# AUTONOMY DENIED: INTERNATIONAL HUMAN RIGHTS AND THE MENTAL HEALTH ACT 1986 (VIC.)

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[*In November last year, a United Nations General Assembly resolution adopted the Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care. These Principles embody a philosophy of mental health care predicated upon considerable autonomy for those suffering from mental illness. It is argued that the Mental Health Act 1986 (Vic.) is inconsistent with these Principles in significant respects, denying their degree of autonomy. It is hoped that a recent undertaking by Australian Health Ministers to amend their mental health regimes will result in reform consistent with the Principles.*]

## 1. *INTRODUCTION*

The Human Rights and Equal Opportunity Commission (HREOC) Inquiry continues to expose the deficiency of Australia's treatment of the mentally ill.[1] In terms of legislation for the care and treatment of the mentally ill, a distinctive feature in Australia is the fact that each state has its own legislative scheme. The differences between them are significant, and not the least in relation to patient rights.[2] Nationally consistent standards in this realm would seem imperative, when there are such great implications for 'universal' human rights. Moreover, the international community has, in the United Nations Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care, agreed upon *internationally* applicable guidelines.[3] They are the

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1 National Inquiry Concerning the Rights of the Mentally Ill. The National Inquiry is expected to make its formal report early in 1993. The Inquiry has the following terms of reference:

a. To inquire into the human rights and fundamental freedoms afforded persons who are, have been or are alleged to be affected by mental illness, having due regard to the rights of their families and members of the general community.

b. In particular, to inquire into the effectiveness of existing legislative provisions, legal mechanisms and other measures in protecting and promoting the human rights of such persons.

c. To examine the respective roles of Commonwealth and State or Territory Governments in these areas.

d. Without limiting the generality of the preceding terms, to consider:

i) any discrimination on the basis of mental illness in Commonwealth laws or programs;

ii) any discrimination in employment, occupation, accommodation or access to goods and services on the basis of mental illness;

iii) human rights in relation to institutional and non-institutional care and treatment of persons with mental illness.

2 *Infra* n. 7.

3 The Principles were adopted by General Assembly Resolution on November 18 1991, 46th Session, Item no. 98b.

first comprehensive articulation by the United Nations of the specific rights of the mentally ill. The international acceptance of the Principles should encourage Australian legislatures to effect consistency. Furthermore, Australian state governments will be required, under the recently devised national mental health policy, to amend their legislation in line with the Principles.[4] The proposed deadline for such amendment is January 1998. The object of this piece is to analyse the great discrepancies between the Principles and, in particular, Victoria's Mental Health Act. As will be shown, significant reform of Victoria's mental health regime is vital if international human rights obligations are to be realized.

General Assembly principles, like conventions, treaties and all other international instruments, are not automatically part of the law of Australia; they must be formally incorporated.[5] However, a cogent argument could be made that these principles are part of customary international law. Passed by the General Assembly of the United Nations, they certainly have the agreement of numerous states, from across the international spectrum.[6] Moreover, the fact that Australia co-sponsored the General Assembly resolution adopting the Principles would seem to impose a particular obligation. In relation to the legislation of Australian states, conformity to international principles seems particularly crucial. The vast disparities between the basic philosophies, and specific provisions, of mental health legislation in different Australian states[7] indicates the potency of parochial pressures and interests. The psychiatric profession, for example, is a very powerful and partial interest group in the mental health care debate, considered by some to have inordinate influence on statutory safeguards. As a marginalised and politically powerless group, the mentally ill need the protection of universal, internationally sanctioned standards.

It may be argued that national, as opposed to international, consistency is a sufficient solution. It seems, however, that there are two factors leading to the opposite conclusion. Firstly, there is the vitally international, universal character of all human rights enshrined in United Nations instruments. These Principles, like all other United Nations human rights instruments, developed as a result of extensive consultation, and were legitimated by the concurrence of member states. The Principles were in genesis in the UN Commission on Human Rights, and more particularly, the Sub-Commission on the Prevention of Discrimination and Protection of Minorities, for 11 years.[8] The universal, carefully considered character of such rights renders highly desirable their application by all nations.

4 *Age* (Melbourne), 4 May 1992. The policy was agreed to by all Australian Health Ministers in April 1992.

5 Crawford, J. and Edeson, W. R., 'International Law and Australian Law' in Ryan K. W. (ed.), *International Law in Australia* (2nd ed. 1984) 77.

6 Harris, D. J., *Cases and Materials on International Law* (4th ed. 1991) 59, 60. Such widespread adoption can be sufficient to establish the state practice required under customary international law. The language of the Principles, however, may not have a sufficiently mandatory character to impose obligations. *E.g.*, principle 23 requires that 'states *should* implement these principles.' (emphasis added).

7 *E.g.* the Mental Health Act 1983 (NSW) s. 5 contains criteria for involuntary hospitalization which in their stringency meet, and indeed exceed, the requirements of the Principles. This is in contrast to the Victorian legislation.

8 UN *Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care* (November 1991) Annex: Introduction.

The second reason for the desirability of their application is that the Principles endorse an approach to mental health care based on extensive autonomy and freedom of choice for those suffering from mental illness. The literature on mental health law evinces a strong dichotomy of views. On one side is the 'involuntariness' stance, and on the other, patient autonomy.[9] The involuntariness view is pervaded by the belief that in many circumstances the mentally ill should be denied freedom of choice, for their own good. This view is typically manifest by reposing great discretion in the hands of the psychiatric profession, which makes care and treatment decisions on behalf of patients. The patient autonomy school, on the other hand, advocates much wider control by the mentally ill over what care or treatment is in their best interests. The right to personal autonomy and freedom of choice has long been central to general human rights discourse and instruments. Traditionally, however, the particular needs of the mentally ill have not been considered in the process of formulating such universal rights, though existing human rights instruments of course apply to the mentally ill as to anyone else.

It might seem that mental illness renders inappropriate the realization of a general right to autonomy and freedom of choice. The involuntariness stance is predicated upon the very real concern that mental illness may often preclude the clear judgement of 'best interests', and in some cases does produce violent, dangerous behaviour. In extreme instances there is no easy solution; should a person's right to refuse treatment enable him or her to choose not to ameliorate a profoundly debilitating or potentially perilous state? The difficulty is often heightened by an apparent lack of awareness on the part of the mentally ill that any danger to themselves or others exists. Ultimately, the conundrum is deciding where to draw the line. The principles recognise this. The autonomy they advocate is qualified, their difference from the Victorian Act lying in the extent of those qualifications. It is submitted that the Principles, by restricting interference with patient autonomy to more extreme cases than does the Act, draw the line at a more appropriate point. The concurrence of the international community in these Principles is a recognition, resounding though belated, that the notion of universal rights must comprehend the rights of the mentally ill. It is, moreover, an acknowledgement that the autonomy and freedom of choice so long denied the mentally ill must be implemented.

## 2. *CONTENT OF THE PRINCIPLES AND THE ACT — A GENERAL OVERVIEW*

The scope of the Principles and the Victorian Mental Health Act are roughly parallel. Both deal with such matters as the criteria for involuntary hospitalization of the mentally ill, the review of such hospitalization, standards of mental health care, and the criteria for the administration of specific types of treatment. Each also contains provisions relating to mentally ill persons who have been

[9] Weisstub, D. N. (ed.), *Law and Mental Health: International Perspectives* (1980) vol. II, 1.

convicted of offences.[10] The Principles, however, include enunciation of many fundamental rights which the Act omits. For example, the Principles contain provisions guaranteeing patient rights to their own records,[11] and such rights as privacy, freedom of religion or belief, and access to various resources.[12] Most significantly, the Principles' pervasive philosophy is to maximize patient autonomy and freedom of choice. This is in stark contrast to the Victorian regime.

Victoria's current mental health legislation is the result of significant law reform in the area. The Mental Health Act 1959 was replaced by the present legislation in 1986, taking up a trend evident in many jurisdictions around the world. That trend was away from absolute involuntariness and psychiatric discretion and towards a more 'legalistic' model seeking to promote the objective of patient autonomy. The 1986 legislation introduced significant reforms. For example, it created a greater emphasis on deinstitutionalization,[13] provided more stringent criteria for involuntary hospitalization,[14] and a formal mechanism for reviews of both initial hospitalization and continued detention.[15] It also apparently[16] allowed for some refusal of treatment by involuntary patients. As will be discussed, however,[17] this latter advance was reversed in a 1990 amendment. Despite its reforming aims, the Act has not taken the Victorian mental health system as far down the patient autonomy path as either the Principles, or legislative schemes in other jurisdictions.

The Victorian Act is ostensibly aimed at keeping 'any restriction upon the liberty of patients and other persons who are mentally ill and any interference with their rights, dignity and self respect ... to the minimum necessary in the circumstances'.[18] However, it seems that those 'circumstances' by which the rights of patients are to be qualified extend to an inherent bias in the legislation towards the 'psychiatric/treatment' model, and away from the philosophy of the UN Principles. Under the Principles a paramount and guiding concern is the patient's right to *care* of a high standard.[19] In the Act, however, it is both care and *treatment* which are the stated objectives.[20] Further, under the Act, that care and treatment is to be in the 'least restrictive *environment* possible,[21] whereas the Principles provide for the 'least restrictive or intrusive *treatment*'.[22] The difference may appear subtle, but it assumes great significance in the broader context of both instruments. The Principles' primary emphasis is on care and

[10] Mental Health Act 1986 (Vic.) Part 4 Division 4. There is not scope in this essay to deal with the distinct issues relating to security patients.
[11] UN *Principles*, *op. cit.* n. 3, principle 19.
[12] *Ibid.* principle 13.
[13] Mental Health Act 1986 (Vic.) s. 14 introduced community treatment orders, which provide for more widespread treatment in the community, as opposed to hospitalization.
[14] Mental Health Act 1986 (Vic.) s. 8.
[15] *Ibid.* Part 4 created the Mental Health Review Board. Prior to this, review of involuntary hospitalization was not automatic and the only recourse available was judicial review.
[16] Mental Health Act 1986 (Vic.) s. 12(5).
[17] *Infra* n. 57.
[18] Mental Health Act 1986 (Vic.) s. 4(2)(b).
[19] *Op. cit.* n. 3, principle 1(1).
[20] Mental Health Act 1986 (Vic.) s. 4(1)(a).
[21] *Ibid.* s. 4(2)(a).
[22] *Op. cit.* n. 3, principle 9(1).

patient choice, the Act's is on treatment in the patient's best interests. Unlike the Act, the Principles require treatment, as well as merely the place in which it is administered, to be the least restrictive and intrusive. In this sense, it may well be that the Act is a manifestation of the 'Parens Patriae' philosophy of mental health care, consistent with a psychiatric or 'involuntariness' model — the objectives are what are thought by the medical profession to be the patient's 'best interests'. The Principles, on the other hand, favour the individual patient's view of his or her best interests. This inconsistency is manifest in relation to the following areas: Involuntary hospitalization, treatment in the community, the right to refuse treatment, restraint, seclusion, psychosurgery, ECT and experimental treatment, the right to due process, and representation and advocacy.

## 3. *INVOLUNTARY HOSPITALIZATION AND FREEDOM OF CHOICE*

### 3.1 *The Criteria for Involuntary Hospitalization under the Principles and the Act*

Gostin chose the phrase 'new legalism'[23] to describe the shift he perceived from the involuntariness model to the 'civil libertarian' emphasis on patient autonomy. In his view, 'a person's consent should be the operative factor, and not what others feel would be in the patient's best interests'.[24] In relation to hospitalization, this is clearly manifest in the Principles: the first of the admission principles requires that 'every effort shall be made to avoid involuntary admission'.[25] Controversy about involuntary hospitalization focuses upon how the deprivation of a person's liberty can be satisfactorily justified. At one pole is J. S. Mill's position — the only legitimate basis for 'interfering with the liberty of action of another is self protection . . . own good, either physical or moral, is not sufficient warrant'.[26] At the opposite extreme is the criterion of the former Victorian legislation, that a person could be committed if 'mentally ill', and there was a recommendation of a medical practitioner based upon a recent examination.[27] Debate has focussed on two alternative criteria for commitment: the person's need for treatment, or protection of the person or others. An older, 1988 draft of the United Nations Principles in fact contained a more stringent criterion for commitment. In that draft, a person could only be committed if there was an 'immediate or imminent likelihood'[28] that the person would cause serious harm to himself, herself, or another. The revised draft, however, also allows for involuntary admission where it is necessary to prevent a serious deterioration in condition or to give appropriate treatment which can only be given in hospital, the mental illness is severe and impairs the person's judgement, and wherever

[23] Weisstub, *loc. cit.* n. 8.
[24] *Ibid.* 17.
[25] *Op. cit.* n. 3, principle 15(1).
[26] Broday, B. (ed.), *Mental Illness: Law and Public Policy* (1980) 140.
[27] Mental Health Act 1959 (Vic.) s. 42.
[28] U.N. *Draft Body of Principles and Guarantees for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care* (25 August 1988) UN Doc. No. E/CN/4SUG/2/1988/23.

possible, a second medical opinion is obtained.[29] The New South Wales legislation in fact appears to employ more stringent criteria than both the current Principles and the Victorian Act. It is based on the protection of the person, or others, from risk of 'serious bodily harm',[30] with no general 'care and treatment' ground for detention.

The Victorian Act's criteria for involuntary admission are an amalgam of the 'protection' and 'care and treatment' approaches. The person must appear to be mentally ill, require immediate treatment or care in a hospital, require hospitalization for their own health or safety or the protection of members of the public, and have refused or be unable to consent to the necessary treatment. There is also the requirement, consistent with the Principles, that adequate treatment and care cannot be provided in a less restrictive manner. The 'protection of members of the public'[31] consideration was only introduced after considerable pressure, particularly from groups representing the families and carers of often-violent schizophrenic patients.[32] Requiring both the 'protection' and 'care and treatment' criteria to be met, the Victorian Act may seem to meet the Principles' stringency. However, they are inconsistent in two respects. Firstly, the Principles speak of 'a serious likelihood of immediate or imminent harm' to the patient or another person. In the Act, it is merely the person's 'health or safety or protection of members of the public'. Secondly, though the Principles allow for commitment to avoid serious deterioration of condition or to provide appropriate treatment, that is only in cases where the person's mental illness is severe, and there is a second opinion where possible. The Victorian Act offers none of those safeguards. It is sufficient if according to the authorized psychiatrist hospitalization is required for the person's 'health or safety'. It is indeed a legitimate fear that this ground confers too broad a discretion on the psychiatric profession — that mere risk to health or safety is not sufficient justification for incarceration against a person's will.

### 3.2 *The Involuntary Hospitalization Criteria as Applied by the Mental Health Review Board*

It is futile to concentrate on the mere words of the legislation: being so broad, the crucial consideration is their interpretation by the Mental Health Review Board. The Board reviews the involuntary hospitalization of patients and hears patient appeals,[33] determining in individual cases whether the criteria are satisfied. In some respects it seems that the Board's decisions have moved towards the Principles' greater stringency. For example, the Principles' requirement that judgement be impaired where hospitalization is for the patient's health seems to be applied in the Board's decisions. In the case *B v. Mental Health Review Board*[34] the fact that the person's insight into the need for treatment was

29 *Op. cit.* n. 3, principle 16(1)(b).
30 Mental Health Act 1983 (N.S.W.) s. 5(1).
31 Mental Health Act 1986 (Vic.) s. 8(1)(c).
32 Victoria, *Parliamentary Debates*, Legislative Council, 26 April 1986.
33 Mental Health Act 1986 (Vic.) s. 29.
34 *B v. Mental Health Review Board*, unreported, AAT, 28 June 1988 (Judge Jones).

seriously impaired was part of the basis for finding that hospitalization was necessary for the person's health or safety. The Board has established a test as to whether a person should be detained for the sake of his or her health. The criteria are met if there is a real risk of significant deterioration in physical or mental condition without hospitalization or, more contentiously, if there is a real risk that the illness will 'result in the person's isolation in the community in which he or she lives, interacts and is sustained'.[35] Though the first arm of the test reflects the Principles' requirement of a serious deterioration in condition, the alternative 'isolation from the community' departs markedly from the Principles. This is not to say that interaction within one's community is not integral to good health, perhaps particularly for people who are mentally ill. It is simply a troubling indication of how much discretion the Act's 'health or safety' criteria may confer, and the great capacity within the Act for divergence from the United Nations Principles. The breadth of these statutory criteria certainly seems inconsistent with the Principles.

### 3.3 *'Mental Illness' for the Purpose of Involuntary Hospitalization*

The philosophy of the Principles is that hospitalization against a person's wishes should be the option of last resort. It must be borne in mind that the move in Victorian mental health care over the past 30 years has been towards de-institutionalization. In the 1950s, Victoria had more than 15,000 public psychiatric hospital beds, compared with less than 3000 today.[36] However, the 1990 amendments to the Act appear in several ways to have heightened its inconsistency with the UN Principles and 'freedom of choice' approach. Formerly, the medical practitioner was only entitled to conclude that the person was, or appeared to be, mentally ill on the basis of facts observed personally by that practitioner.[37] Under the amendment, however, the conclusion of the practitioner may be based on facts observed by another practitioner not more than 28 days earlier, if the first has 'reasonable grounds for relying on the facts' and has 'personally observed some fact which supports the recommendation or certificate'.[38] Clearly this amendment would seem to provide for commitment in more cases. The facts on which the assessment of mental illness is based need not be presently operative, and need not be observed by the practitioner responsible for the commitment decision. It is very likely that committing psychiatrists will not feel bound to conduct such thorough examinations as formerly, being entitled to rely on the observations of another. Effectively allowing for commitment on the basis of hearsay evidence from a doctor who may have seen the person as long ago as 28 days, this amendment would seem to render the Act even more divergent from the Principles' stringent approach to involuntary hospitalization.

One of the reasons for the original requirement of personal observation was to

[35] *In the Review of BC*, Mental Health Review Board, Decision No. 181287:Z01:572047.
[36] Author's interview with Neil Rees, former President of the Mental Health Review Board, 5 July 1991.
[37] Mental Health Act 1986 (Vic.) s. 123.
[38] Mental Health (General Amendment) Act 1986 (Vic.) s. 26.

prevent 'collaborative' hospitalization, whereby parties with a vested interest in the detention of a person, could perhaps fabricate or exaggerate elements of the condition to achieve committal. At the time of the amendment, the Board had discovered at least seven such incidents.[39] The amendment is bound to increase the scope for inappropriate committals, where partisan interests are allowed to interfere in what should be the most impartial of determinations — the consequences being deprivation of liberty.

Of great controversy is the definition of 'mental illness'. Neither the Principles nor the Act define with any specificity what 'mental illness' is. However, Principle 4 does provide that a finding of mental illness must not be based on 'any reason not directly related to mental health status' including, for example 'non-conformity with moral, social, cultural or political values or religious beliefs prevailing in a person's community'.[40] The Act includes a quite extensive list of factors, such as 'political activity' or 'sexual orientation',[41] which are not sufficient basis for a mental illness finding. However, the Act does not include any such general provision as Principle 4.

## 4. *TREATMENT IN THE COMMUNITY AND FREEDOM OF CHOICE*

### 4.1 *Community Treatment Orders*

Consistent with the 'least restrictive alternative' predicate, the Principles stress the importance of life in the community for the mentally ill. Principle 3 enshrines the right 'to live and work, as far as possible, in the community'.[42] Principle 7 articulates a right to be 'treated and cared for, as far as possible, in the community', the right to be hospitalized near his or her community, and the right to 'return to the community as soon as possible'.[43] Deinstitutionalization is also part of the Victorian system's philosophy. One of the objectives enumerated by the Act is to 'support the patient in the community and co-ordinate with community services'.[44] The provisions most clearly intended to realise this objective are those providing for community treatment orders. Described by the former President of the Mental Health Review Board as the 'flavour of 1991',[45] they are being used extensively by committing psychiatrists as an alternative to involuntary hospitalization. Patients on community treatment orders are still involuntary patients, and so must satisfy the involuntary criteria. They essentially mean that patients considered with the Act's terms to require medication, and unwilling to take it voluntarily, are subject to an order to take prescribed drugs at specified intervals from particular practitioners or services. Whilst giving effect to the Principles' preference for community treatment, these orders are a telling

39 *Re: The Mental Health (General Amendment) Act 1989*, Submission on proposed amendments to the Mental Health Act 1986 (Vic.) (1989), Mental Health Legal Centre, 4.
40 *Op. cit.* n. 3, principle 4(3).
41 Mental Health Act 1986 (Vic.) s. 8(2).
42 *Op. cit.* n. 3, principle 3.
43 *Ibid.* principle 7.
44 Mental Health Act 1986 (Vic.) s. 5(a)(vii).
45 Neil Rees Interview, *supra* n. 36.

illustration of the fundamental limit upon the Victorian system's adherence to the objective of patient choice. The essence of these orders is compulsory treatment, which is irreconcilable with the Principles.

Both the former President of the Board[46] and mental health patient interest groups[47] have expressed concern at the deleterious impact of these orders on some patients. They are often a means of keeping people on damaging drugs for protracted periods without adequate supervision. Many patients have been placed on extremely high dosages of drugs, for as long as three or four years.[48]

Community treatment orders are a cogent indication of how apparent realization of one right can violate another. Ostensibly to avoid the compulsory detention of patients in hospitals (or, more cynically, to facilitate the 'mass use'[49] of CTOs), an amendment was made in 1990 to allow for 'lounge room CTOs'. These mean that a patient need not be taken to hospital for examination prior to the making of a treatment order. This procedure will trivialize highly intrusive enforced drug treatment. Moreover, there are fears that such a change will increase gratuitous drug treatment, a proper medical examination only being possible in a hospital facility. This may be particularly so in the case of initial diagnoses of schizophrenia. In many cases young people admitted with schizophrenic symptoms may actually be experiencing the effects of drugs, but only after observation in hospital is that likely to be discovered.[50]

### 4.2 *Relevance of Community in the Board's Decisions*

Just as important as any statutory provision preferring life in the community is the attitude which the Board, and the psychiatric profession, take towards the importance of a patient's community. The Act does not expressly recognize the right in the Principles of a patient to be in a hospital 'near his or her home or the home of his or her relatives or friends'.[51] The Board, however, does appear to consider this amongst the criteria when it is hearing appeals against the transfer of involuntary patients. For example, in *Re Dr DF and the Mental Health Review Board*, the fact that a patient would be further from family and friends if transferred was instrumental in the success of her appeal against transfer. This does, however, appear to be yet another example of how it is not so much the patient's wishes, but what is perceived as the need for treatment, which is determinative. It seems that what was decisive was not the fact that the patient wanted to remain near her 'community', but that removal from the community would have had a deleterious effect on treatment; there was 'a real risk that she will not respond to the program because of the transfer'.[52] The end result may be

46 *Ibid.* 11.
47 Author's interview with Rod Salvage, former Chairperson of the Victorian Mental Illness Awareness Council, 19 July 1991.
48 *Ibid.* 11.
49 Citizens Commission on Human Rights, *Submissions re: Mental Health Act Amendments* (1989), 1.
50 Neil Rees Interview, *supra* n. 36.
51 *Op. cit.* n. 3, principle 7(2).
52 *Re Dr DF and the Mental Health Review Board*, unreported, AAT, 23 March 1989 (Judge Jones).

the same. However, such a decision is illustrative of the Act's preference for the 'involuntary treatment' philosophy over patient choice. Had it been that the treatment was more likely to succeed upon transfer, the patient's 'right' and desire to be near her community may have been overridden.

## 5. *THE RIGHT TO REFUSE TREATMENT*

### 5.1 *The Right to Refuse Treatment — Denial and Discrimination*

The area in which the Act most expressly, deliberately and probably self-justifyingly contravenes the Principles is a person's right to refuse medical treatment. The general provision of the Principles is that 'No treatment shall be given to a patient without his or her informed consent'.[53] The right is then qualified. Where a person lacks capacity to consent, treatment may be administered, but only with the approval of an independent authority. Where a person has the capacity to consent, that consent is not required where 'a qualified mental health practitioner authorised by law determines that it is urgently necessary in order to prevent immediate or imminent harm to the patient or to other persons'.[54] There are also particularly stringent criteria pertaining to sterilization and psychosurgery.

To become consistent with the Principles' clear 'patient choice' approach to treatment, the Act's pervasive 'treatment' philosophy would have to be radically altered. Under the Act, the need for treatment is inherent in the criteria for involuntary admission; the person must have refused or been unable to consent to treatment and require immediate treatment or care which can be obtained by admission and detention.[55] Compulsory treatment is the implicit *raison d'etre* of the Act. This is also evident from another criterion for involuntary admission — Section 12(4) states 'Upon admission an involuntary patient is to be detained and *treated* for his or her mental illness.[56] A 1990 amendment gave psychiatrists express power to consent to treatment on the behalf of those who refused to.[57] Until that time, there was only a power in the authorized psychiatrist to consent on behalf of those themselves *incapable* of consenting.[58]

Now, however, even those deemed capable of making a treatment decision are effectively denied the right to do so. This involuntarist treatment philosophy is clearly evident in the outlook of the Mental Health Review Board. In one case, a patient was not treated with drugs because the patient did not wish to be treated; instead the doctors decided to await the outcome of an appeal before attempting further treatment. The Board held that it was inappropriate to defer to the patient's wishes in such a way:

53 *Op. cit.* n. 3, principle 11(1).
54 *Op. cit.* n. 3, principle 11(8).
55 Mental Health Act 1986 (Vic.) s. 8.
56 *Ibid.* s. 12(4) (emphasis added).
57 Mental Health (General Amendment) Act 1990 (Vic.) s. 6(d).
58 Mental Health Act 1986 (Vic.) s. 12(5).

> It is a matter for the patient's treating doctor to assess whether medication should be administered, and in the event that medication is considered appropriate and necessary, it should be offered and given with or without the patient's consent.[59]

It seems from the recommendations of the Consultative Council established to review the 1959 legislation that it was never intended that patients should be given a general right to refuse treatment, though this issue is not adverted to in parliamentary debate. The Council recommended that 'the primary function of psychiatric hospitals is the treatment or amelioration of mental illness', and 'treatment decisions should remain primarily the decision of the treating psychiatrist'.[60] However, it seems that the Council did envisage something more than just the plenary power conferred by s. 12(5)[61] for one psychiatrist to consent to treatment which the patient 'refused'. The Council recommended that the mechanism 'approximate as closely as possible to a second opinion'.[62] There is no such 'second opinion' safeguard provided for in the Act.

Theoretically, the position prior to the amendment was that a person could be involuntarily hospitalized, and not be treated if consent was withheld. Whatever the theoretical intention, however, it seems that in practice involuntary treatment prevailed. The process of amendment perhaps disturbingly vindicates the view of Gordon and Verdun-Jones that such statutory provisions may not reform the law at all, but 'simply be the expression of policies and procedures informally adopted by psychiatrists for some time'.[63] According to Neil Rees, former President of the Mental Health Review Board, admitting psychiatrists simply circumvented the problem of consenting on behalf of those who refused by deciding that *all* patients were incapable of consent, whether or not that would objectively have been the case. Rees says that he recommended in favour of the amendment in order that the Act reflect prevalent psychiatric practice: 'If you have parts of the legislation that are certainly being flouted, there is a tendency to develop the view that you don't have to worry about the law ... from my perspective it's better to argue that the law should be changed to accord with practice.'[64] Parliamentary debate adds further weight to the conclusion that the legislative change was an absolute endorsement of the 'involuntariness' premise. An Opposition member said: 'It is the responsibility of doctors, if they see it as being in the best interests of the patient, to accept the delegation of that consent ... on the basis that the medical profession is a responsible profession, and that the community has faith in the medical profession acting responsibly.'[65] It may well be that any such faith in psychiatry is being significantly undermined by the interim revelations of the HREOC National Inquiry.

Organisations such as the Victorian Law Institute opposed the amendment's denial of the right to refuse treatment.[66] However, it was concluded that 'on

[59] *The Appeal of J.A.F.*, Mental Health Review Board, Decision No. 300890:Z22:358293.
[60] Victoria, *Report of the Consultative Council on the Review of Mental Health Legislation* (1981) 42.
[61] Mental Health Act 1986 (Vic.) s. 12(5).
[62] *Op. cit.* n. 60, 43.
[63] Gordon, R. and Verdun-Jones, S., 'Mental Health Law Reform in the Commonwealth' in Weisstub, D. (ed.), *Law and Mental Health: International Perspectives* (1984) 38.
[64] Neil Rees Interview, *supra* n. 36, 12.
[65] Victoria, *Parliamentary Debates*, Legislative Council, 3 April 1990, 509.
[66] Victorian Law Institute, *Submission re Mental Health Act Amendments* 2.

balance, the welfare of the patient to be treated outweighs the concerns of these groups'.[67] Inherent in this is the conclusion, contrary to the Principles, that mental health patients who are capable of understanding the general nature of their condition and the proposed treatment should still not have any discretion as to what is for their own welfare. Discrimination on the grounds of mental illness is prohibited by the Principles,[68] and it is certainly arguable that this denial of freedom of choice is discriminatory. The requirement that general medical treatment be given only where there is informed consent has been recognised in Australian courts.[69] In the United States, it has been affirmed in relation to psychiatric treatment.[70] This argment would seem to have particular cogency in light of the Victorian Medical Treatment Act, which provides legislative protection of the 'patient's right to refuse unwanted medical treatment.'[71]

For those deemed 'capable' of consenting to treatment, the Act's provision may well amount to discrimination on the grounds of mental illness. As well as to the Principles, such a regime is contrary to the anti-discriminatory provisions of the United Nations Declaration on the Rights of Disabled Persons,[72] and the International Covenant on Civil and Political Rights.[73] Moreover, it would seem to be at odds with the spirit, if not the letter, of Australia's proposed national disability discrimination legislation, due to be debated in the Autumn 1992 session of Parliament. There is an inherent contradiction in an Act which purports to '[p]rovide standards and conditions of care and treatment . . . which are in all possible respects at least equal to those provided for persons suffering from other forms of illness'[74] and yet denies mentally ill patients who are capable of consent a right enshrined for those suffering from other types of illnesses.

### 5.2 *Refusal of Treatment and Insight into Mental Illness*

The general justification for presuming to override a patient's wishes in the interests of their own welfare is that, in the majority of cases of involuntary hospitalization, the patients lack sufficient insight into their own condition to be capable of assessing their own 'best interests'. This lack of insight is manifest by patients' frequent denial that they are mentally ill. This view of capacity to consent seems also to be held by the Board. Typical of the Board's reasoning in deciding that patients lack the capacity to consent is:

> The patient is able to consent to treatment . . . she has said in evidence that she recognises she has been mentally ill . . . in our view she understands 'the broad nature and effect of the treatment for which consent is sought.[75]

It appears that if this 'insight into the illness' test of capacity were to prevail, very few involuntary patients would be held to have capacity to consent, even if

67 Victoria, *Parliamentary Debates*, Legislative Council, 3 April 1990, 507.
68 *Op. cit.* n. 3, principle 1(4).
69 *F v. R* (1983) 33 S.A.S.R. 189.
70 *Rogers v. Okin* 478 F Supp. 1342 D. Mass (1979).
71 Medical Treatment Act 1988 (Vic.), preamble.
72 U.N. G.A. Resolution No. 3447(xxx), 9 December 1975, *Declaration on the Rights of Disabled Persons*, principle 10.
73 U.N. *International Covenant on Civil and Political Rights* 99 (1966); U.N.T.S. 141, art. 26.
74 Mental Health Act 1986 (Vic.) s. 5(a)(1).
75 *In the Review of BV*, Mental Health Review Board, Decision No. 190190:H12:3155.

the Victorian Act *did* recognise the prerogative enshrined in the Principles. This does not, however, negate the need to protect the right to refuse treatment, however small the group of patients affected might be. Moreover, the Principles do not themselves define capacity to consent, and in light of their advocacy of the 'least restrictive or intrusive treatment', an argument could be mounted that many involuntary patients would in fact have capacity. Steven Hurd, formerly a legal advocate for mentally ill persons before the Board, has suggested that 'the Board has to look very closely at what they call insight into an illness . . . it has to make a distinction or try to tease out more from people whether they are really not accepting that they have an illness or whether it's the treatment that they are not wanting.'[76] It seems that people often deny their illness not because they believe they are well, but because they fear what are often grave side effects of treatment. It seems that a reevaluation, consistent with the Principles, of the paramountcy of treatment over patient choice may also require review of the nature of 'insight' into mental illness.

Patients may also deny their condition because the nature of it is not sufficiently explained to them. Rod Salvage, once an involuntary patient himself, and former Chairperson of the Victorian Mental Illness Awareness Council, refused treatment '[b]ecause I didn't see any proof of being mentally ill. I suppose as treatment progressed I had more insight into my condition, but it would have been speeded up if someone just came up and explained my treatment to me.'[77] It seems that this sort of situation may be avoided if the Act gave effect to the provision of the Principles that '[t]he treatment and care of every patient shall be based on an individually prescribed plan, *discussed with the patient*.'[78]

## 6. *RESTRAINT, SECLUSION, PSYCHOSURGERY, ELECTRO CONVULSIVE THERAPY AND EXPERIMENTAL TREATMENT*

In relation both to restraint and seclusion, the broad criteria of the Victorian Act extend its mandate to restrict patient freedom beyond what is accepted by the Principles. Physical restraint and seclusion are only permitted under the Principles where they are the only means of avoiding 'immediate or imminent harm to the patient or others.'[79] The Act's criteria are much broader than this. Restraint is permissible if it is necessary for medical treatment, to prevent injury to the patient or others, or to prevent persistent destruction of property.[80] Moreover, the only restrictions on restraint which the Act imposes pertain to *mechanical* restraint.[81] According to Rod Salvage, drugs are often used to restrain and demobilise patients to an equally great extent.[82] The grounds for seclusion are

76 Author's interview with Steven Hurd, former solicitor with Mental Health Legal Centre, 5 July 1991.
77 Rod Salvage Interview, *supra* n. 47.
78 *Op. cit.* n. 3, principle 9(2) (emphasis added).
79 *Ibid.* principle 11(11).
80 Mental Health Act 1986 (Vic.) s. 81(1).
81 *Ibid.* s. 81.
82 Rod Salvage Interview, *supra* n. 47.

similarly wide and inconsistent with the Principles. A patient may be confined if it is necessary for the 'safety, protection or well-being'[83] of the patient or others. Rod Salvage believes that seclusion is 'very much used as a punishment'.[84] This indicates just how open to abuse are the Act's broad criteria for such liberty-denying practices. It also shows compellingly the desirability of the Principles' stringency, and privileging of patient autonomy.

The Principles prohibit the carrying out of psychosurgery (such procedures as lobotomies) on involuntary patients altogether.[85] The Act is clearly inconsistent with this: it allows for the performance of psychosurgery, though only under stringent conditions of consent and approval.[86] This is the only provision of the Act which acknowledges the patient's prerogative to refuse treatment absolutely. However, the fact that, inconsistent with the Principles, psychosurgery may be carried out with the Board's approval, is of considerable concern. This is particularly so given that between July 1990 and June 1991, the Board approved psychosurgery in two cases.[87]

There are also slightly more stringent safeguards in relation to electro convulsive therapy (ECT) in the Act. Consent is required if ECT is to be performed, unless the patient is incapable of consenting, or treatment is urgently required.[88] This provision is consistent with the Principles' requirements for treatment *generally*: for all treatments the consent requirements are as stringent as for ECT under the Act. In an early draft of the legislation, there was in fact to be a provision that 'other prescribed treatments' could be declared by regulation to be subject to the same consent requirements as ECT.[89] In Parliament, the distinction drawn between ECT and other treatments was explained on the grounds that it 'does attract a degree of fear in the minds of a significant section of the public and some patients regard its use as a threat to their sense of integrity.'[90] Not only is the Act's 'preferential' treatment of ECT inconsistent with the Principles — it also throws into question the ostensible rationale that ECT is viewed as a threat to patients' 'sense of integrity'. Drugs, by far the most widely used treatment of all, may be regarded as equally intrusive and threatening to integrity. Patients say of the effect of many of the drugs that 'they feel a real dullness inside, that they are not real people and that they are shut off.'[91] This is aside from the fact that commonly used drugs such as modecate often lead to loss of employment.[92] The New South Wales legislation, though not conferring a general right to refuse treatment, does provide much tighter criteria for many specified treatments. In relation to drug treatment it prohibits the administration of 'a dosage or dosages of a drug or drugs which, having regard to proper

83 Mental Health Act 1986 (Vic.) s. 82(2).
84 Rod Salvage Interview, *supra* n. 47.
85 *Op. cit.* n. 3, principle 11(14).
86 Mental Health Act 1986 (Vic.) s. 57.
87 Psychosurgery Review Board, *Annual Report 1991*, 86.
88 Mental Health Act 1986 (Vic.) s. 73.
89 Victoria, *Parliamentary Debates*, Legislative Assembly, 19 March 1986, 403.
90 *Ibid.* 311.
91 Steven Hurd Interview, *supra* n. 76.
92 *Ibid.*

professional standards, is or are excessive or inappropriate.'[93] There is a widely held view that it is those 'professional standards' themselves which are at fault.[94] Much more than legislative change, then, may be required: it is the nature of psychiatric practice and training which must be tackled as well. It seems clear, however, that legislative safeguards in line with the Principles would have some practical result. A woman thought she had a brain tumor for two months until it was revealed that her symptoms were a side effect of a drug she was taking.[95] Clearly, a provision in the Victorian Act requiring informed consent to drug treatment would have made a difference in that case. The woman would at least have been aware of what side effects to anticipate. Moreover, consistent with her entitlements under the Principles, she would have been able to refuse treatment.

Similarly, the Act fails to recognize the right, enshrined in the Principles, to freedom from experimental treatment. Principle 11(15)[96] prohibits the carrying out of experimental treatment on patients without their informed consent, or, if incapable of consent, without the consent of an independent authority. In the Act, there is no protection relating to experimental treatment at all.

## 7. *PSYCHIATRIC DISCRETION V. RIGHT TO DUE PROCESS*

### 7.1 *Appeal and Review of Involuntary Hospitalization*

The HREOC Inquiry, and government investigations into the Lakeside Psychiatric Hospital[97] and Aradale Psychiatric Centre,[98] indicate that fears about the abuse of the extensive discretion of psychiatrists and medical staff might not be completely ill-founded. The psychiatric profession may indeed genuinely have as its motivation the patient's 'best interests'.[99] However, it is precisely this assumption which contravenes the philosophy of freedom of choice integral to the Principles. Psychiatrists are clearly a partial interest group in the debate about patient autonomy. Moreover, the consequence of exercise of discretion is often denial of one's right to liberty. This right is protected in the Covenant on Civil and Political Rights,[100] which is incorporated into the Principles.[101] The least expected safeguard may be the sort of impartial adjudication guaranteed to those facing detention who are charged with criminal offences.

With involuntary hospitalization or treatment only as a last resort, the Principles clearly reject the model of plenary psychiatric discretion as operated under the former Victorian legislation. The present scheme, though providing some redress with mandatory reviews of involuntary hospitalization by the Board, and the opportunity for patients to appeal, still places extensive power in

93 Mental Health Act 1983 (N.S.W.) s. 181.
94 Rod Salvage Interview, *supra* n. 47.
95 Steven Hurd Interview, *supra* n. 76.
96 *Op. cit.* n. 3, principle 11(15).
97 *Age* (Melbourne), 29 May 1991.
98 *Age* (Melbourne), 20 November 1991.
99 Neil Rees Interview, *supra* n. 36.
100 U.N. *Covenant on Civil and Political Rights*, 99 (1966); U.N.T.S. 141, art. 9.
101 *Op. cit.* n. 3, principle 1(5).

the hands of the medical profession. In relation to involuntary hospitalization, the Principles provide that the initial admission decision is made by a psychiatrist, as under the Act. However, admission is to be 'initially for a short period . . . pending review'[102] by a 'judicial or other independent and impartial body . . . as soon as possible after the decision by the psychiatrist.'[103] Under the Act, the Board's initial review takes place between four and six weeks after the patient's admission.[104] It can hardly be said that more than a month after admission is 'as soon as possible'. This is particularly grave when it is considered that most involuntary patients spend only five or six weeks in hospital at a time,[105] and so would be released in many cases before the review took place at all.

The tardy review under the Act also seems grossly inconsistent with the decision by the European Court of Human Rights in *Winterwerp v. The Netherlands*.[106] Article 5 of the European Convention on Human Rights provides '[e]veryone who is deprived of his [*sic*] liberty by arrest or detention shall be entitled to take proceedings by which the lawfulness of his [*sic*] detention shall be decided speedily by a court'. This was held to require speedy review of the detention of the mentally ill. Perhaps indicative of the rights-obscuring view of the psychiatric profession is the fact that one of their interest groups exhorted that review not take place for six to eight weeks after admission,[107] effectively precluding review in the majority of cases. In contrast, the New South Wales legislation provides a mechanism which would seem much more consistent with the Principles. Under that legislation, the involuntary hospitalization of a patient must be swiftly confirmed by a magistrate.[108]

### 7.2 *The Mental Health Review Board — Independent and Impartial?*

Even if the Act required the Board to review detention sufficiently soon after admission, there is some question as to whether it is in fact 'an independent and impartial'[109] body. The conflict is essentially that of the patient's desire to leave hospital and the psychiatrist's belief that the patient should remain. The Board consists of a psychiatric member, a member who is a lawyer, and a community member from neither profession.[110] The fact that it may be predisposed towards the psychiatrist's perspective denies the requisite impartiality. There is a view that, partly because of their expertise, there is a tendency for the views of the psychiatric members of the Board to be predominant, and that the Board may in effect become a 'rubber stamp' for inordinate psychiatric discretion. Indeed, 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

102 *Ibid.* principle 16(2).
103 *Ibid.* principle 17(2).
104 Mental Health Act 1986 (Vic.) s. 30.
105 Neil Rees Interview, *supra* n. 36.
106 (1979) 2 E.H.R.R. 387.
107 Neil Rees Interview, *supra* n. 36.
108 Mental Health Act 1983 (NSW) ss 42-7.
109 UN Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care, principle 17(1).
110 Mental Health Act 1986 (Vic.) schedule 1.

will support them in their awesome task of making crucial decisions about a person's liberty and his or her right to treatment'.[111] It seems that the Board also regards the evidence and opinions of psychiatrists as most highly persuasive in hearings before it: '[T]he Board will always give great weight to the opinion of treating doctors . . . it would only be in a rare case that a board would reject a clinical judgment reached by a treating doctor'.[112] The resultant dominance of psychiatric discretion appears particularly undesirable when it is often the case that different psychiatrists will come to quite disparate opinions in relation to the same person's illness.

### 7.3 *Due Process and Treatment Decisions*

The other area in which the Principles seek to impose some control on the discretion of the psychiatric profession is treatment decisions. Again, the Victorian Act appears to omit these safeguards. Under the Principles, where a person lacks capacity to consent to treatment, any treatment is to be given to that patient only if an 'independent authority' is satisfied of the lack of capacity and that the proposed treatment is in the patient's best interests and that, having regard to the patient's own safety or the safety of others, the patient unreasonably withholds such consent. The independent authority must also be satisfied that the proposed treatment is in the best interests of the patient's health needs.[113] Under the Act, treatment discretion in such circumstances is left entirely in the hands of the authorized psychiatrist where there is no guardian appointed.[114] The Principles provide that wherever treatment is given to a patient without the patient's consent, the patient or any interested person has the 'right to appeal to a judicial or other independent authority' against the treatment decision.[115] There is no such right expressly stated in the Act. The only option is judicial review according to ordinary principles. However, due to delay and expense, this is effectively almost meaningless for mental health patients.[116]

## 8. *REPRESENTATION AND ADVOCACY*

When a person's liberty is at stake, it would seem that of paramount importance at hearings of the Mental Health Review Board would be some sort of representation of patients. This is particularly so given that a representative of the hospital, usually the treating psychiatrist, is always present at hearings. Further, the imbalance between a mental health patient and a member of the psychiatric profession may be considerable. That the Board 'is bound by the rules of natural justice'[117] may seem meaningless in cases where there is not patient representation. The Principles provide that at hearings before the Board,

111 Victoria, *Parliamentary Debates*, Legislative Assembly, 19 March 1986, 409.
112 *In the Appeal of TJS*, Mental Health Review Board, Decision No. 220989:Z01:525372.
113 *Op. cit.* n. 3, principle 11(6).
114 Mental Health Act 1986 (Vic.) s. 12(5).
115 *Op. cit.* n. 3, principle 11(15).
116 Neil Rees Interview, *supra* n. 36.
117 Mental Health Act 1986 (Vic.) s. 24(1).

representation of patients is compulsory. It is provided that if the patient does not secure such representation 'a counsel shall be made available without payment by the patient to the extent that the patient lacks sufficient means to pay.'[118] The only provision under the Act for representation is that 'the patient *may* be represented before the Board by any person authorized to that effect by the patient.'[119] There is similar inconsistency with the Principles in relation to representation of patients before the Guardianship and Administration Board.[120] At the heart of this is one of the most intractable problems in the mental health realm — that of resources. No doubt it would be extremely costly to provide representation in all cases, though the South Australian legislation provides that in all appeals to their comparable tribunal, representation must be provided, and funded by the Legal Aid Commission if necessary.[121] Perhaps the most realistic solution is a system of voluntary advocates such as is being initiated by the Victorian Mental Health Legal Centre.

The same eligibility criteria for Legal Aid assistance apply for mental health applicants as all others, and so, all other factors being equal, patients are no more or less likely to gain representation funding than any other applicant. In practice, representation of patients before the Board is minimal and only occurs in approximately 5%-7% of cases.[122] It is perhaps useful to contrast this with figures for representation in criminal cases, which range from 25% in summary offences to more than 96% in serious indictable matters.[123] When the consequence of the Board's decisions may be incarceration, this disparity seems inordinate. Moreover, it would seem that representation does increase the chances of a person's release considerably; the average discharge rate of patients is about 7%, but increases to 14% or more with representation.[124] Neil Rees, former Board President, believes that in the mental health jurisdiction, representation may be particularly desirable, given the technical medical nature of much of the material and the fact that, under the Act hearings of the Board are closed to the public. 'Certainly it helps keep us honest ... [T]here is an inevitable tendency in jurisdictions like this not to become as definite about sticking to the statutory guidelines as you might otherwise be.'[125] This view is reiterated in the Board's 1991 Annual Report: 'Legal representation has invariably been of assistance to the Board as it has enabled the Board to be better appraised of the wishes of the patient.'[126]

Speaking of the need for representation of mental health patients in striving for autonomy, Justice Kirby stated 'there is probably no function upon which lawyers have more to offer than representation of the individual when his [*sic*]

[118] *Op. cit.* n. 3, principle 18(1).
[119] Mental Health Act 1986 (Vic.) s. 26(3).
[120] Guardianship and Administration Board Act 1986 (Vic.) s. 12.
[121] Mental Health Act 1977 (S.A.) s. 39.
[122] Neil Rees Interview, *supra* n. 36.
[123] Clerk of Courts, Melbourne Magistrates Court. The author spoke to Stephen Webster, Clerk Co-ordinator, 2 June 1992.
[124] Steven Hurd Interview, *supra* n. 76.
[125] Neil Rees Interview, *supra* n. 36.
[126] Mental Health Review Board, *Annual Report 1991* 18.

freedom is at stake.'[127] However, in mental health law, as in many other realms, the conceived efficacy of traditional legal representation may need to be debunked, or at least supplemented. Further, as the HREOC Inquiry has shown, the monitoring mechanism of 'community visitors' which the Act provides for, has probably not been sufficiently vigilant in its observation of standards of treatment and care in mental health facilities. Perhaps a step in the right direction is the scheme of mental health advocates in the process of establishment by the Public Advocate's Office. Although it is also fettered by resource constraints, (there will be five people working in the context of 2500 psychiatric hospital beds),[128] the advocates will not be lawyers, and will not appear before the Board. Their role will be to liaise directly with hospital authorities, monitoring standards and handling complaints. It seems that their role will not be to advocate what they believe to be in the patients' best interests, but to aim to respect the patient's wishes in relation to their care and treatment.

## 9. *CONCLUSION*

With its treatment-oriented philosophy, the Victorian Act fails to realise the paramountcy of personal choice and autonomy, to which all those suffering from mental illness are entitled. This entitlement has been given irrefutable recognition and cogency by the international community. Compelling obligations, both legal and moral, demand response from Australian legislatures. Marginalized politically, legally and socially for so long, it is to be hoped that the mentally ill will gain from the Principles recognition of their rights. The Victorian Mental Health Act is contrary to international law, and denies many of those entitlements. The only tenable response is reform, consistent with their realization.

[127] Kirby, M., 'Mental Health Law Reform' (1980) *Barton Pope Lecture* 23.
[128] Public Advocates Office, Victoria. The author spoke to Niki Sheldon, 8 April, 1992.