for the CRPD, March 2008, Frequently asked Questions (available http://www.un.org/disabilities/default.asp?id=151 18 February 2009).

[53] According to the Supreme Court of Canada, the values of a 'free and democratic society' include: respect for the inherent dignity of the human person, social justice, equality, accommodation of a plurality of beliefs, and respect for cultural and group identity: *R v Oakes* [1986] 1 SCR 103, 136.

[54] See, eg, *Derbyshire County Council v Times Newspapers* [1993] AC 534, 550; *Handyside v UK* [1976] 1 EHRR 737. See also *R v Oakes* [1986] 1 SCR 103, in which the Supreme Court of Canada stated that the aim must be 'of sufficient importance to warrant overriding a constitutionally protected right or freedom', which required that it must 'relate to concerns which are pressing and substantial'.

[55] See, eg, *Zundel v R* [1992] SCR 731.

3. financial considerations in and of themselves will almost never constitute a legitimate aim or justify a limitation on human rights.[56]

(c) *the nature and extent of the limitation* - the limitation must be proportionate.[57] This requires consideration, particularly in regard to section 8(1)(d), of the right to less restrictive treatment and alternative means available to achieve the legitimate aim, being the mental health of the consumer.

(d) *the relationship between the limitation and its purpose* - the limitation must be reasonably, rationally and by evidence connected to the aim. It should be accompanied by 'relevant and sufficient reasons'.[58] It should not be, or operate in a way which is, arbitrary, unfair or not based on rational considerations.[59] For example, in regard to the right to equality a difference in treatment may be discriminatory if it 'has no objective justification'.[60] Justification requires a 'legitimate aim' and a 'reasonable relationship of proportionality between the means employed and the aims sought to be realised'.[61]

(e) *any less restrictive means reasonably available to achieve the purpose that the limitation seeks to achieve* - this involves a consideration of whether the objective of the limitation be achieved in a way that does not interfere with, or interferes less with, human rights.[62]

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[56] See, eg, *Newfoundland (Treasury Board) v NAPE* [2004] 3 SCR 38; *Reference re Remuneration of Judges of the Provincial Court of Prince Edward Island* [1997] 3 SCR 3.

[57] See, eg, *Stanková v Slovakia* [2007] ECtHR 7205/02 (9 October 2007).

[58] See, eg, *Stanková v Slovakia* [2007] ECtHR 7205/02 (9 October 2007).

[59] See, eg, *R v Oakes* [1986] 1 SCR 103, 139.

[60] *In the case of Van Raalte v the Netherlands* (1), 108/1995/614/702, 21 February 1997

[61] Ibid

[62] These factors are drawn from s 36(1) of the *South African Constitution* which, in turn, was informed by the decision of Chaskalson P in *State v Makwanyane* (1995) Case No CCT/3/04 (Constitutional Court of the Republic of South Africa) where it was stated at [104] that:

> The limitation of constitutional rights for a purpose that is reasonable and necessary in a democratic society involves the weighing up of competing values, and ultimately an assessment based on proportionality…[P]roportionality…calls for the balancing of different interests. In the balancing process, the relevant considerations will include the nature of the right that is limited, and its importance to an open and democratic society based on freedom and equality; the purpose for which the right is limited and the importance of that purpose to such a society; the extent of the limitation, its efficacy, and particularly where the limitation has to be necessary, whether the desired ends could reasonably be achieved through other means less damaging to the right in question.

75. These factors are used to determine the compatibility of involuntary treatment, as provided for in section 8 of the MHA, with Victoria's legal obligations as described in section 7(2) of the Charter.

3.3 Discussion and Analysis

(a) Is involuntary treatment compatible with international law and the Charter?

76. The Review invites consideration of the right to consent to or refuse medical treatment in the context of mental health. The Review recognises that both the Charter and the CRPD contain, respectively, a right to protection from medical treatment without the 'full, free and informed consent' and respect for physical and mental integrity for people with disabilities on an equal basis with others.[63]

77. This prompts consideration of the compatibility of involuntary treatment with these rights. Accordingly, before assessing the process to be followed in determining mental illness and requiring involuntary treatment, there is a broader question to be answered: in light of recent developments in international human rights law, most notably the entry into force of the Charter[64] and CRPD,[65] is involuntary treatment compatible with human rights law? If so, when?

78. In the interim report of the Special Rapporteur of the Human Rights Council on torture and other cruel, inhuman or degrading treatment or punishment, Manfred Nowak, the Rapporteur recognises that the CRPD provides authoritative guidance on the prohibition against torture and ill-treatment as it applies to persons with disability. The Rapporteur describes how the CPRD recognises the principle of respect for the individual autonomy of persons with disabilities (article 3) and the equal right to enjoy legal capacity 'in all areas of life, such as deciding where to live and whether to accept medical treatment'.[66] Further, medical care of persons with disabilities must be based on their free and informed consent (article 25). With this in mind, the Special Rapporteur concludes that 'the acceptance of involuntary treatment

[63] Consultation Paper, above n 1, p 29.

[64] The Charter entered into full force on 1 January 2008; Charter, above n 6, s 2.

[65] The *Convention on the Rights of Persons with Disabilities* and Optional Protocol opened for signature 30 March 2007, 993 UNTS 3 and entered into force on 3 May 2008, after the Convention received its 20th ratification, and the Optional Protocol 10 ratifications (available at http://www2.ohchr.org/english/law/pdf/disabilities-convention.pdf).

[66] Nowak's Report, above n 27, p 44.

and involuntary confinement runs counter to the provisions of the Convention on the Rights of Persons with Disabilities'.[67]

79. Other commentators, including Baroness Hale of the UK House of Lords,[68] have also questioned whether involuntary treatment for people with mental illness is acceptable, when involuntary treatment with a physical disorder is strenuously rejected: is this discrimination as between people with mental or physical disorders?[69]

80. Reform of mental health legislation in the UK in 1999 focused on non-discrimination and concluded that any justification should be based on a rigorous definition of incapacity in order to prevent discrimination on the basis of a mental illness, [70] particularly, for example where a person retains capacity to refuse treatment.

81. In the HRLRC's view, involuntary treatment must not occur where a person is deemed to have capacity and has refused treatment. Where treatment is imposed on a person involuntarily and that person has capacity, the treatment constitutes a violation of the person's rights to freedom from discrimination and protection from medical treatment without consent and several other rights which are explored below.

82. A series of further difficult question arise to determine the compatibility of involuntary treatment where a person does not have legal capacity. These include:

(a) Does the consumer have a mental illness as determined in accordance with international standards and by a medical practitioner?

(b) Has the consumer unreasonably refused medical treatment?

(c) Is there a risk that the consumer may harm themselves or someone else? Is the potential harm serious? Is that risk known, imminent and preventable?

(d) In response to each of these questions, is the limitation on a person's right a permissible limitation compatible with section 7(2) of the Charter?

83. At the very least, each of these questions should be answered in the positive before involuntary treatment under mental health legislation is considered as an option.

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[67] Ibid.

[68] *R (Wilkinson)* v *Broadmoor Special Hospital Authority* [2002] 1 WLR 419.

[69] Brenda Hale, 'The Human Rights Act and Mental Health Law: Has it Helped?' (20097 *Journal of Mental Health Law* 7-18, p 12.

[70] See review of the Mental Health Bill: United Kingdom House of Lords and House of Commons Joint Committee on Human Rights, *Legislative Scrutiny: Seventh Progress Report – Fourth Report of Session 2006-07* (***Joint Committee Fourth Report***) published 4 February 2007, p 37.

(b) Concerns with the current provision for involuntary treatment under the MHA

84. Section 8 provides the criteria for involuntary treatment under the MHA as:

(a) the person appears to be mentally ill;

(b) the person's mental illness requires immediate treatment and that treatment can be obtained by the person being subject to an involuntary treatment order;

(c) because of the person's mental illness, involuntary treatment of the person is necessary for his or her health or safety (whether to prevent a deterioration in the person's physical or mental condition or otherwise) or for the protection of members of the public;

(d) the person has refused or is unable to consent to the necessary treatment for the mental illness; and

(e) the person cannot receive adequate treatment for the mental illness in a manner less restrictive of his or her freedom of decision and action.

85. The application of section 8 to a person with mental illness results in that person's rights (for example, to liberty, equality, privacy and to refuse treatment) being limited. The HRLRC considers that the limitations represented by section 8 do not meet the requirement that they be demonstrably justified in a free and democratic society[71] based on human dignity, equality and freedom and taking into account all relevant factors.

86. The legislation must prohibit involuntary treatment imposed on a person with capacity and require that:

(a) the principal aim of involuntary treatment is the mental health of the consumer;

(b) alternatives measures to involuntary treatment be first considered;

(c) a person's refusal to treatment be unreasonable in the circumstances;

(d) that treatment be proportionate to the aim of involuntary treatment;

(e) that treatment that is the least restrictive of rights be imposed; and

(f) that the risk of harm to self or others meet a particular threshold having regard to the risk's level of severity, probability and imminence.

[71] According to the Supreme Court of Canada, the values of a 'free and democratic society' include: respect for the inherent dignity of the human person, social justice, equality, accommodation of a plurality of beliefs, and respect for cultural and group identity: *R v Oakes* [1986] 1 SCR 103, 136.

87. This section considers the current test for involuntary treatment. In order to produce a test for involuntary treatment which is compatible with the rights protected by the CRPD and the Victorian Charter, this section draws on procedural safeguards outlined in a range of jurisdictions, including the ECHR, the UN General Assembly, the HRC, and the United Kingdom.

(c) 'Appears to be Mentally Ill'

88. The first criterion for involuntary treatment is that the person 'appears to be mentally ill'.[72]

89. In our view, as a person must not be involuntarily detained if they retain capacity and refuse treatment, the appearance of mental illness should not be included as a criterion for involuntary treatment. Section 8(1)(a) should be repealed.

90. A corollary concern is the use of the words 'appears to be'. The appearance or otherwise of a mental illness may be a factor of consideration in determining mental illness and the application of section 8 more broadly, but should not be a determinative criterion.

(i) Definition of Mental Illness

91. Turning to the definition of mental illness, in considering legislation on mental health around the world, the WHO emphasises the importance of well defined terms for those affected by the legislation. When the UK Mental Health Act was undergoing reform, the Bill was criticised for its broad definition of mental disorder.[73] Article 5(1)(e) of the ECtHR provides for detention on the grounds of 'unsoundness of mind'. While the European Court of Human Rights (**ECtHR**) has refused to define the term, for example in *Winterwerp*, certain considerations have emerged:

(a) it must be construed narrowly;[74]

(b) the disorder in question must be 'of a degree warranting compulsory treatment';

(c) this must be established by 'objective medical expertise'; and

(d) a consumer's confinement on grounds of mental disorder will remain valid only for as long as the disorder persists.[75]

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[72] MHA, s 8(1)(a).

[73] Joint Committee Fourth Report, above n 70, p 9.

[74] *Litwa v Poland* (2001) 33 EHRR 53.

[75] *Winterwerp v Netherlands* (1979) 2 EHRR 387; see also David Hewitt 'Re-considering the Mental Health Bill: The view of the Parliamentary Human Rights Committee' (2007) *Journal of Mental Health Law* 57-71, 58.

92. The term mental illness in the MHA, as opposed to the alternative terms mental disorder, mental disability, mental incapacity or unsoundness of mind, is narrow in scope and well defined. It is also a term of common usage and thus easily understood by stakeholders. One, perhaps minor concern, is that the term reinforces the 'medical model'.[76]

93. Mental illness is defined in the MHA as a 'mental condition that is characterised by a significant disturbance of thought, mood, perception or memory.'[77] Importantly, a person must not be considered mentally ill by reason of a number of factors, including that the person:

(a) expresses, refuses or fails to express a particular philosophy or political or religious opinion or belief;

(b) expresses or refuses or fails to express a particular sexual preference or sexual orientation;

(c) engages in or refuses or fails to engage in a particular political or religious activity;

(d) engages in sexual promiscuity or immoral or illegal conduct;

(e) is intellectually disabled;

(f) takes drugs or alcohol;

(g) has an antisocial personality; or

(h) has a particular economic or social status or is a member of a particular cultural or racial group.[78]

94. The MI Principles do not define mental illness but provide guidelines for how mental illness can and cannot be determined.[79] These excluded factors are consistent with the MI Principles and should be retained. The definition of mental illness in the MHA should remove the reference to 'appears to be'. Otherwise, the definition should remain the same.

(ii) Determination of mental illness on the basis of medical evidence

95. The MI Principles require that, except in emergency cases, a true mental disorder must be established:

(a) before a competent authority: the MI principles provide that a consumer with a 'mental illness' may only be admitted by a 'qualified mental heath practitioner authorised by

[76] WHO Legislative Handbook, above n 8.

[77] MHA, s 8(1A).

[78] MHA, s 8(2).

[79] MI Principles, above n 23, principle 16.

law…'.[80] Mental health practitioner is defined under the MI principles to mean 'a medical doctor, clinical psychologist, nurse, social worker or other appropriately trained and qualified person with specific skills relevant to mental health care';[81] and

(b) on the basis of objective medical expertise.[82] The MI principles similarly state that a determination of mental illness shall be made 'in accordance with internationally accepted medical standards';[83]

96. Further, the MI Principles state a background of past treatment shall not in itself justify any future determination of mental illness.[84] This means that a person's medical history cannot be sole justification for involuntary treatment. The MHA notes that a recommendation for involuntary treatment must be made by a registered medical practitioner. However, the MHA does not require that this recommendation be made with reference to international medical standards and without undue reliance on medical history.

97. In the UK Joint Committee's Fourth and Fifteenth Reports, the Committee considered the need for objective medical evidence of a true mental disorder to justify detention and treatment. This view was based on the European Court's decision in *Winterwerp v Netherlands*.[85] Further, the opinion justifying detention should come from a medically qualified expert with recognised skills in psychiatric diagnosis and treatment.[86]

98. In reply to the Fifteenth Report, the Government rejected the recommendation that a determination to involuntarily detain and treat a consumer only occur on objective medical expertise provided by a medical practitioner. In the Government's view, such expertise could be provided by other skilled and experienced professionals such as nurses and psychologists.[87] If deprivation of liberty is provided for without the opinion of a medical expert,

[80] MI Principles, above n 23, principle 16: Involuntary admission, 16(1) Preamble.

[81] MI Principles, above n 23, see definitions.

[82] *Winterwerp v Netherlands* (1979) 33 Eur Ct HR (Ser A), [39].

[83] MI Principles, above n 23, principle 4: Determination of mental illness: 4(1).

[84] MI Principles, above n 23, principle 16.

[85] (1979) 2 EHRR 387.

[86] Joint Committee Fourth Report, above n 66, p 12 and UK Joint Committee, *Legislative Scrutiny: Seventh Progress Report – Fifteenth Report of Session 2006-07*, 6, citing *Varbanov v Bulgaria* judgment of 5 October 2000.

[87] http://www.publications.parliament.uk/pa/jt200708/jtselect/jtrights/174/174.pdf

the provision would fall short of the required protection against arbitrariness inherent in the right to liberty.[88]

99. On its face, the MHA does not require a registered medical practitioner to have recognised skills in psychiatric diagnosis and treatment. Rather, a registered medical practitioner is defined by reference to the *Health Professions Registration Act 2005* which fails to delineate between registered medical practitioners operating in the area of mental health, as opposed to other areas of health.

(d) The person's mental illness 'requires immediate treatment'

100. Section 8(1)(b) provides the second criterion for involuntary treatment as: the person's mental illness requires immediate treatment and that treatment can be obtained by the person being subject to an involuntary treatment order.

101. As discussed above in paragraph 74, s 7(2) requires that this criterion for involuntary treatment be shown to be a reasonable, justified, necessary and proportionate limitation on the rights of involuntary consumers. Further, s 7(2) should be interpreted to place the burden of proof of limitation's permissibility on the party arguing the limitation is justified and proportionate. 'Demonstrable justification' require a 'very high degree of probability' and evidence.[89] In regard to s 8(1)(b) of the MHA, this requires that the burden of proof to show a consumer requires treatment rests on the medical practitioner. This may sound self-evident. Anecdotal evidence suggests consumers are required to justify why they should not receive involuntary treatment.

102. First, the limitation must fulfil a pressing need and pursue a specific, legitimate aim. Second, there must be proportionality between the aim (mental health) and the means sought to achieve that aim (involuntary treatment). While mental health may be a legitimate aim, the intrusive nature of involuntary treatment requires that the consumer's needs be compelling and immediate, rather than general or trivial. For example, in no circumstances should treatment be imposed to manage behavioural problems or fluctuating temperaments. The additional elements of s 7(2), the nature and extent of the limitation and whether there are less restrictive means available, are also relevant. Accordingly, that a person *requires* immediate

[88] *Varbanov v Bulgaria* judgment of 5 October 2000, [47] cited in the Joint Committee Fourth Report, above n 66, p 12.

[89] See, eg, *R v Oakes* [1986] 1 SCR 103, 105, 136-7; *Minister of Transport v Noort* [1992] 3 NZLR 260, 283; *Moise v Transitional Land Council of Greater Germiston* 2001 (4) SA 491 (CC), [19]. See also P Hogg, *Constitutional Law of Canada* (2004) 795-6.

treatment must be determined by having regard to all of the factors in s 7(2) and the rights engaged. For s 7(2) to be satisfied, a strict, narrow application of s 8(1)(b) is required.

103. Michael Perlin argues that the:[90]

> justification for the entire enterprise of inpatient psychiatric hospitalization rests on one thin reed: that meaningful, ameliorative individualized treatment is available at the facility to which the individual has been committed, and that that treatment is logically geared to improving that individual's condition so that optimally he can be released

104. This position presents two tests: first, can treatment be provided that is individualised, humane and results in improvement in the person's health; and second, is the treatment geared towards its conclusion such that the person is on a progressive program towards independence and mental health.

105. Involuntary treatment represents a significant infringement on a number of rights. In order for a person to *require* involuntary treatment (that is compatible with s 7(2)), there must be:

(a) an evidenced base case that the consumer *requires* the treatment;

(b) a clear, proportionate relationship between the treatment and the aim of improving the consumer's health; and

(c) a determination that the consumer's needs are compelling and immediate.

106. Section 8(1)(b) also requires that treatment can be obtained by the consumer subject to the order. Having regard to the rights to freedom from medical experimentation (Charter, s 10(c)) and the right to health (CRPD, article 25), 'can be obtained' should be interpreted to include a high expectation that the treatment will be successful.

107. There are a number of relevant procedural requirements under international human rights law to determine whether a person 'requires immediate treatment'. These include:

(a) involuntary treatment should only occur where a person is diagnosed with a mental disorder of a kind or degree warranting compulsory confinement;[91]

(b) the validity of continued confinement depends upon the persistence of such a disorder;[92]

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[90] Michael Perlin, 'International Human Rights Law and Comparative Mental Disability Law: the Universal Factors' (2006-2007) 34 *Syracuse Journal of International Law and Commerce* 333-357, p 343.

[91] *Winterwerp v Netherlands* (1979) 33 ECt HR (Ser A), [39].

[92] *Winterwerp v Netherlands* (1979) 33 ECt HR (Ser A), [39].

(c) [i]f at any time the mental health practitioner responsible for the consumer's case is no longer satisfied that the conditions for detention are satisfied, the consumer must be discharged';[93]

(d) periodic review of non-punitive detention should be carried out;[94] and

(e) the medical health practitioner[95] whose decision leads to non-consensual detention of a mentally ill consumer must provide reasons as to their conclusion that detention is necessary.[96]

108. These procedural safeguards seek to prevent arbitrary deprivations of liberty. In respect of detention of a mental health consumer, the ECtHR has stated that:

> The notion underlying the term in question is one of fair and proper procedure, namely that any measure depriving a person of his liberty should issue from and be executed by an appropriate authority and should not be arbitrary.[97]

109. In particular, the European Court has observed that lawfulness with respect to detaining a mental consumer presupposes conformity with the procedural and substantive rules of domestic law as well as consistency with the objectives of detaining a mental health consumer.[98] An example of the latter is that the placement of a mental health consumer in an institution for the purpose of treatment is unlawful if that institution is unable to provide the treatment necessary.[99]

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[93] MI Principles, above n 23, principle 17(6).

[94] *A v Australia*, HRC Communication No 560/1993, UN Doc CCPR/C/59/D/560/1993 (3 April 1997) [9.4]; MI Principles, above n 23, principle 16(1). See also Lawrence O. Gostin 'Human Rights of Persons With Mental Disabilities' (2000) 23 *Int'l J L Psychiatry* 125, 147.

[95] Or practitioners.

[96] See *Wooder, R (on the application of) v Feggetter & Anor* [2002] EWCA Civ 554.

[97] *Winterwerp v Netherlands* (1979) 33 ECt HR (Ser A), [45].

[98] *Bouamar v Belgium* (1988) Application no 9106/80 Eur Ct HR (Ser A)[50].

[99] See *Winterwerp v Netherlands* (1979) 33 ECt HR (Ser A), [39].; *Bouamar v Belgium* (1988) Application no 9106/80 ECt HR (Ser A)[52] where the applicant was placed in a remand centre for the purposes of 'educational supervision'. However, the facility was unable to provide such education. It was held that '[t]he detention of a young man in a remand prison in conditions of virtual isolation and without the assistance of staff with educational training cannot be regarded as furthering any educational aim'. See also *Aerts v Belgium* (1998) 61/1997/845/1051) ECt HR [9],[42] – [47] where the applicant was held in a psychiatric wing of a prison pending transfer to a psychiatric facility. His condition required treatment which could calm his 'constant anxiety', which was unable to be provided at the prison. It was held that '[t]he proper relationship between the aim of the detention and the conditions in which it took place was therefore deficient'.

(e) Because of the person's illness there is a risk of harm to self or others

110. Section 8(1)(c) of the MHA provides a further criterion:

> because of the person's mental illness, involuntary treatment of the person is necessary for his or her health or safety (whether to prevent a deterioration in the person's physical or mental condition or otherwise) or for the protection of members of the public;

111. A principal concern with this approach is the Act fails to give any guidance on the level of risk necessary to trigger section 8(1)(c). The HRLRC considers that to meet the requirements of section 7(2), this criterion must be supplemented by a requirement that the risk of harm must be of a particular level of severity, known and probable.

112. In reviewing the Mental Health Bill, the UK Joint Committee on Human Rights noted 'it is essential that the involuntary interventions be imposed only when the risk of harm to the person concerned or to others is sufficiently serious to warrant them.'[100]

113. In discussing risk of harm to others as a justification for involuntary treatment in Finland, Tuohimäki et al recognise that 'risk assessment of violence is always an estimation' that will take into account previous violent behaviour, severe mental illness with active symptoms, abuse or drugs or alcohol and personality disorders.[101] However, studies have shown the 'poor reliability of attempts to predict violent behaviour' and so Tuohimäki questions, 'could this mean that the harmful to others criterion is used "just to be sure"' in cases without sufficient information?[102] Potential to harm in Finland is not determined following a structured process, interview or assessment. Rather it is generally based on the health practitioners' view of information provided by the consumer or by relatives.[103] Comfort is found in their conclusion that potential for harm is rarely used as a motivation for involuntary treatment, even in combination with other factors. Nevertheless, it is essential that where the criterion is used, it is justified by a rigorous assessment of the risk, its probability and severity.

114. For the reasons identified above, including the risk that treatment is imposed 'just to be sure', assessment of risk of harm to others as a criterion for involuntary treatment must be rigorous.

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[100] UK United Kingdom House of Lords and House of Commons Joint Committee on Human Rights, *Scrutiny of Mental Health Legislation: Government Response to the Committee's Sixteenth Report of Session 2007-08: Thirty-second Report of Session 2007-8* **(Joint Committee Thirty-second Report)**, published 13 October 2008, 7 (available http://www.publications.parliament.uk/pa/jt200708/jtselect/jtrights/174/174.pdf accessed 2 February 2009).

[101] C. Tuohimäki, R Kaltiala-Heino, J. Korkeila, T. Tuori, V. Lehtinen and M. Joukamaa, (2003) 'The Use of Harmful to Others For Involuntary Treatment in Finland' 183-199 *European Journal of Health Law*, 194.

[102] Ibid.

[103] Ibid.

To satisfy s 7(2) of the Charter, involuntary treatment may only be imposed where it is proportionate to the risk of harm, the risk meets a threshold level of severity and probability and there is a clear relationship between the identified risk and the imposed treatment to address that risk.

(f) The person has refused or is unable to consent

115. The fourth criterion for involuntary treatment under the MHA is that a person has 'refused or is unable to consent to the necessary treatment for the mental illness.'[104] Section 12AD of the MHA provides that an involuntary consumer is to be given treatment for his or her mental illness and if they refuse or are unable to consent, consent may be provided by the authorised psychiatrist.

116. As currently drafted, these provisions are redundant and circular:

(a) if a consumer consents to the treatment, the treatment is administered;

(b) if a consumer refuses the treatment, the treatment is administered;

(c) if a consumer is unable to consent to the treatment; the treatment is administered.

117. Section 10 of the Charter provides for protection from torture and cruel, inhuman or degrading treatment and that a person must not be subjected to medical or scientific experimentation or without his or her full, free and informed consent. This is unambiguous. Section 8 and 12AD are prima facie incompatible with this right.

118. Section 10 of the Charter expands on the right contained in the ICCPR by recognising not only a right to refuse to be subjected to medical *experimentation*, but also a right to refuse medical *treatment*. Further, in addition to 'free consent', section 10 requires consent to be full, free and informed.[105] This means that consent must be voluntary and that the consumer has been given sufficient information on which to make an informed decision.[106] The right to refuse medical treatment is also recognised under section 11 of the *New Zealand Bill of Rights Act* and section 10 of the ACT *Human Rights Act*.

119. The right to be free from discrimination is the first right articulated in the Charter. Section 8(2) provides every person has the right to enjoy his or her human rights without discrimination. In combination, sections 8(2) and 10 require that a person enjoys their right to be free from

[104] MHA, section 8(1)(d).

[105] This modification is intended to reflect the requirements for consent outlined in section 5(1) of the *Medical Treatment Act 1988* (Vic).

[106] Explanatory Memorandum, above n 45.

medical treatment without consent, without discrimination on the basis of mental illness. This position is further articulated in Article 25(d) of the CRPD which requires that health care be provided to persons with disabilities on the basis of free and informed consent, on an equal basis with others. The Committee on Economic Social and Cultural Rights has recognised the right to be free from non-consensual medical treatment as a fundamental aspect of the right to the highest attainable standard of health.[107] The status of the right to be free from medical treatment without consent is clear. Any limitation on the right to free and informed consent that only applies to people with mental illness constitutes discrimination.[108] The limitation of this right must meet the test set out in s 7(2).

120. Victorians with mental illness have suffered discrimination in the enjoyment of their right to freedom from medical treatment. Prior to the enactment of the Charter, the laws of Victoria protected the right to refuse medical treatment in the *Medical Treatment Act 1988* (Vic). In the Preamble to the *Medical Treatment Act* Parliament recognises 'that it is desirable to give protection to the consumer's right to refuse unwanted medical treatment… and to state clearly the way in which a consumer can signify his or her wishes in regards to medical care'.[109] The right created by the *Medical Treatment Act* is conferred on a consumer that:

(a) has clearly expressed their decision to refuse medical treatment generally, or of a particular kind;

(b) has made the decision voluntarily without inducement or compulsion;

(c) has been informed about their condition to an extent sufficient to enable them to make the decision; and

(d) is of sound mind.[110]

121. Importantly, the *Medical Treatment Act* creates an offence of medical trespass where a registered medical practitioner provides medical treatment to a person who has, consistently with the *Medical Treatment Act,* refused that medical treatment.[111] The Second Reading Speech does not explore why a person of unsound mind is not also entitled to this right. The stark test set out in the *Medical Treatment Act* reveals the systematic discrimination which

[107] HRC, *General Comment 14*, see also UN Economic and Social Council (ECOSOC) Communication on Human Rights, *Situation of Detainees at Guantanamo Bay* UN Doc E/CN.4/2006/120 (27 February 2007).

[108] Tina Minkowitz, 'The United Nations Convention on the Rights of Persons with Disabilities and the Right to be Free from Non-Consensual Psychiatric Interventions', *Syracuse Journal of International Law and Commerce;* Spring 2007; 34, p 406.

[109] *Medical Treatment Act 1988* (Vic), Preamble.

[110] *Medical Treatment Act 1988* (Vic), section 5.

occurs between people with and without a mental illness in regard to the right to refuse medical treatment. The discrimination is unequivocal yet unexplained.

122. The right to consent to medical treatment in the Charter is modelled on article 7 of the ICCPR, an absolute right,[112] which provides: 'no one shall be subjected without his free consent to medical or scientific experimentation.' It is pertinent that this right was drafted in 1966, prior to deinstitutionalisation yet in recognition of the horror of the medical experimentation without consent which occurred during World War II.[113] This drafting reflects article 7's purpose, according to the HRC, to 'protect both the physical and mental integrity…and the dignity of the individual'.[114] A person's autonomy is intrinsically connected to their physical and mental integrity. Article 7 of the ICCPR therefore prohibits 'not only…acts that cause physical pain but also…acts that cause mental suffering to the victim'.[115] The right is construed strictly and in favour of the individual. In its *General Comment No 20*, the HRC affirms that 'no justification or extenuating circumstances may be invoked to excuse a violation of article 7 for any reason including those based on an order from a superior officer or public authority'.[116] This direction is firm and clear.

123. Clarence Sundram, President of Mental Disability Rights International, concedes that despite the plain language of article 7 of the ICCPR, respected researchers at the time continued to perform 'experiments at high levels of risk upon persons with mental impairments, without any consent at all and certainly not voluntary informed consent'.[117] Sundram explains,

> Generic recognition of human rights for **all** people has been insufficient to bring people with mental disabilities under the same umbrella because there had been a long history in society of regarding them as a separate class, with separate and lesser human rights.

124. For Sundram, this is explained by the issue of capacity, where a lack of capacity is the key barrier to enjoyment of rights by people with a mental illness. The MI Principles put in place substantive and procedural safeguards to be met before a finding of incapacity results in a person's rights being transferred to a guardian. Sundram argues, 'in reality the transfer of

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[111] Ibid., s 6.

[112] *Ireland v the United Kingdom* (1978) 2 EHRR 25; *Aksoy v Turkey* (1996) 23 EHRR 553

[113] Clarence J Sundram, *A Discussion of Legal Capacity in the Draft Convention on Disability*, (paper published by the National Disability Authority, Ireland), 15 June 2006, p 6 (available at http://www.mdri.org/mdri-web-2007/pdf/A%20discussion%20of%20Capacity.pdf, accessed 10 February 2009).

[114] HRC, *General Comment No 20: Replaces General Comment No 7 concerning Prohibition of Torture and Cruel Treatment or Punishment* (2001) [1]–[2]

[115] Ibid, [2].

[116] Ibid, [3].

[117] Sundram, above n 109, p 6.

personal rights to guardians and other personal representatives is often too easy, too informal and too complete, and yet often fails to offer the protection of the individual which this bargain is supposed to assure.'[118] For this reason, legal capacity was a central issue in the drafting of the CRPD.[119]

125. Article 12 of the Convention protects the right to equal recognition before the law and provides:

(1) persons with disabilities have the right to recognition everywhere as persons before the law;

(2) persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life;

(3) appropriate measures shall be taken to provide access by persons with disabilities to the support they may require in exercising their legal capacity;

(4) all measures that relate to the exercise of legal capacity shall 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:

(ii) respect the rights, will and preferences of the person,

(iii) are free of conflict of interest and undue influence,

(iv) are proportional and tailored to the person's circumstances,

(v) apply for the shortest time possible and

(vi) 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; and

(5) all appropriate and effective measures shall be taken to ensure the equal right of persons with disabilities to own or inherit property and to control their own financial affairs.

126. Article 12 was one of the most controversial provisions during the negotiation of the Convention. In particular, article 12(4) provoked the most intense discussion and was amongst the last provisions to be agreed.[120] The final provision is clearly the result of compromise.[121]

[118] Sundram, above n 109, p 8.

[119] Ibid, p 9.

[120] Ad Hoc Comm. On a Comprehensive & Integral Int'l Convention on the Prot. And Promotion of the Rights and Dignity of Persons with Disabilities, *Report of the Ad Hoc Committee on a Comprehensive and Integral International Convention on the Protection and Promotion on the Rights and Dignity of Persons with Disabilities on its Fifth Session,* 12-24, U.N. Doc. A/AC.265/2005/2 (23 February 2005).

127. It is arguable that article 12 permits involuntary treatment in a limited range of circumstances. This view has been put forward by Graeme Innes, Human Rights Commissioner & Commissioner Responsible for Disability Discrimination. He argues that it is not possible to makes sense of paragraph 4 unless 'measures that relate to the exercise of legal capacity' include substituted decision making. If a person's capacity is to be exercised by a substituted decision maker rather than by the person him or herself, there is a clear need for such a measure to conform with article 12(4) of the CRPD.

128. An alternative construction of section 12(4) is that the 'measures that relate to the exercise of legal capacity' only encompass supported decision making. Tina Minkowitz points to the fact that article 12(4) requires that all measures relating to the exercise of legal capacity respect the 'will and preferences' of the person and argues that a measure cannot do this if it consists of involuntary treatment.[122] In her view, article 12(4) must be read in the context of the CRPD as a whole. This includes paragraph (n) of the Preamble, article 12(2) and article 25(d) which requires health professionals to provide care of an equal standard to persons with disabilities, including on the basis of free and informed consent. Minkowitz argues that the article 12(4) requirements of review, proportional safeguards and application for the shortest time possible refer to necessary limitations on the nature of support given to persons with a disability in order to exercise their legal capacity and not to limitations on legal capacity itself.

129. The CRPD makes very strong statements about the importance of individual autonomy and non-discrimination in the Preamble and articles 3(a) and 25(d). Article 14 provides that the existence of a disability shall in no case justify a deprivation of liberty. Likewise, the requirements of non-discrimination (explicitly stated in article 5 and also contained in other provisions) reinforce that a person with a disability should not have their legal capacity restricted in situations where a person without a disability would not.

130. These statements show that the CRPD marks a move from substituted decision making to individual autonomy and support.[123]

131. In assessing whether the UK *Human Rights Act 1998* have improved the application of mental health law, Brenda Hale agrees and considers there should be a presumption of capacity, until

[121] Amita Dhanda provides a good overview of the drafting history of article 12 of the Convention in 'Legal Capacity in the Disability Rights Convention: Stranglehold of the Past or Lodestar for the Future?' *Syracuse Journal of International Law and Commerce;* Spring 2007; 34, p 2.

[122] Minkowitz, above n 104, p 405.

[123] Anna Lawson, 'The United Nations Convention on the Rights of Persons with Disabilities: New Era or False Dawn?', *Syracuse Journal of International Law and Commerce*; Spring 2007; 563 at p 597.

it is established, by taking all practicable steps to assist that person to make the decision, that he or she cannot.[124] The HRLRC adopts this view.

(g) The person cannot receive treatment in a manner less restrictive

132. The final criterion for involuntary treatment is that the person 'cannot receive adequate treatment for the mental illness in a manner less restrictive of his or her freedom of decision and action.'[125] The MI Principles state in Principle 9:

> 1. Every patient shall have the right to be treated in the least restrictive environment and with the least restrictive or intrusive treatment appropriate to the patient's health needs and the need to protect the physical safety of others.

133. This is reflected in section 8(1)(e) of the MHA where the final criterion for involuntary treatment is:

> the person cannot receive adequate treatment for the mental illness in a manner less restrictive of his or her freedom of decision and action.

134. Least restrictive treatment requires that treatment be no more harsh, hazardous, intrusive, or restrictive than necessary to achieve legitimate mental health aims and protect the person and others from physical harm.[126] Where treatment is imposed on a person (and the other criterion outlined above are met), the treatment must be:

(a) conducive to the most effective and appropriate treatment that will give that person a realistic opportunity to improve their functioning; and

(b) no more restrictive of a person's human rights than is necessary to achieve the dual purposes of protecting either that persons or others from harm and providing the consumer with holistic treatment and care.

135. An early application of the doctrine of least restrictive treatment occurred in an American case where a sixty year old woman involuntarily detained in a hospital argued she should be treated in a less restrictive setting than total confinement. The Court held 'deprivations of liberty solely because of dangers to the ill persons themselves should not go beyond what is necessary for their protection.'[127] Subsequently, the United States Supreme Court held that consumers required treatment in an integrated community setting, rather than in an unnecessarily

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[124] Hale, above n 64, p 8.

[125] MHA, s 8(1)(e).

[126] Ingo Keilitz, David Conn & Andrea Giampetro (1985) 'Least Restrictive Treatment of Involuntary Patients: Translating Concepts into Practice' 29:691 *Saint Louis University Law Review* 691-745, p 682.

[127] *Lake v Cameron* 364 F.2d 657 (D.C. Cir. 1966), per Chief Judge David Bazelon, Court of Appeals, at 660.

segregated state hospital.[128] The majority of the Supreme Court held '[u]njustified isolation…is properly regarded as discrimination based on disability' and that the states should maintain a 'comprehensive, effectively working plan for placing persons with mental disabilities in less restrictive settings'.[129] This decision was part of an American, and international, development towards a right to community integration.

136. These decisions show the evolution of the doctrine such that enjoyment of the recognised right to least restrictive treatment should take into account the factors available in the particular context and treatment should seek to minimise the intrusion on consumer's rights and freedoms.

137. Building on case law and developments in international human rights law, Rosenthal and Szeli argue that 'international law recognises a right to community integration'[130] citing principles 3 and 7 of the MI Principles (every person shall have the right to live, work and receive treatment, as far as possible, in the community) and General Comment 5 to ICESCR which recommends governments adopt legislation that 'enable persons with disabilities to live an integrated self-determined and independent life'.[131] The General Comment states that Governments are required to allocate resources to ensure enjoyment of the right to community integration.

138. This view is validated by article 19 of the CRPD on the equal right of all persons with disabilities to live in the community, with choices equal to others. Article 19 requires Victoria to ensure that persons with a mental illness, like any one else, can choose where and with whom they live. They should have access to a range of in-home, residential and other community support services, including the personal assistance necessary to support living and inclusion in the community and to prevent isolation or segregation.

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[128] *Olmstead v L.C* 527 US 581, 582 (1999) cited in Perlin, above n 86, p 349

[129] Ibid, at 597, p 605-606.

[130] Eric Rosenthal & Eva Szeli, 'Not on the Agenda: Human Rights of People with Mental Disabilities in Kosovo' (2002) *reprinted in* Michael Perlin, *International Human Rights and Comparative Mental Disability Law: Cases and Materials* (2006), pp 874-875.

[131] CESCR General Comment 5 (Persons with Disabilities) (available http://www.bayefsky.com/general/cescr_gencomm_5.php accessed 2 February 2009), [16]. Rosenthal and Szeli, above n 126, also note the Convention on the Rights of the Child (article 23), the UN Declaration on the Rights of Mentally Retarded Persons, the 1993 Standard Rules on Equalisation of Oppourtunities for Persons with Disabilities and the European Convention for the Protection of Human Rights and Fundamental Freedoms.

3.4 Conclusions and Recommendations

139. This section summarises the findings and recommendations outlined above.

140. In summary, the current involuntary treatment regime set out in the MHA is incompatible with rights protected by the Charter and does not satisfy the requirements for a permissible limitation on rights as set out in s 7(2) of the Charter. Amendments to the MHA to provide for involuntary treatment must be shown to be reasonable, justified, necessary and proportionate limitations on the human rights of involuntary consumers.

141. The following recommendations are made in the context of the above human rights analysis:

Recommendation 4:

As a person must not be involuntarily detained if they retain capacity and refuse treatment, the appearance of mental illness should not be included as a criterion for involuntary treatment. Section 8(1)(d) should be repealed.

Recommendation 5:

Determinations of mental illness should be made by a qualified mental health practitioner on the basis of objective medical evidence.

Recommendation 6:

Where treatment is imposed on a person (and the other criteria outlined above are met), the treatment must be proportionate to the legitimate aim of achieving mental health for the consumer and no more intrusive than is required to meet that aim.

4. Consumer Participation

4.1 Introduction

142. Part 3, Division 5 of the MHA contains provisions relevant to consumers' rights. This includes provisions relevant to: (a) the provision of information about legal rights (section 18); (b) the entitlement to and requirements of a treatment plan (section 19A); and (c) the rights ensuring the privacy of correspondence (section 20).

143. A person providing information to a consumer pursuant to this division, or drafting and executing a treatment plan pursuant to section 19A, is likely to be acting as a public authority. Accordingly, it will be necessary for them to have regard to the Charter rights and to act consistently with those rights.

4.2 Human Rights Relevant to Consumer Participation

144. The former Special Rapporteur on the right of everyone to enjoy the highest available standard of health, Paul Hunt, has stated that:[132]

> The right of persons with mental disability to participate in decision-making processes that affect their health and development, as well as every aspect of service delivery, is an integral part of the right to health.

145. The CDRP's emphasis on individual autonomy and non-discrimination, in particular as embodied in the preamble and article 3, should strengthen already existing obligations to take into account the wishes of the consumer.

146. In addition, principle 9(2) of the MI Principles requires that:

> The treatment and care of every patient shall be based on an individually prescribed plan, discussed with the patient, reviewed regularly, revised as necessary and provided by qualified professional staff.

147. Charter rights relevant to consumer participation include:

(a) equality before the law;

(b) right to protection against torture and cruel, inhuman or degrading treatment;

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[132] Paul Hunt, *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health* **(Hunt's Report)**, United Nations, E/CN.4/2005/51, 11 February 2005 [59].

(c) the right to privacy and reputation;

(d) the right to liberty and security of person; and

(e) the right to humane treatment when deprived of liberty.

148. Each of these rights is discussed in greater detail in Chapter 3 on Involuntary Orders.

4.3 Discussion and Analysis

(a) Advance Directives

149. Advance Directives are written statements which set out a person's wishes and preferences for care and treatment to be used in the event that they become unable to make such decisions.[133]

150. Victorian law does not provide a right for consumers to make an Advance Directive in respect of mental health treatment. An Advance Directive can nonetheless impact decision making in a number of ways, for instance by being taken into account by a decision maker who is formulating a treatment plan under section 19A of the MHA.

151. In *Fleming v Reid,* the Ontario Court of Appeal recognised such a right in relation to competent mental health consumers. The case involved a man with schizophrenia who had been involuntarily admitted to a psychiatric facility but had stated, while competent, that he did not wish to be treated with anti-psychotic medication. The court held that the legislative provision that allowed an incompetent consumer's prior competent wishes to be overruled in favour of the consumer's present best interests breached section 7 of the Canadian Charter.[134]

152. In 2006, a Senate Committee inquiry into the mental health sector in Australia reported that, as a matter of priority, state and territory governments consider making advance directives available to people who suffer from mental illness. To date, advance directives have not been granted legal recognition in any Australian jurisdictions.

4.4 Conclusion and Recommendations

153. The HRLRC considers that the human rights of persons with mental illness would be better protected through the availability of legally recognised Advance Directives and makes the following recommendation:

[133] Consultation Paper, above n 1, p 33.

Recommendation :

Mental health legislation should provide for the making and legal recognition of advance directives.

[134] (1991) 4 OR (3d) 74, cited in Carney et al, above n 9.

5. Restraint and Seclusion

5.1 Introduction

154. First hand accounts from mentally ill consumers who have been subjected to restraint and seclusion[135] all too often reveal a dark truth - the gulf between the purpose of the Charter, the spirit of the CRPD and the objectives of the MHA on the one hand, and the practical reality of mental health services on the other.

155. The following extract illustrates one consumer's experience of seclusion:[136]

> This was the beginning of what now seems like a nightmare: I feel as if I will never be the same... I was ill, confused and very afraid. To my horror, after my parents left, I was ordered by the nurse to go inside a small cell-like room with no window, only a makeshift bed in one corner, and in the heavy wooden door, a tiny window made of thick glass for the nursing staff to look into the cell. What terrified me was that after I had gone in, the nurse slammed the door shut and audibly bolted it from the outside. I thought I was going to suffocate in there with no windows... Becoming desperately scared, I started pounding on the door, shouting for the nurse to come, as I needed to go to the toilet. My yells were ignored...no one came to see whether I needed something... I ended up having to suffer the utter humiliation of passing urine on the floor of that cell. It is very embarrassing for me to write this — I have to keep reminding myself that it was not my fault... Despite being locked up like a dangerous criminal, I did not commit any crime. [I feel] rage, disbelief and sheer bewilderment at having been treated like this...the feelings are as strong today [1992] as they were back in July 1990 — I still cannot comprehend how this treatment is supposed to benefit the 'mentally ill'.

156. Another consumer in Victoria has described how she was dragged off to seclusion and left there until morning. No one checked on her during that time. She too was forced by the lack of toilet facilities to relieve herself on the floor in a corner of the room, as she recalls, 'like an animal'. She described how 'utterly degraded' she felt. She also feared that she would be criticised or severely reprimanded by nursing staff for soiling the floor.[137]

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[135] Refer Vivienne Topp, Martin Thomas and Mim Ingvarson, *Lacking Insight – Involuntary Patient Experience of the Victorian Mental Health Review Board*, Mental Health Law Centre, October 2008; Eric Rosenthal and Clarence J Sundram, *The Role of International Human Rights in National Mental Health Legislation*, World Health Organisation, 2004; and *Report of the National Inquiry into Human Rights of People with Mental Illness*, Human Rights and Equal Opportunity Commission, 1993 (**National Inquiry Report**).

[136] National Inquiry Report, above n 131.

[137] Ibid

157. The loss of dignity reported by consumers in this respect is a humiliating breach of their human rights.

158. The following rights which are engaged by the practice of restraint and seclusion are discussed below:

(a) the right to be protected against torture and cruel, inhuman or degrading treatment;

(b) the right to liberty and security;

(c) the right to human treatment when deprived of liberty; and

(d) freedom of movement.

159. Non-discrimination and the right to privacy are also engaged by the practice of restraint and seclusion. These rights are discussed in Chapter 3 on involuntary treatment.

5.2 Human Rights Relevant to Restraint and Seclusion

(a) Protection from torture and cruel, inhuman or degrading treatment

160. Article 15 of the CRPD states:

> No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment. In particular, no one shall be subjected without his or her free consent to medical or scientific experimentation.
>
> States Parties shall take all effective legislative, administrative, judicial or other measures to prevent persons with disabilities, on an equal basis with others, from being subjected to torture or cruel, inhuman or degrading treatment or punishment.

161. Leaving aside the experimentation component, domestically, this protection is reflected in sub-sections 10(a) (torture) and (b) (cruel, inhuman and degrading) of the Charter, and internationally in art 7 of the ICCPR, art 3 of the European Convention and art 37 of the Convention on the Rights of the Child. The importance of the right is confirmed by the fact that state parties to the ICCPR are not permitted to derogate from the right.[138]

162. Nowak's interim report on 'torture and other cruel, inhuman or degrading treatment or punishment' provides guidance on distinguishing between the two different constituents. Nowak states that 'for an act against or an omission with respect to persons with disabilities to constitute *torture*, the four elements of the Convention definition – severe pain or suffering, intent, purpose and State involvement – need to be present. Acts falling short of this definition

[138] HRC, *General Comment 20*, at [3].

may constitute *cruel, inhuman or degrading treatment or punishment* under art 16 of the CAT.'[139]

163. Considering the relatively high threshold for what constitutes torture, we will focus on the content of the right to be protected against cruel, inhuman and degrading treatment.

164. The right to be protected against cruel, inhuman or degrading treatment in section 10(b) of the Charter is based on the values of human dignity,[140] autonomy and physical and mental integrity.[141] As Ackermann J of the Constitutional Court of South Africa said in *S v Dodo*:[142]

> While it is not easy to distinguish between the three concepts "cruel", "inhuman" and "degrading", the impairment of human dignity, in some form and to some degree, must be involved in all three. One should not lose sight of the fact that the right relates, in part at least, to freedom.

165. The right protects consumers in medical institutions from infliction of physical pain or mental suffering.[143]

166. The term "treated" is a broad one. In Canada, it is accepted that any act which involves the exercise of state control over an individual amounts to treatment.[144] Treatment that is degrading involves an assault on the dignity and physical integrity of an individual which humiliates and debases.[145] The absence of intention to cause actual humiliation or debasement is not decisive, nor is the inability of the individual to point to any ill affects.[146]

167. Although a "minimum level of severity"[147] is required in order to engage the right, that level of severity must be assessed not only by reference to the inherent nature of the treatment but also by reference to "whether in the circumstances of a particular individual the application of a

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[139] Nowak's Report, above n 27, at [46].

[140] HRC, *General Comment 20* at [2]; Andrew Butler and Petra Butler, *The New Zealand Bill of Rights Act: A Commentary* (2005) at [10.4.1]

[141] HRC, *General Comment 20* at [2].

[142] (2001) (3) SA 382 (CC) at [35].

[143] HRC, *General Comment 20* at [5].

[144] *Rodriguez v British Columbia* [1993] 3 SCR 519 at 611-612.

[145] *Ireland v United Kingdom*, application no 5310/71 (18 January 1978) at [167] (ECt HR); *Becciev v Moldova*, application no 9190/03 (4 October 2005) at [39].

[146] *Becciev v Moldova*, application no 9190/03 (4 October 2005) at [39] (ECt HR); *Keenan v United Kingdom*, application no 27229/95 (3 April 2001) at [113] (ECt HR).

[147] See *Ireland v United Kingdom*, above n 141, at [162] (ECt HR); *Labita v Italy*, application no 26772/95 (6 April 2000) at [120] (ECtHR).

normally proportionate or acceptable treatment would be cruel, degrading or disproportionately severe".[148] In short, the assessment of severity is contextual.[149]

168. All of the circumstances of the case are relevant to that assessment, including the duration of the treatment, its physical and mental effects and the age, sex and health of the victim.[150]

169. It is worth noting that Principle 5 of the UN Principles of Medical Ethics relevant to the Role of Health Personnel, particularly physicians, in the protection of prisoners and detainees against torture, cruel, inhumane or degrading treatment or punishment states that:

> It is a contravention of medical ethics for health personnel, particularly physicians to participate in any procedure for restraining a prisoner or detainee unless such a procedure is determined in accordance with purely medical criteria as being necessary for the protection of the physical or mental health or the safety of the prisoner or detainee himself, of his fellow prisoners or detainees, or of his guardians, and presents no hazard to his physical or mental health.

170. Principle 6 states that there should be no derogation from any of these principles on any ground whatsoever including public emergency.

171. What is required of a public authority under s 10(b) of the *Charter* is that it provide "protection from" cruel, inhuman or degrading treatment. Those words in the section heading confirm that the section imposes a positive duty on the public authority to afford protection.[151] The public authority is required to take positive measures to prevent the breach of the right.[152] The European Court has confirmed that the state must "exercise supervision and control" over decisions about detention and treatment, especially treatment without consent.[153]

(b) Right to liberty and security of the person

172. Restraint and seclusion also engage and violate the right to liberty and security of the person.

173. Article 14(1) of the CRPD states:

> State Parties shall ensure that persons with disabilities, on an equal basis with others:
> (a) enjoy the right to security and liberty of person;

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[148] Andrew Butler and Petra Butler, *The New Zealand Bill of Rights Act: A Commentary* (2005) at [10.1.3].

[149] *Taunoa v Attorney-General* [2007] NZSC 70 at [91] (Elias CJ).

[150] *Dybeku v Albania*, application no 41153/06, 18 December 2007 at [36].

[151] HRC, *General Comment 20* at [2].

[152] HRC, *General Comment 20* at [8].

[153] *Storck v Germany*, application no 61603/00 (16 June 2005) at [103], [150] (ECtHR). See also Joint Committee Fourth Report, above n 66, at [66], [69], [93]-[98].

(b) are not deprived of their liberty unlawfully or arbitrarily, and that any deprivation of liberty is in conformity with the law, and that the existence of a disability shall in no case justify a deprivation of liberty.

174. Domestically this is reflected in sub-sections 21(1) to (3), and sub-section 22(1) of the Charter and internationally, in art 9 of the ICCPR and art 5 of the European Convention.

175. The right to liberty and security of the person is not an absolute right and is subject to internal qualifications. The primary purpose of sub-sections 21(1) to (3) (inclusive) of the Charter is to prevent arbitrary or unlawful deprivation of liberty. The procedural safeguards also have the effect of reducing the risk of persons who are deprived of their liberty being subjected to inhumane treatment and so protecting the security of their person.

176. The concept of 'security' refers to both the physical and mental health of a person.

177. What constitutes detention or deprivation of liberty in the context of mental health consumers, will depend on "all the facts of the case, including the nature, duration, effects and manner of implementation of the measures concerned"[154].

178. The Canadian Supreme Court and the UK House of Lords have discussed the concept of 'residual liberty'. Residual liberty is that right to liberty and security of person which is not lawfully derogated from when a person is detained.

179. For example, in *Miller v The Queen*,[155] the Canadian Supreme Court stated that *habeus corpus* should be available to an individual who, although imprisoned, had subsequently been placed in solitary confinement, because the deprivation of liberty in such a case was more restrictive or severe than the norm, which involved the mere loss of certain privileges.[156]

180. The concept of residual liberty has arguably been accepted by the House of Lords in *Regina v Ashworth Hospital Authority (now Mersey Care National Health Service Trust) ex parte Munjaz (FC)*[157] by Lords Steyn and Hope of Craighead.[158] Lord Steyn concluded that 'a substantial period of unnecessary seclusion of a mentally disordered consumer, involving total deprivation

[154] Alistair Pound and Kylie Evans, *An annotated guide to the Victorian Charter of human rights and responsibilities*, (2008), p 150.

[155] *Miller v The Queen (*1985) 24 DLR (4th) 9.

[156] *Miller v The Queen (*1985) 24 DLR (4th) 9, 31.

[157] *Regina v Ashworth Hospital Authority (now Mersey Care National Health Service Trust) ex parte Munjaz (FC)* [2005] UKHL 58.

[158] Ibid (Lord Steyn); [85] (Lord Hope of Craighead). Note that Lord Bingham of Cornhill did not agree that the concept was accepted by the House of Lords (at [30]).

of any residual liberty that the consumer may have within the hospital, is capable of amounting to an unjustified deprivation of liberty'.[159]

(c) Right to humane treatment when deprived of liberty

181. Article 14(2) of the CRPD states:

> State Parties shall ensure that if persons with disabilities are deprived of their liberty through any process, they are, on an equal basis with others, entitled to guarantees in accordance with international human rights law and shall be treated in compliance with the objectives and principles of this Convention, including by provision of reasonable accommodation.

182. Section 22(1) of the Charter states

> All persons deprived of liberty must be treated with humanity and with respect for the inherent dignity of the human person.

183. The Charter provision mirrors article 10(1) of the ICCPR, which states

> All persons deprived of their liberty shall be treated with humanity and with respect for the inherent dignity of the human person.

184. General Comment 21 of the Human Rights Committee notes that article 10(1) of the ICCPR applies to anyone deprived of liberty under the laws and authority of the State, and makes particular reference to those detained in psychiatric hospitals.

185. Further, General Comment 7 notes that article 10(1) of the ICCPR supplements article 7 of the ICCPR (the right to freedom from torture, inhumane and degrading treatment).

186. The central theme of the right to humane treatment is that a person should be treated with humanity and with respect for the inherent dignity of the human person, and should not be subjected to any hardship or constraint beyond their deprivation of liberty.[160] A person that is detained, therefore, should be guaranteed the same conditions as free persons, as far as possible, in their detained environment.

187. In the case of *Madafferi v. Australia*[161] Mr Madafferi was sent to immigration detention to await his committal to a psychiatric hospital. This form of detention was adverse to his mental health, and the HRC found that the decision to return him to immigration detention was not based on a proper assessment of the circumstances of the case. On this basis, it was held to be disproportionate, and in violation of the right to humane treatment.

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[159] n 153 above.

[160] HRC, *General Comment 21*, and *General Comment 7*, at [2].

[161] (1011/2001), ICCPR, A/59/40 vol. II (28 July 2004) 208 at [9.3].

188. This reinforces that treatment inconsistent with a broad interpretation of the best interests of the consumer is likely to be found to be inconsistent with this right.

(d) Right to freedom of movement

189. Article 18 of the CRPD, amongst matters relating to freedom of residence and nationality, states that:

> State Parties shall recognise the rights of persons with disabilities to liberty of movement.

190. Domestically, this is reflected in section 12 of the Charter, and internationally in art 12 of the ICCPR.

191. The right to freedom of movement more often deals with instances where a person is excluded from premises (law of trespass) or particular areas (orders excluding people from licensed premises such as casino or bar,)[162] but read broadly, this right may be engaged in the context of the restraint and seclusion of consumers. Where the right to freedom of movement is potentially engaged in the context of consumers, the content of the right conceptually overlaps with the right to liberty and security and is therefore more appropriately dealt with in that section.

192. More broadly, it has been recognised in the Consultation Paper and in the Victorian Chief Psychiatrist's Guidelines on the use of restraint and seclusion that these practices are 'very restrictive' in nature. Restraint and seclusion can be traumatic for the consumers, and where problems occur, the consequences can be profound, even resulting in death.[163] The discussion of the MI Principles below provides guidance as to what constitutes a human rights compliant application of such practices.

193. In the context of restraint and seclusion, the MI Principles state:

> Physical restraint or involuntary seclusion of a patient shall not be employed except in accordance with the officially approved procedures of the mental health facility and only when it is the *only means available* to prevent *immediate* or *imminent* harm to the patient or others. It shall not be prolonged beyond the period which is strictly necessary for this purpose. All instances of physical restraint or involuntary seclusion, the reasons for them and their nature and extent shall be recorded in the patient's medical record. A patient who is restrained or secluded shall be kept under humane conditions and be under the care and close and regular supervision of qualified members of the staff. A personal representative, if any and if relevant,

[162] Pound and Evans, above n 150, p 108.

[163] Consultation Paper, above n 1, p 39.

> shall be given prompt notice of any physical restraint or involuntary seclusion of the patient[164]. [Emphasis added]

194. In dealing with standards of care, the MI Principles state:

> Every patient shall be protected from harm, including unjustified medication, abuse by other patients, staff or others or other acts *causing mental distress or physical discomfort*[165] [Emphasis added].

5.3 Discussion and Analysis

(a) Restraint

195. Under the MHA, mechanical restraint can only be applied if the restraint is necessary for the purpose of medical treatment of the consumer, to prevent the person from causing injury to himself or herself or any other person, or to prevent the person from persistently destroying property. There are limitations and conditions on the application of mechanical restraint, including the period of time that restraint may be applied and also that the consumer must be under continuous observation. Their condition must be reviewed by a nurse at least every 15 minutes and the consumer is to be examined by a medical practitioner at least every 4 hours. The consumer is also to be provided with basic needs such as appropriate bedding and clothing, food and drink and adequate toilet arrangements.

196. The MHA does not cover physical restraint. Nor does the MHA cover the use of drugs as a form of restraint – often referred to as the 'chemical straightjacket'. The National Inquiry Report revealed the view by many consumers that medication in psychiatric hospitals is commonly used to keep people quiet or to control them, rather than for sound therapeutic reasons. Evidence was given by an experienced psychogeriatrician that, in some in consumer facilities for the elderly, consumers are routinely sedated as a management technique.[166] Nowak has also noted that consumers are often overmedicated as a form of chemical restraint.[167]

197. The origins of these unacceptable practices are understandable in so-called 'acute wards' where staff are under great stress, under-resourced or inadequately supported professionally. However, the fact that the origins of such practices (predominantly related to resource

[164] See MI Principles, above n 23, principle 11, at [11].

[165] See MI Principles, above n 23, principle 11, at [2].

[166] National Inquiry Report, above n 131.

[167] Nowak's Report, above n 27, at [54].

constraints) are understandable does not mean the practices themselves can be tolerated. To accept them would mean that the rights of consumers can be dismissed as inconsequential and set aside in favour of easier management techniques by the elimination of a 'nuisance' factor in wards or other institutional settings.

198. Indeed, the Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental heath ("**Hunt's Report**")[168] notes the very fact that resource constraints are an unacceptable means by which to justify violation of human rights and urges that a State is obliged to use the maximum of its available resources towards the realization of the right to health.

(b) Seclusion

199. Seclusion is permitted to be applied in more limited circumstances than restraint. Seclusion may only be applied if it is necessary to protect the consumer or any other person from an *immediate* or *imminent* risk to his or her health or safety or to prevent the person from absconding. The same limitations and conditions that apply to mechanical restraint apply to seclusion, except that a consumer in seclusion is not required to be under continuous supervision.

200. More broadly, in determining whether restraint and seclusion under the MHA violate human rights, the pivotal point will be circumstances of the individual case and the principle of proportionality. Key in this regard is whether the purpose of the restraint and seclusion is for the best interests of the consumer, or for another, impermissible purpose.

201. Nowak's interim report on 'torture and other cruel, inhuman or degrading treatment or punishment' provides guidance on the application of a human rights framework to the treatment of mental illness consumers. As mentioned above, Nowak states that 'for an act against or an omission with respect to persons with disabilities to constitute torture, the four elements of the Convention (against Torture) definition – severe pain or suffering, intent, purpose and State involvement – need to be present. Acts falling short of this definition may constitute cruel, inhuman or degrading treatment or punishment.'[169]

202. The UN Human Rights Committee also specifically mentions 'prolonged solitary confinement' as a practice that may amount to a violation of article 7 of the ICCPR[170].

[168] Hunt's Report, above n 128.

[169] Nowak's Report, above n 27, at [46].

[170] UN Human Rights Committee, General Comment 20 [6].

203. As for the right to liberty and security, a recent report from the WHO[171] has drawn on the Siracusa Principles and the MI Principles to establish the internationally accepted standards set forth for the limitation of this right. The WHO report recommends that any limitation of a person's right to be free from detention must be 'strictly necessary' to achieve a legitimate public objective – such as public safety. In addition, there must be 'no less intrusive or restrictive means available' to meet the same objective.

204. The internal qualifications of the right to liberty and security mean that this right can be limited in circumstances where there is legislative authority to do so. Clearly, sections 81 and 82 of the MHA provide legislative authority to limit a consumer's right to liberty and security, albeit in particular circumstances and subject to conditions. However, the legislative authority to restrain and seclude may nevertheless be arbitrary, and therefore unlawful under s 21(2) of the Charter, if it is so vague that it lacks sufficient criteria to govern its exercise, or where there are less intrusive measures that can achieve the same end.[172] Also, 'even if the restraint or seclusion is lawful and not arbitrary at the outset, it must end as soon as the purpose for which the consumer was restrained or secluded is fulfilled, otherwise the treatment will *become* arbitrary.'[173] 'In the context of mentally ill consumers, procedural safeguards such as regular reviews of the consumer's condition will be important in protecting against an initially lawful and reasonable detention *becoming* arbitrary.'[174] The further danger is that where this legislative authority is misused, or even overused, there is the potential for the consumer's right to be protected against torture, cruel and inhuman or degrading treatment to be violated.

5.4 Conclusion and Recommendations

(a) Restraint

205. Where administering mechanical restraint is being applied for the purposes of medical treatment such as a drug, then presumably the consumer has provided his or her full, free and informed consented to the medical treatment[175] and the restraint is a necessary consequence of the medical treatment. We do not have the necessary practical experience for such

[171] Eric Rosenthal and Clarence J Sundram, *The Role of International Human Rights in National Mental Health Legislation*, World Health Organisation, 2004.

[172] Pound and Evans, above n 150, p 152.

[173] For example: where restraint or seclusion continues for a longer period than originally authorized – see Pound and Evans, above n 150, p 152 generally.

[174] Pound and Evans, above n 150, p 152.

[175] In compliance with s10(c) of the Charter which states that a person must not be subjected to medical treatment without his or her full, free and informed consent.

circumstances to readily come to mind but proceed on the assumption that such circumstances would only arise in very limited and extreme cases, and that there are no less restrictive means available to meet the same objective of administering the drug. In such circumstances and subject to necessary procedural safeguards, mechanical restraint may be permissible as it would be applied for the legitimate aim of beneficial medical treatment.

206. Conversely, there is no doubt that when a consumer is subjected to any form of restraint for any reason other than the legitimate aim of administering consensual medical treatment, such as when restraint is applied to prevent the destruction of property, or as an administrative control mechanism due to a lack of staff resources, or as an intimidation technique, there is a violation of human rights.

207. Consumers subjected to restraint in other than strictly permitted circumstances, could, in the most severe cases, claim that they have been subjected to torture, in most cases, claim that they have been subjected to inhuman and degrading treatment and, at the very least, in all cases claim that their right to liberty and security has been violated.

208. Abolishing restraint and substituting it with the use of less restrictive means such as 'break-out', relax or 'self-soothe' rooms would alleviate the risk of human rights being violated.

(b) Seclusion

209. Currently under the MHA, seclusion is only permitted in limited circumstances, that is, for the legitimate aim to prevent immediate or imminent risk to the health or safety of the consumer or others or to prevent the person from absconding. However the ways in which seclusion operates practically could be improved to safeguard against the practice amounting to torture, ill-treatment or an arbitrary or unlawful deprivation of the consumer's right to liberty and security. Continuous observation of the consumer and the use of less restrictive means such as 'break-out', relax or 'self-soothe' rooms could alleviate the risk of human rights being violated.

210. Finally, the negative impact of restraint and seclusion on the consumer are well documented; so much so, that is difficult to see the therapeutic aims of either of these practices. Restraint can lead to muscle atrophy, life-threatening deformities and even organ failure,[176] and the exacerbation of psychological damage.[177] The HRC[178] and Nowak[179] consider that prolonged

[176] Mental Disability Rights International report, "Torment not treatment: Serbia's segregation and abuse of children and adults with disabilities", 2004. pp 19, 47 and 49.

[177] See Inter-American Court of Human Rights, *Ximenes Lopes v Brasil*, judgement of 4 July 2006, paras 133-136

[178] HRC, *General Comment 20,* at [6].

solitary confinement may constitute torture or ill-treatment. Considering the gravity of the potential consequences for the consumer when subjected to restraint or seclusion, the practice of restraint and seclusion should be abolished or at the very least, strictly and specifically regulated by law.

211. The following recommendations are made in the context of the above human rights framework and analysis:

Recommendation 8:

More resources should be directed towards infrastructure and resource development so that seclusion and restraint are not used due to resource deficiencies.[180]

Recommendation 9:

Mental Health legislation should provide that:

- Mechanical restraint is not to be applied unless the consumer (or his or her appointed carer/guardian where the consumer lacks capacity) has provided his or her full, free and informed consent to medical treatment where mechanical restraint is absolutely necessary for administering that consensual medical treatment.
- Mechanical restraint for the purposes of preventing a consumer from causing injury to themselves or others should only be applied in the most limited circumstances and should be strictly applied. For example, only if necessary to protect the consumer or any other person from an *immediate* or *imminent* risk to the consumer's or other person's health or safety.
- Where mechanical restraint is authorised, it must be strictly and continuously monitored and time bound. The new MHA should provide that mechanical restraint is to end immediately when a consumer ceases to meet the grounds for the mechanical restraint.
- Mechanical restraint may only be applied for the purposes of preventing a consumer from causing injury to themselves or others, after proper consideration of other less restrictive means which achieve the same aim, such as use of "break-out", relaxing or self-soothing rooms.
- Mechanical restraint is not permissible to prevent the person from destroying property.

[179] Nowak's Report, above n 27, at [56].

[180] WHO Legislative Handbook, above n 8.

Recommendation 10:

Mental Health legislation should introduce a prohibition against *physical restraint* except to prevent the person from causing *immediate* or *imminent* risk to the health or safety or himself, herself or other persons

Recommendation 11:

There is currently no prohibition against *'chemical restraint'*. 'Chemical restraint' should be defined and explicitly prohibited

Recommendation 12:

Mental Health legislation should require that any seclusion:

- Be strictly, actively and continuously monitored and time bound.
- Be authorised only after giving proper consideration to other less restrictive means which achieve the same aim of preventing physical harm to self/others or absconding - such as use of "break-out", relaxing or self-soothing rooms.
- cease immediately when a consumer ceases to meet the grounds for the seclusion

6. External Review

6.1 Introduction

212. For any involuntary order to comply with international human rights law it must be subject to external review and appeal by a 'competent, independent and impartial authority or judicial body'.[181] Currently the Mental Health Review Board (**MHRB**) is tasked with conducting reviews and appeals under the MHA.

213. The MHRB states that it aims to 'provide an accessible mechanism of independent review that is impartial, skilled, fair, informal and expeditious and which ensures the protection of rights according to law.'[182] The MHRB also has the obligation under s 24 of the Charter to ensure a fair hearing.

214. The HRLRC is of the opinion that certain aspects of the functioning of the MHRB are inconsistent with international human rights standards and should be reformed. These relate to:

(a) the timing of review;

(b) access to legal representation; and

(c) independent review.

6.2 Human Rights Relevant to External Review

215. Multiple human rights principles apply to the conduct of the MHRB.[183] Indeed, all those standards set out in Chapter 3 on Involuntary Orders are engaged when the right to a fair hearing is not realised. However, this section focuses on the meaning and content of the right to a fair hearing as it applies to the operation of the MHRB.

(a) CDRP

216. The right to a fair hearing as it relates to persons with a disability is set out in article 13(1) of the CRPD which provides:

[181] CRPD, above n 5, article 12(4).

[182] MHRB, *2006 Annual Report*, September 2006, p 8.

[183] See, eg, *Thwaites v Health Sciences Centre Psychiatric Facility* (1988) 51 Man R (2d) p 196.

> States Parties shall ensure effective access to justice for persons with disabilities on an equal basis with others, including through the provision of procedural and age-appropriate accommodations, in order to facilitate their effective role as direct and indirect participants, including as witnesses, in all legal proceedings, including at investigative and other preliminary stages.

217. Article 12(4) requires that States parties:

> 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 … are subject to regular review by a competent, independent and impartial authority or judicial body…

(b) ICCPR

218. Article 14 of the ICCPR provides procedural guarantees as to the conduct of a hearing. Essentially, the right ensures that litigants have the opportunity to present their case in conditions without substantial disadvantage compared to the other party. However, the right to procedural fairness does not amount to a guarantee of a favourable outcome and errors of fact or law do not amount to a violation of the right.[184]

219. The procedural guarantees include equal access to courts, fair and public hearings, and the competence, impartiality and independence of the judiciary.[185] The same procedural rights must be given to each party involved unless distinctions can be justified on objective and reasonable grounds.[186]

220. In addition, article 9(4) requires that:

> Anyone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings before a court, in order that that court may decide without delay on the lawfulness of his detention and order his release if the detention is not lawful.

221. Specific jurisprudence in relation to the timing of review, legal representation and the independence of the tribunal and is set out below.

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[184] *RM v Finland*, UN Doc CCPR/C/35/D/301/1998. See also *BdB v Netherlands*, UN Doc CCPR/C/35/D/273/1988 and *Martinez Mercader et al v Spain*, UN Doc CCPR/C/84/D/1097/2002.

[185] *BdB v Netherlands*, UN Doc CCPR/C/35/D/273/1988.

[186] HRC *General Comment 32,* at [3].

(c) Victorian Charter

222. Section 24 of the Charter is modelled on art 14(1) of the ICCPR and protects the right to a fair hearing. Section 24 provides:

> A person charged with a criminal offence or a party to a civil proceeding has the right to have the charge or proceeding decided by a competent, independent and impartial court or tribunal after a fair and public hearing.

223. The HRLRC considers that a broad construction should be given to the phrase 'a party to a civil proceeding' so that it applies to all hearings before tribunals established by statute that are bound to determine the rights and obligations of those who invoke their processes. This would include hearings before the MHRB.

224. The Human Rights Committee observed in its General Comment on the right to equality before the law and a fair hearing, that what is protected by the right to a fair hearing 'is based on the nature of the right in question rather than on the status of one of the parties or the particular forum provided by domestic legal systems for the determination of particular rights'.[187] The MHRB hears matters that are 'probably the most important issues decided by any tribunals. The Tribunals make decisions as to the compulsory detention and treatment, and thus the liberty, of the individual'.[188] It is therefore of particular importance that the MHRB recognises and realises the right to a fair hearing.

(d) MI Principles

225. The right to a fair hearing is also reflected in the MI Principles. Principles 16 and 17 require the admission or retention of a person as an involuntary consumer to be reviewed by a 'review body'. The review body shall be 'a judicial or other independent and impartial body established by domestic law'. Initial reviews are to take place 'as soon as possible' and thereafter the review body 'shall periodically review' the cases of involuntary consumers. In addition Principle 18 sets out a series of procedural requirements covering, among other things, access to representation, interpreters, medical reports and records and reasons for decisions.

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[187] Ibid [16].

[188] *R (KB) v Mental Health Review Tribunal* [2002] EWHC 639 (Admin) at [32].

6.3 Discussion and Analysis

(a) The Timing of Review

226. Currently the MHRB must conduct a review of involuntary orders (including the extension of a CTO) within eight weeks of the orders being made and at least once every 12 months thereafter.[189] While people can appeal to the Board for review at any time, it is insufficient to leave the initiation of the review to those subject to the order. The HRLRC consider that, for the review process to comply with human rights law, reviews must be conducted within a significantly shorter time frame.

227. The Consultation Paper notes that the World Health Organization (**WHO**) has suggested that involuntary orders should be automatically externally reviewed within three days after they are made and every six months thereafter.[190]

228. International law is less specific about the precise time frames for review. As set out above, the MI Principles require that review take place 'as soon as possible'. The HRC has also recognised that an important element of the right to a fair hearing is expeditious proceedings.[191] The HRLRC is of the opinion that, in order to be compatible with international human rights law and *Charter* obligations, external review of an ITO must occur within 48 hours.

229. The extent of the requirement that a person facing criminal charges be 'promptly' brought before a court and to trial is unclear. In General Comment 8, the Human Rights Committee ('HRC') has stated that:[192]

> Paragraph 3 of article 9 requires that in criminal cases any person arrested or detained has to be brought "promptly" before a judge or other officer authorized by law to exercise judicial power. More precise time-limits are fixed by law in most States parties and, in the view of the Committee, delays must not exceed a few days.

230. This comment relates to article 9(3) (which states that persons deprived of liberty by consequence of criminal arrest or detention must be brought 'promptly before a judge'). However, we consider that the principles articulated similarly apply regarding review of

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[189] MHA, ss 21, 22(1)(b), 30(3), 30(5).

[190] Consultation Paper, above n 1, p 51 citing WHO 1996, *Mental health care law: ten basic principles*, WHO, Geneva.

[191] *Fei v Columbia*, communication no 514/92, UN Doc CCPR/C/53/D/514/1992 at [8.4] (UN HRC). Note that in this case the matter took several years and there were inexplicable delays on the part of the State.

[192] HRC, *General Comment No 8: Right to liberty and security of persons (Art. 9),* 30/06/82, at [2].

detention under Article 9(4) which, as stated above, requires that a court decide 'without delay' the lawfulness of any detention.

231. While it has been suggested that around three days is likely to be the limit for detention without judicial review, there are signs that there is a trend towards a stricter view regarding this limit.[193]

232. In its 2000 Observations on Gabon, the HRC stated:[194]

> The State party should take action to ensure that detention in police custody never lasts longer than 48 hours and that detainees have access to lawyers from the moment of their detention. The State party must ensure full de facto compliance with the provisions of article 9, paragraph 3 of the Covenant.

233. According to Nowak, 'in many States, the length of custody is limited to 48 hours, in others, even to 24 hours.'[195]

234. The timing requirements for a fair trial have been subject to consideration by the European Court of Human Rights (**ECtHR**). Article 5 of the European Convention provides that '[e]veryone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings by which the lawfulness of his detention shall be decided speedily by a court.' In *E v Norway* the ECtHR found that an eight week delay violated the requirement of speedy review.[196]

235. A greater emphasis has been placed on an expeditious hearing in the case of a terminally ill AIDS patient in *X v France,*[197] and in a case concerning the adoption of a child in *H v United Kingdom*.[198] These decisions indicate that a speedy hearing is of greater importance when the act being challenged is ongoing or particularly time sensitive (as in the case of involuntary

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[193] Joseph, Schultz and Castan, *The International Covenant on Civil and Political Rights: Cases, Materials and Commentary* (2004, 2nd ed), 325, citing *Van der Houwen v The Netherlands,* HRC, Communication No 583/1994, UN Doc CCPR/C/54/D/583/1994 (24 July 1995), *Jijon v Ecuador,* HRC, Communication No 277/1988, UN Doc CCPR/C/44/D/277/1988 (26 March 1992), *Borisenko v Hungary* (852/99), *Freemantle v Jamaica (625/95), and HRC, Consideration of Reports Submitted by States Parties under Article 40 of the Covenant: Concluding Observations on Gabon, UN doc. CCPR/CO/70/GAB; Concluding Observations of the Human Rights Committee: Zimbabwe, UN Doc CCPR/C/79/Add.89 (1998)* [17].

[194] HRC, Concluding Observations on Gabon, UN doc. CCPR/CO/70/GAB, [13].

[195] Manfred Nowak, *UN Covenant on Civil and Political Rights: CCPR Commentary,* (2005, 2nd ed), 230. Also see HRC, *General Comment No 8: Right to liberty and security of persons (Art. 9),* 30/06/82, 231 (Nowak does not list the States and the time limits).

[196] [1994] 17 EHRR 30.

[197] 18020/91 [1992] ECtHR 45 (31 March 1992).

[198] 9580/81 [1987] ECtHR 14 (8 July 1987).

detention and treatment). The ECtHR has also held that the complexity of a medical case does not absolve national authorities of their obligation to provide a prompt review.[199]

236. In England, delays in reviews of decisions by the Mental Health Review Tribunal have been considered by reference to the right to a fair hearing and the right to liberty. In *R (KB) v Mental Health Review Tribunal*, the court noted that:[200]

> delays in tribunal hearings may result in the unjustified detention of patients who, if their cases had been considered earlier, would have been discharged. Even when discharge is not directed, the delay prolongs the period of uncertainty for the patient.

237. In that case, the Court held that repeated adjournments of review applications amounted to a breach of the right to speedy review of deprivations of liberty. It should be noted that the Act did not specify a time within which the application for review was to be heard.[201]

238. In *R (C) v London South and West Region Mental Health Review Tribunal*, the UK Court of Appeal found an administrative practice of listing reviews of decisions under the Mental Health Act for hearing 8 weeks after the receipt of the application was a breach of the European Convention. The Court considered that such an administrative practice made no effort to see that individual applications were heard as soon as reasonably practicable. The Master of the Rolls recognised that in some cases the consumer may well seek an independent psychiatric assessment and that those cases may well require 8 weeks preparation for the hearing, but many cases could be reviewed within a shorter time.[202]

239. In assessing appropriate periods for the timing of review, some commentators have expressed the concern that early review would disadvantage those consumers who are still acutely unwell.[203] However, whatever pre-review period is set effectively becomes a period in which a consumer is automatically deemed to lack capacity. In other words, 'such an approach teeters dangerously on predetermination of the very issues in question'.[204] In any case, as Delaney

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[199] *Musial v Poland*, App N 32605/96 para 54 (2001) (Court report).

[200] [2002] EWHC 639 (Admin) at [8].

[201] [2002] EWHC 639 (Admin) at [27].

[202] [2002] 1 WLR 176 at [57], [64].

[203] Julian Gardner "Mental Illness – Freedom and Treatment" (2000) *Law in Context* 120, cited in Sophie Delaney, *An Optimally Rights Recognising Mental Health Tribunal* (2002) available at http://www.communitylaw.org.au/clc_mentalhealth/cb_pages/mental_health_act_reform.php, accessed on 13 February 2008.

[204] Sophie Delaney, 'An Optimally Rights Recognising Tribunal' available at http://www.communitylaw.org.au/clc_mentalhealth/cb_pages/mental_health_act_reform.php, accessed on 13 February 2008.

points out 'the varying levels of wellness of people at the point of hearing is a matter for flexible, accommodating hearing processes – not a justification for denying a hearing at all'.[205]

240. Another concern that is raised in relation to early review is related to funding. However, a lack of funding is not a sufficient reason to limit the right to an expedient review. In *Procurator Fiscal v Watson and Burrows*, the House of Lords (drawing on jurisprudence of the ECtHR) stated that it is generally incumbent on states to organise their legal systems so as to ensure that the reasonable time requirement is honoured.[206]

(b) Representation

241. Involuntary consumers have a right to appear at their MHRB hearings in person.[207] They also have a right to authorise any person to be their representative before the Board.[208] The MHA requires that every person, on becoming an involuntary consumer, must be given information about their legal rights, including the right to obtain legal representation.[209]

242. Despite these safeguards, of the 5447 hearings conducted under the Act in 2006–07, only 5.6 per cent involved legal representation[210] This extremely low rate of representation is of even greater concern given that individuals who appear before the MHRB and who have legal representation are two to three times more likely to successfully challenge their order.[211]

243. The very low level of representation in matters before the Board is particularly concerning given the extreme consequences of Board decisions on the liberty and security of persons who may be subjected to involuntary orders.

244. Many consumers are unable to present their cases as well as they might wish because of their mental illness, or they may be reluctant to speak openly at a MHRB hearing. The presence of an advocate provides support and ensures that the consumer's rights are appropriately protected. This is recognized in the MI Principles, which provide that:[212]

> The person whose capacity is at issue shall be entitled to be represented by a counsel. If the person whose capacity is at issue does not himself or herself secure such representation, it

[205] Ibid.

[206] *Procurator Fiscal v Watson and Burrows* [2002] UKPC D1, 55.

[207] MHA, s. 26(1).

[208] MHA, s.26(3).

[209] MHA, s 18(1).

[210] Consultation Paper, above n 1, p 55.

[211] Information taken from the Mental Health Legal Centre (Victoria) Annual Report 2006-07.

[212] MI Principles, above n 23, principle 1(6).

> shall be made available without payment by that person to the extent that he or she does not have sufficient means to pay for it.

245. In its General Comment on article 14 of the ICCPR, the HRC stated that:[213]

> The availability or absence of legal assistance often determines whether or not a person can access the relevant proceedings or participate in them in a meaningful way. While article 14 explicitly addresses the guarantee of legal assistance in criminal proceedings in paragraph 3 (d), States are encouraged to provide free legal aid in other cases, for individuals who do not have sufficient means to pay for it. In some cases, they may even be obliged to do so.

246. In its Concluding Observations on Norway, the HRC noted that civil proceedings are serious enough to warrant an entitlement to legal aid when they concern the attempted enforcement of a right protected by the ICCPR.[214]

247. The HRC has pointed out the anomaly that exists when consumers do not have legal representation in relation to Poland's claim that a mentally ill consumer was legally capable:[215]

> the Committee finds it difficult to reconcile the State party's view that although the author was recognised, in accordance with the Act, to suffer from deteriorating mental health and inability to provide for her basic needs, she was at the same time considered to be legally capable of acting on her own behalf. … [The Committee] considers that as the author suffered from diminished capacity that might have affected her ability to take part effectively in the proceedings herself, the court should have been in a position to ensure that she was assisted or represented in a way sufficient to safeguard her rights throughout the proceedings.

248. Conversely, this case indicates if a mentally ill consumer who wishes to challenge an involuntary order is considered to be capable of acting on their own behalf, they should not be subject to the involuntary order in the first place.

249. The Joint Committee on Human Rights of the UK Parliament has said, relying on *Storck v Germany*,[216] that in cases involving compulsory medical treatment the UK Government has a positive obligation 'to provide effective supervision and review of treatment without consent'.[217]

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[213] HRC, *General Comment 32, Article 14: Right to equality before courts and tribunals and to a fair trial*, U.N. Doc. CCPR/C/GC/32 (2007).

[214] *Concluding Observation on Norway*, UN Doc CCPR/C/79/Add. 112(1999). This was particularly so in the context of the discriminatory impact of high legal costs and the absence of legal aid on Sami protection oftraditional livelihood from competing land uses.

[215] *Fijalkowska v Poland*, communication no 1061/2002, UN Doc CCPR/C/84/D/1061/2002 at [8.3].

[216] *Storck v Germany*, application no 61603/00 (16 June 2005) at [103], [150] (ECtHR).

[217] See Joint Committee Fourth Report, above n 66, at [66], [97].

To be 'effective', those safeguards must account for the vulnerability of mentally-ill persons,[218] their inability (in some cases) to complain about how they were being affected by the treatment and their position of powerlessness and inferiority.[219]

250. The ECtHR has also considered the issue of legal representation in relation to the right to a fair trial. In *P C and S v UK*, which concerned child protection and adoption proceedings, the ECtHR held that the failure to provide an applicant with a lawyer was a violation because, in the circumstances, legal representation was deemed to be indispensable.[220] Lack of legal representation prevented the party from putting forward their case effectively because of the complexity, high emotional content and serious consequences of the proceedings.

251. Further, in *Airey v Ireland*,[221] the European Court held that fulfilment of a duty under the ECtHR requires positive action by the state and thus it is under a positive duty to ensure effective access to the courts.

(c) Independent Review

252. It was commented in Parliament that the Minister believed 'the review board is likely in the main to vindicate the professional judgment of psychiatrists… it will support them in their awesome task of making a crucial decision about a person's liberty and his or her right to treatment'.[222]

253. The HRLRC does not act for consumers before the Board and is therefore not in a position to make a comment on the extent to which this occurs. Presumably, the dominance of any particular member's view would differ from panel to panel.

254. However, given the prevalence of this view of the MHRB's operation, we emphasise the requirement that the MHRB conduct a full and independent review of the merits of involuntary detention and treatment.[223] We also reiterate that civil commitments based solely on a medical assessment of a person's need for treatment breaches the right to freedom from arbitrary detention.[224]

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[218] *Renolde v France*, application no 5608/05 (18 October 2008) at [114] (ECtHR).

[219] *Herczegfalvy v Austria*, application no 10533/83 (24 September 1992) at [82] (ECtHR).

[220] 56547/00 [2002] ECtHR 604 (16 July 2002).

[221] 6289/73 [1979] ECtHR 3 (9 October 1979).

[222] Ibid, p 581.

[223] See, for example, *Varbanov v Bulgaria* App. No. 31365/96 para 58 (2000).

[224] *Thwaites v Health Sciences Centre Psychiatric Facility* (1988) 51 Man R (2d) 196.

255. In *R (H) v North London and East Region Mental Health Review Tribunal (Secretary of State for Health intervening)* the UK House of Lords issued a declaration of incompatibility stating that the requirement that a consumer prove to the tribunal that he was not detainably ill (rather that the hospital proving that he was) was incompatible with Convention rights.[225] In addition, the ECtHR has found that the independent review of detention must not be a mere formality, but must provide a serious examination of the merits of the case.[226]

6.4 Recommendations

256. In light of the discussion and analysis above, the HRLRC makes to following recommendations in relation to external review:

> ***Recommendation 16:***
>
> All involuntary orders should be reviewed within 48 hours and then again after 6 months. Consumers should be entitled to request an additional review at any time and additional reviews should be listed within two weeks.

> ***Recommendation 17:***
>
> All involuntary consumers should have effective access to legal representation and advocacy support.

> ***Recommendation 18:***
>
> The MHRB (or other body responsible for review and appeals of involuntary orders) must be constituted and organised in such a way as to ensure a full and independent merits review of all involuntary orders.

[225] [2001] EWCA Civ 415, [2002] QB 1.

[226] Gostin and Gabl, above n 24, p 71.

7. Monitoring Consumer Well-Being

7.1 Introduction

257. The effective monitoring of consumer well-being is necessary to ensure that any restrictions or limitations on rights or freedoms are, and remain, permissible and lawful. 'Unless rights are supported by a system of accountability, they can become no more than window dressing.'[227] Further, Hunt notes that 'because of the acute vulnerability of some persons with mental disabilities, it is especially crucial that effective, transparent and accessible monitoring and accountability arrangements be available.'[228] Clearly for a monitoring mechanism within the MHA to be effective, it must at a minimum provide for transparency, accountability and promotion of service improvement.

7.2 Human Rights Relevant to Monitoring Consumer Well-being

258. The CRPD and MI Principles provide authoritative guidance and a sound basis from which the monitoring provisions of the MHA may need reform in the context of a human rights framework.

259. Art 16(3) of the CRPD states:

> In order to prevent the occurrence of all forms of exploitation, violence and abuse, State Parties shall ensure that all facilities and programs designed to serve persons with disabilities are effectively monitored by *independent authorities*.

260. The importance of independence and impartiality to achieve effective accountability embodied by art 16(3) of the CRPD is also emphasized in principle 17(1) of the MI Principles and the WHO Resource Book on Mental Health, Human Rights and legislation[229] which states that all review bodies should make decisions purely on the merits of the situation before them, and should not be influenced by political or departmental pressures or by health service providers.

261. Victoria's obligation to provide appropriate safeguards for the protection of the rights of mentally ill consumers is further reinforced by art 16(5) of the CRPD which states:

[227] Hunt's report, n 128 above, at [67]

[228] Ibid

[229] WHO legislative handbook, above n 8

> State Parties shall put in place effective legislation and policies… to ensure that instances of exploitation, violence and abuse against persons with disabilities are identified, investigated and, where appropriate, prosecuted.

262. MI Principle 22 is also relevant to accountability and promotion of service improvement:

> States shall ensure that appropriate mechanisms are in force to promote compliance with these Principles, for the inspection of mental health facilities, for the submission, investigation and resolution of complaints and for the institution of appropriate disciplinary or judicial proceedings for professional misconduct or violation of the rights of a patient.

7.3 Discussion and Analysis

263. Hunt[230] observes that a lack of surveillance in the context of mentally ill consumers is doubly problematic as such consumers are often unable to access independent and effective accountability mechanisms when their human rights have been violated. This may arise for various reasons, including: where the severity of their condition renders them unable to independently protect their interests through legal proceedings; the absence of effective procedural safeguards, such as the right of persons who are deemed to lack legal capacity to have a personal representative; a lack of access to legal aid; and a lack of awareness of their human rights and other entitlements.

264. Under the MHA, the Chief Psychiatrist and Community Visitors (**CVs**) perform the role of monitoring the treatment and care provided to consumers.

265. The Chief Psychiatrist has many and varied monitoring functions, including receiving reports on incidences of restraint and seclusion and performance of ECT, reviews of clinical incidents, death reviews, issuing clinical guidelines, promoting systemic improvement and ECT licensing. However, the purpose for which information about incidences of restraint and seclusion and performance of ECT is collected is not stated in the MHA; outcomes of clinical reviews or investigations into deaths or clinical incidents which would serve as learnings to facilitate systemic improvement are not publicly reported and nor has any clinician or mental health service ever been prosecuted for failure to comply with the Act. Where there are no learnings or consequences that flow from the Chief Psychiatrist's monitoring functions, this practice is ineffective and inadequate for the purposes of transparency, accountability and promotion of service improvement.

266. CVs make regular, unannounced visits to public mental health services and inquire into:

(a) the adequacy, appropriateness and standard or facilities;

(b) whether consumers are being given the best possible treatment and care appropriate to their needs in the least restrictive environment and least intrusive manner possible; and

(c) any failure to comply with the Act and complaints.

CVs are required to report biannually to the Public Advocate and Minister, and annually to Parliament. The benefit of CV reports is that, because they are unannounced there is the potential for issues, which may not otherwise be apparent from scheduled family visits, to be revealed. Accordingly, it could prove to be a useful and effective accountability parameter. However, there is no institutional mechanism by which recommendations are implemented, or by which reports are made public for the identification of system shortcomings and to promote service improvement. Further, CVs are volunteers who come from 'all walks of life'. While a guiding criteria for becoming a CV is that they should have good listening and observations skills, CVs are not required to be have any formal qualification or degree of expertise in the sorts of issues that may arise in a mental health service, however training and support is provided by the OPA.

7.4 Conclusion and Recommendations

267. As mentioned above, where there are no learnings or consequences that flow from the Chief Psychiatrist's monitoring functions, this practice is ineffective and inadequate for the purposes of transparency, accountability and promotion of service improvement. As for CVs, while their importance and the contribution that they make cannot be underestimated, considering that CVs are acting in a volunteer capacity they obviously do not have measurable performance indicators. Therefore, similar to the functions of the Chief Psychiatrist, the function of CVs is ineffective and inadequate for the purposes of an optimal model of transparency, accountability and promotion of service improvement.

Recommendation 19:

A body with the relative independence of a tribunal, as opposed to an office within the department responsible for provision of services, should be mandated to take on the role and fulfil the functions that are currently undertaken by the Chief Psychiatrist and CVs.

[230] Hunt's report, n 128 above, at [70].

8. Confidentiality and Information Sharing

8.1 Introduction

268. The confidentiality provisions in the MHA, broadly start on a footing that recognizes the importance of protecting a consumer's confidential information. A psychiatric service or a member of its board, proprietor or employee, is prohibited from disclosing confidential information about a consumer, which is capable of identifying the consumer except in certain circumstances. That said, the circumstances which warrant disclosure of confidential information are rather broad and vague. Also, the protection of the right to privacy afforded by the prohibition is further diluted by yet another extensive set of broad and vague exceptions which practically render the prohibition almost ineffective, or at most, mean that the prohibition is only operative in very limited circumstances.[231] A discussion of the content of the human rights relevant to confidentiality will assist in determining the extent to which the confidentiality provisions in the MHA are compatible with human rights law and the extent to which these provisions should be enhanced.

8.2 Human Rights Relevant to Confidentiality and Information Sharing

269. Section 13 of the Charter establishes a person's right not to have his or her privacy unlawfully or arbitrarily interfered with and not to have his or her reputation unlawfully attacked. Section 13 is reflected in art 22(1) of the CRPD and is modelled on article 17(1) of the ICCPR.

270. Article 22(1) of the CRPD states:

> No person with disabilities, regardless of place of residence or living arrangements, shall be subjected to arbitrary or unlawful interference with his or her privacy, family or correspondence or other types of communication or to unlawful attacks on his or her honour and reputation. Persons with disabilities have the right to the protection of the law against such interference or attacks.

271. The MI Principles also recognise that the right to confidentiality of information of mentally ill consumers shall be respected[232] and that every consumer shall have the right to full respect for his or her privacy.[233] While the right to privacy is not an absolute right, the breadth of its

[231] See MHA, s 120A.

[232] MI Principles, above n 23, principle 6.

[233] MI Principles, above n 23, principle 13(b).

recognition in both domestic and several international human rights instruments and principles, emphasises the importance of protecting of this right.

272. Pound and Evans[234] state that the concept of 'privacy' defies precise definition and suggest that at its most basic, privacy is concerned with notions of personal autonomy, dignity and human development. Autonomy and dignity are the cornerstones of the CRPD as evidenced by the CRPD's preamble which recognises[235]:

> the importance for persons with disabilities of their individual autonomy and independence, including the freedom to make their own choices.

273. The United Nations Human Rights Committee (**HRC**) has said that privacy refers to those aspects of life in which a person can freely express his or her identity, either alone or in relationships with others[236]. The European Court of Human Rights (**ECtHR**) has held that the determination of information as private will depend on whether the person in question has 'a reasonable expectation of privacy' in all the circumstances.[237]

274. In relation to the equivalent ICCPR provision, Nowak[238] suggests, that reputation refers to one's appraisal by others.

275. The HRC has stated that the term 'unlawful' means that no interference can take place except in cases envisaged by the law. Interference authorised by States can only take place on the basis of law, which itself must comply with the provisions, aims and objectives of the ICCPR.[239] Also, the ECtHR has said that interference will only be lawful if it is authorised by a positive law that is adequately accessible and formulated with sufficient precision to enable a person to regulate his or her conduct by it.[240]

276. The prohibition on 'arbitrary' interference requires that a lawful interference must also be reasonable, necessary and proportionate in all the circumstances.[241]

277. While section 13 is couched in negative terms,[242] inherent in section 13 and particularly relevant for the panel to consider in the context of this review, is a requirement that the State

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[234] Pound and Evans, above n 159, p 111.

[235] CRPD, above n 5, paragraph (n) of the Preamble.

[236] *Coeriel and Aurik v The Netherlands* (Communication No 45/1991) at [10.2].

[237] *Princess Caroline case* [2004] ECtHR 294 at [50] – [53]; *Campbell v MGN Ltd* [2004] 2 AC 457.

[238] Manfred Nowak, *UN Covenant on Civil and Political Rights: CCPR Commentary* (1993), p 306.

[239] HRC, *General Comment 16*, [3].

[240] See *Sunday Times v United Kingdom* (1979) 2 EHRR 245; [1979] ECtHR 1 at [49].

[241] HRC, *General Comment 16*, [4].

adopt legislative and other measures to give effect to the prohibition against such interferences and attacks, as well as to give effect to the protection of this right.[243] There is also a further obligation on public authorities to ensure that any personal information they collect is necessary, secure and accurate.[244]

8.3 Discussion and Analysis

278. As stated above the confidentiality provisions in the MHA, broadly start on a footing that recognizes the importance of protecting a consumer's confidential information but are diluted by an extensive set of broad and vague exceptions which practically render the prohibition against disclosing confidential information almost ineffective, or at most, mean that the prohibition is only operative in very limited circumstances.

279. Confidentiality is governed by section 120A of the MHA. Section 120A was introduced by way of amendment in 2003. The Second Reading Speech of the Mental Health (Amendment Bill) 2003 states that the amendments provide for better sharing of important information within health services and better access by the Secretary of the Department of Human Services or her agent to use consumer information for planning, monitoring and other important purposes. It also attempts to provide assurance that a careful balance has been struck between the need for information sharing and the very important principles of privacy and the absolute confidentiality of details.

280. The HRLRC does not dispute the importance of information sharing as between health services for the legitimate aim of improving the quality of consumer care and treatment. However, when a consumer's confidential information is disclosed *without his or her consent*, it is questionable whether a careful balance has in fact been struck. It is questionable whether the limiting nature of section 120A on a consumer's right to privacy is reasonable and proportionate, and in compliance with international human rights law and the Charter.

281. The importance of information sharing as between health services is not recognised in the CRPD or the MI Principles. Information sharing as between health services is more of an administrative matter and beyond the scope of this submission. Therefore no more will be said about that other than to say, consistent with the right to privacy embodied in the Charter, the CRPD and other international human rights instruments, confidential information should

[242] Compare Article 17(2) of the ICCPR and Schedule 1 Art 8 of the *Human Rights Act 1998* (UK).

[243] HRC, *General Comment 16*, [1].

[244] *Norman Baker MP v Secretary of State for the Home Department* [2001] UKHRR 1275; *Gunn-Russo v Nugent Care Society and Secretary of State for Health* [2002] 1 FLR 1.

not be disclosed under any circumstances without a consumer's consent. In limited circumstances, where it is determined that the consumer is unable to consent, the consumer's guardian, family member or primary carer should be consulted and their consent obtained before confidential information is disclosed.

282. While the importance of information sharing as between health services is not expressly recognised in the CRPD, the contribution of families, and therefore the need for supporting and assisting them in the treatment of consumers, is emphasised in the CRPD. Both the contribution of families and a consumer's right to privacy are noted in the preamble to the CRPD.

283. On the one hand, the CRPD:

> recognises the importance for persons with disabilities of their individual autonomy and independence, including the freedom to make their own choices,

and on the other hand, the CRPD states that:

> persons with disabilities and their family members should receive the necessary protection and assistance to enable families to contribute towards the full and equal enjoyment of the rights of persons with disabilities.

284. A review of the MHA should aim to strike the right balance between these interests, taking into consideration the facts of each individual case and the principle of proportionality.

285. Various bodies such as the Mental Illness Fellowship, Beyond Blue and the Department of Human Services, already provide assistance and support to families, carers, guardians and friends of persons with mental illness in the form of fact sheets, brochures, community groups and help lines. These measures are all aimed at information sharing, education and support, enabling interested parties to more effectively contribute towards the enjoyment of the rights of persons with disabilities.

286. As for the individual rights of the mentally ill consumer, the right to privacy is not absolute and may be interfered with, however such interference must not be unlawful or arbitrary, and it must be reasonable and proportionate in all the circumstances. Section 7 of the Charter only permits limitations on a person's human rights in circumstances where such limitation is reasonable and demonstrably justified in a free and democratic society based on human dignity, equality and freedom.

287. With that in mind, providing information to a court in the course of criminal proceedings[245] may be considered a reasonable interference with the right to privacy, as this exception to the prohibition on disclosing confidential information operates to serve the interest of public safety. Similarly, providing information in a way where the consumer is not capable of being identified[246] does not encroach on the consumer's autonomy or dignity and would therefore not be considered a violation of a consumer's right to privacy.

288. However, where the MHA authorizes the disclosure of confidential information in 'general terms', this is broad, vague and illustrates a lack of legislative rigour. Based on international human rights law jurisprudence, this is potentially unlawful as it is not formulated with sufficient precision to enable a person to regulate his or her conduct by it.[247] Further, it is not immediately apparent what a consumer stands to gain form their confidential information being disclosed, without their consent, to such a broad range of people and organisations, such as the Australian Statistician, the Secretary, the Minister. Where there is the potential for a consumer to be identified from this information sharing process, this may be considered an arbitrary interference with the consumer's right to privacy. It is doubtful that the administrative benefit of information sharing as between health services, especially where it does not serve to improve the quality of the treatment and care of the consumer, would be considered a legitimate interference with a consumer's right to privacy. The complex and vague nature of section 120A is evidenced by the confusion of staff about their duty to maintain the confidentiality of consumer information[248] as well as the difficulties that families and carers face in requesting access to a consumer's information.

289. In 1993, the Human Rights and Equal Opportunity Commission conducted a national inquiry (**Inquiry**) into the human rights of people with mental illness.[249] The Report produced from the Inquiry noted that the majority of relatives and carers who gave evidence to the Inquiry had been frustrated by the lack of information provided about their relatives' condition, treatment, and prognosis as well as confusion in regards to the appropriate member of staff to approach for that information.

290. The Inquiry found that both carers and mental health professionals were unsure of their respective rights and obligations regarding information about the progress of mentally ill

[245] MHA, s 120A(3)(b).

[246] MHA, s 120A(2).

[247] See *Sunday Times v United Kingdom* (1979) 2 EHRR 245; [1979] ECtHR 1 at [49].

[248] In November 2008, the Department of Human Services produced a guideline to explain the operation of the confidentiality provisions under the MHA.

[249] National Inquiry Report, above n 131.

people in hospital. This is a matter which is also of concern to consumers — both those who wish their families to be kept informed, and those who want details of their illness and treatment kept from their relatives.

8.4 Conclusion and Recommendations

291. The HRLRC recognizes the increased responsibility of families and carers to help manage and support the treatment and care of consumers in the context of deinstitutionalisation. We reiterate the CRPD's requirement that:

> persons with disabilities and their family members should receive the necessary protection and assistance to enable families to contribute towards the full and equal enjoyment of the rights of persons with disabilities.

292. However, the decision whether to disclose confidential information about a consumer to any other person, whether it be to another practitioner or the consumer's family or carer, should ultimately be with the consumer wherever possible. Requiring that a consumer's consent be obtained prior to disclosure of confidential information, recognizes and respects the consumer's right to privacy, their autonomy and their inherent dignity and is compatible with the CRPD. Seeking the consumers' consent also empowers and encourages the consumer to become more involved in their own treatment and their path to recovery.

293. Conversely, disclosing a consumer's confidential information without their consent may have adverse consequences. Anecdotal evidence reveals the negative impact on the dynamics of the relationship with guardians, family members or carers, especially when that relationship is already particularly strained.[250] Disclosing a consumer's confidential information without their consent does not promote the consumer's independence or support effective re-integration into the community which requires a degree of responsibility and decision making.

Recommendation 20

A consumer's right to privacy needs to be respected. Wherever possible, confidential information should not be disclosed without the consumer's full, free and informed consent.

[250] Homeless Persons Legal Clinic, *Submission on the Review of the Mental Health Act 1986*, February 2009, p 15.