

Mental Health Legal Centre Inc

Submission to the Review of
Exceptions and Exemptions in the
Victorian *Equal Opportunity Act 1995*

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The Mental Health Legal Centre

The Mental Health Legal Centre (MHLC) provides a free and confidential legal service to anyone who has experienced mental illness in Victoria where their legal problem relates to their mental illness.

All centre activities aim to promote the rights of people who experience mental illness. The Centre is a non-profit organisation run by an independent Committee of Management.

We receive the majority of our funding from the Victorian Department of Human Services and Victoria Legal Aid.

MHLC provides telephone advice and referral, direct advocacy - in some cases, education and general inquiries about mental health and the law for consumers in Victoria.

Attitudes

MHLC would like to begin by saying that it is pleased that the present government is continuing with its avowed policy to improve the political status of *all* citizens in the state of Victoria. The Centre hopes that this current review will contribute to the potential for persons with a psychiatric disability to participate in society to the fullest of their ability.

People with psychiatric disability experience discrimination everyday in all areas of life. Equal opportunity legislation is highly important to our client group not only because it sets a standard but also because it enables people with psychiatric disability to redress inappropriate action by some members of the community in everyday life.

For more than 20 years our Centre has provided legal services to people with psychiatric disability, and we have a keen sense of the extensive discrimination and prejudice to which they are subject. We are very much aware that a great deal of discrimination is legislatively based. It is of particular concern to the Centre that the piece of legislation devised to confront discrimination in society, namely the *Equal Opportunity Act* (the Act), instead appears to too readily defer to other legislation that tends to discriminate.

Exceptions and Exemptions

In our view the greatest weakness in the Victorian Regime is the very large number of exceptions and exemptions when compared to the Commonwealth Disability Discrimination Act 1992 (DDA). We note in particular the following areas:

Employment:

Section 16 of the Equal Opportunity Act should be repealed. Lawful discrimination in the area of personal services is inappropriate because this is a sector where people who experience, or have experienced mental health issues often find an essential entry point into the workplace. This exception is not in the DDA.

Section 21 should be repealed. There should be no exemption on the basis of the size of an employer. Thus small business should be viewed no differently from any other employer. MHLC finds that small businesses can be the most stigmatising of all employer groups. Again, this exemption is not in the DDA.

Section 25 should be altered to show that the mere fact of having an impairment cannot of itself constitute a genuine belief that discrimination is necessary to protect physical, psychological or emotional well being of children. Section 25(1)(c) should also require the belief to be both rational and reasonable.

For example, an alternative provision could instead read:

‘The mere existence of an impairment cannot in itself constitute a reasonable and rational basis for a person’s belief.’

Accommodation:

Section 54 should not allow discrimination of shared accommodation on the basis of impairment, or other attributes. At the very least, the number of people in the household under this exception should be reduced to no more than three other people, as is the case under the DDA.

Community participation:

Section 75 The Centre believes this provision is unduly broad.

Section 78 The exclusion for private clubs should be repealed. This does not appear in the DDA.

Statutory authority exception

Should the statutory authority exception be repealed?

Section 69 of the Equal Opportunity Act

In our view there can be no justification for acceptance of discrimination which is necessary or authorised pursuant to legislation or regulations. The Equal Opportunity Act has built into it all the “sound policy” balancing mechanisms, defences and exemptions that can be justified. In this sense any inconsistent legislation is simply not justifiable.

This is indeed recognised in the comparable provision of the Commonwealth Disability Discrimination Act 1992, section 47(3), under which the exemption for acts done in compliance with other laws was the subject of a sunset clause. Indeed, that provision may well have also been considerably more strict, in that it only applied to anything done “in direct compliance” with another law.

In 2005 the Scrutiny of Acts and Regulations Committee were of a mind that a front-end review of prospective legislation would require time to properly implement. Hence a sunset period of some years was deemed necessary. In 2008, given that a ‘front-end review’ mechanism is now in place in the form of the procedural notification about the rights implications of prospective legislation that comes before Parliament (as required by the Charter of Human Rights and Responsibilities Act 2006), the three year sunset period would now seem questionable. The necessary length of time would now be that required by government departments to properly review existing legislation for compatibility. As this procedure is already well under way, a time less than three years would seem reasonable.

Are there any examples of Acts and enactments that cannot be reconciled with the Equal Opportunity Act?

Mental Health Act 1986

The Mental Health Act is the legislative regime with which our Centre probably has the most extensive experience. It is also one of the most challenging in terms of discrimination – as one of its chief purposes is to subject people with psychiatric disability to a regime of involuntary treatment not experienced by any other groups. A strong argument could be made that all the provisions authorising involuntary treatment discriminate – for people without the impairment of mental illness no such regime applies. For people with capacity to consent, the right to refuse unwanted medical treatment generally is deeply enshrined and respected. As discussed below, many of those treated involuntarily under the Mental Health Act are so treated because they are considered to lack capacity to consent and people with other sorts of disabilities may also be subject to treatment without consent where they lack capacity¹. However, many in the community cannot be subject to involuntary treatment even where they lack capacity and people with mental illness are arguably discriminated against in this sense as well.

Involuntary treatment is best categorised as direct discrimination. It is because there exists a specific impairment - mental illness - that people subject to the Act are at risk of involuntary treatment. For those without that impairment there is no exposure to such a regime where their condition puts health or life at risk. Many people in the community with a right to refuse treatment are in “similar circumstances” to those with mental illness in the relevant sense – a person with cancer and a person with schizophrenia both have serious illnesses with potentially lethal consequences, which may or may not respond well to treatment.

Those who view involuntary mental health treatment unquestionably and simplistically as a “best interests” regime may ask whether involuntary treatment in fact amounts to less favourable treatment. In terms of a person’s subjective experience, and the fundamental rights and freedoms, it certainly is.

Something which must be understood about involuntary psychiatric treatment, is that it usually involves a strongly felt and expressed resistance to the treatment, as opposed to an inability to express or make a decision due to an impairment relating to communication or cognition. And there will often be good reason for a person’s resistance quite apart from the restriction on their autonomy. Treatments provided for mental illness often have serious, debilitating and stigmatising side effects.

¹ See discussion of Guardianship and Administration Act 1986 below.

We do not consider that involuntary treatment could be said to amount to a special service or facility in terms of the section 80 exception either – it would be a misreading of that section to apply it to services being provided to a person without their consent, and, as is generally the case, against their expressed wishes.

Contrary to a strict rights based autonomy approach though it may be, the “best interests” rationale for some degree of involuntary psychiatric treatment is well established and unlikely to change substantially. However, in the context of the Equal Opportunity Act and this review its reasonableness - in what circumstances and subject to what protections it should be sanctioned – must be addressed.

In the Centre’s view there are provisions of the Mental Health Act which are unreasonable and accordingly discriminatory in a number of relevant senses as set out below.

Criteria for Involuntary Treatment

Criteria for people considered able to consent

Probably the starkest example of discrimination is in the case of people considered “able to consent”. Both involuntary treatment as an inpatient and in the community are sanctioned if, amongst other things, a person “has refused or is unable to consent to necessary treatment” (sections 8(1)(d)). It is one thing to impose involuntary treatment where someone lacks capacity to consent because of illness. This is indeed what happens if a Guardian is appointed under the Guardianship and Administration Act 1986. However, it is another to do so if the person is able to consent but refuses. Apart possibly from some people subject to the Guardianship and Administration Act², there are no other groups of people who can be lawfully subjected to unwanted treatment where they have capacity to consent but refuse. It is difficult to see how such a distinction between people with mental illnesses and other illnesses could be said to be

² People with disabilities other than mental illness within the meaning of the Guardianship and Administration Act can have medical treatment without their consent but with that of a guardian. A guardian will only be appointed if, amongst other things, a person is unable because of their disability to make “reasonable judgments” about medical treatment. This may be a different approach to capacity to consent than applies at common law and pursuant to the Medical Treatment Act 1988. In those cases the test is whether a person has enough understanding to make an informed decision and can communicate it. There is no further assessment as to the content of the decision – whether it is reasonable. In this sense the Guardianship and Administration Act may also discriminate against people with disabilities generally as compared to people without disabilities when it comes to the right to refuse unwanted medical treatment. The definition of disability under that regime means intellectual impairment, mental disorder, brain injury or dementia (section 3) but does not include many serious health problems – for example the case of a person with a life threatening cancer who wishes to refuse treatment but whose decision may be considered by others to be “unreasonable”.

reasonably necessary, except perhaps where a resultant risk of serious harm is not to the person with the illness but someone else.

The United Nations Principles for the Protection of Persons with Mental Illness and Improvement of Health Care provide that involuntary treatment (other than more restricted treatment such as psychosurgery, major medical or surgical procedures and experimental treatment) can only be given either:

- in cases where an independent authority is satisfied that a person who has already met the criteria³ to be involuntarily detained lacks capacity to consent and treatment is in the person's best interests, or has capacity and unreasonably refuses treatment required for their safety (Principle 11(6) and 11(8)); or
- without that independent authority's approval if urgently required to prevent immediate or imminent harm (Principle 11(8)).

They limit the circumstances where involuntary treatment can be given where someone has capacity to consent to cases of much greater risk of harm than does the Mental Health Act. The Mental Health Act accepts involuntary treatment, whether or not a person is able to consent, for the person's "health or safety (whether to prevent a deterioration in their physical or mental condition or otherwise) or for the protection of members of the public" (Sections 8(1)c).

Looking at comparable Australian regimes, there is some recognition of the need to limit involuntary treatment where people have capacity to consent. In Queensland (Mental Health Act 2000 section 14(1)) and the Northern Territory (Mental Health and Related Services Act sections 14 and 16) people can only be involuntarily treated if not able to consent or have "unreasonably refused", and, as is discussed below, the level of harm required in both those places is greater than in Victoria.

MHLC is informed by acting for those subject to involuntary treatment. Issues of protection, risk of harm and refusal to consent often rely upon outdated reports of historical events, no longer relevant. For this reason we recommend an amendment that provides a time frame and suggest that sections 8(1)(d) limit the risk to one that is "imminent", consistent with the UN Principle 16.

In our view, it would not be sufficient to amend the legislation by simply requiring "unreasonable" refusal, as that does nothing to expressly establish the entitlement of a person with capacity to refuse treatment where the only resultant risk is to themselves. And even though the position we advocate goes even further than the United Nations position, it seems correct on a strict discrimination law approach.

Accordingly we recommend the following amendment to sections 8(1)(d) :

³ Those criteria are that there is a serious likelihood of imminent or immediate harm, or, if the person's judgment is impaired and the illness is severe, failure to detain will lead to a serious deterioration in condition or will prevent the giving of appropriate treatment that can only be obtained by detention. Principle 16(1).

“the person is unable to consent to the necessary treatment or, in a case where there is a imminent and serious risk to the public, has refused to consent to necessary treatment for the mental illness”.

The broader formulation of the Principles (that treatment can be imposed against the will of someone able to consent where there is an urgent issue of imminent or immediate harm to themselves or a risk to their safety in light of which refusal is unreasonable) may also be appealing. The notion of changing the status quo such that people with mental illness may freely chose to suffer, or indeed die, is uncomfortable to say the least. However, it is difficult to see how it can be reasonable for capable people without mental illness to be entitled to such self determination and those with a mental illness and capacity to not.

Criteria for people considered unable to consent

If a person without a mental illness is unable to consent to treatment, treatment can still be lawfully given treatment:

- If that person has a disability within the meaning of the Guardianship and Administration Act and a “Person Responsible” under that Act consents; or
- If a person to whom an enduring power of attorney has been granted consents.

We are not here arguing that changes should be made such that consent can be given to mental health treatment by people holding powers of attorney – our focus is on people’s right to refuse unwanted treatment. The first category can perhaps not be comparator in relation to involuntary treatment under the Mental Health Act, as people with disabilities generally can be subject to treatment without their consent. However, there is still a significant “comparator” group for whom such intervention is not possible. They are people who do not have disabilities under the Guardianship and Administration Act but suffer from the many other conditions which may put health significantly at risk.

Of course, in the case of people considered unable to consent it may be less clear that involuntary treatment is “less favourable” treatment. However, as set out above it certainly seems arguable where subjectively felt and expressed resistance to treatment may be strong. In our view such involuntary treatment is arguably discriminatory and its reasonableness must be addressed, and the relevant provisions under the Mental Health Act are unreasonably broad.

The vast majority of analysis of whether someone is unable to consent in terms of sections 8(1)(d) turns on whether they have sufficient “insight”, that is understanding of their illness and proposed treatment to consent. Indeed, it may be that a substantial majority of cases where involuntary treatment is sanctioned by the Mental Health Review Board involve a determination that the person is unable to consent due to lack of insight. That does not mean that those deemed able to consent but refusing, possibly being a relatively small minority, should not have the benefit of the amendment suggested above. The issues of autonomy as regards medical treatment are too significant.

The concept of insight does, however, require some unpacking in a way that bears on the reasonableness of involuntary treatment where someone is considered unable to consent. In the Centre's extensive experience in advocacy before the Board tests as to insight can be applied without the sort of rigour best practice would require. People's disagreement with clinicians about their diagnosis may often be as much about concerns connected with the adverse impact of treatment they will receive or the stigma associated with diagnosis as straightforward lack of awareness that they are unwell and of the implications of treatment. In this context, it is particularly important that there be strict constraints on the circumstances under which those considered "unable to consent" can have treatment imposed against their wishes.

It is instructive in this regard to consider the provisions of the comparable New South Wales, Northern Territory and Queensland regimes, which respectively require a risk of "serious harm" (Mental Health Act 1990 (NSW) section 9) "imminent harm" or "serious deterioration" (Mental Health and Related Services Act (NT) sections 14 and 16 and Mental Health Act 2000 (Qld) section 14).

In our view sections 8(1)c should be amended to require a similarly higher level of harm than merely for health to prevent a deterioration in their physical or mental health or otherwise.

We recommend those provisions be amended to reflect the position in New South Wales that there must be a risk of "serious harm" before involuntary treatment can be authorised. At the very least the provision should require a risk of "serious deterioration" as in the Northern Territory and Queensland.

It might be argued that the qualification of the legislative requirement of a deterioration to "serious" is something which can be left to interpretation by the Board. Indeed, there is a strong line of decision making which follows an interpretation that what is required is a significant deterioration (see for example Appeal of HL (1997) 2 MHRBD (Vic.) 485). However, quite apart from the distinction between "seriousness" and "significance", any interpretation by the Board or VCAT is not binding as between its different divisions, and the few Supreme Court considerations of the Act have not addressed substantive meaning of any of the criteria. In a context such as this the limits on power to impose involuntary medical treatment should be precisely defined in legislation.

Procedural safeguards for those subject to involuntary treatment

Not only substantive criteria, but the level of procedural safeguards applying to involuntary treatment is relevant to the issue of discrimination. The adequacy of safeguards certainly goes to the reasonableness of the provisions. There are significant respects in which the Mental Health Act does not provide optimal safeguards in comparison with both other Australian jurisdictions and the United Nations Principles.

Reference is made above to the UN Principles' requirement that, if treatment is to be given to someone who cannot consent on the basis that it is in their best interests an "independent authority" must be satisfied it is appropriate. Under the Mental Health Act involuntary treatment can be imposed on the basis of the views of the clinicians involved, and there may be no independent review of that decision for up to eight weeks – if at all. Victoria's Auditor General has identified that 70% of Victoria's involuntary patients do not have their status reviewed by the Mental Health Review Board at all because they have been discharged before the hearing takes place⁴.

This is just one example of the inadequacies of the procedural safeguards around involuntary treatment under the Mental Health Act which we consider require amendment if the Act is to be rendered more consistent with anti-discrimination principles.

Confidentiality and Discrimination

A further arguably discriminatory provision of the Mental Health Act is section 120A. That section governs the right to confidentiality of users of public mental health services. In relation particularly to the provision of confidential information to carers it provides less protection to users of mental health services than users of general health services.

The provision of particular concern is section 120A(3)(ca). It provides an exception to the general right of confidentiality in the following circumstances:

the giving of information by a member of the medical staff or a member of a prescribed class of staff relating to a person who is, or has been, receiving services from a relevant psychiatric to a guardian, family member or primary carer of the person to whom the information relates if

- I) the information is reasonably required for the ongoing care of the person to whom it relates; and
- II) the guardian, family member or primary carer will be involved in providing that care.

⁴ Auditor-General Victoria *Mental Health Services for People in Crisis*, October 2002, Government Printer for the State of Victoria, p.8.

The Health Services Act 1988 provides confidentiality protection for people receiving treatment in public health services generally. The comparable provision refers to

the giving of information concerning the condition of a person who is a patient in, or is receiving health services from, a relevant health service if the information

- (I) is communicated in general terms; or
- (II) is communicated by a member of the medical staff of a relevant health service to the next of kin or a near relative of the patient in accordance with the recognised customs of medical practice.

It is clear that the “recognised customs of medical practice “do not sanction disclosure in as broad a range of circumstances as section 120A. For example, the 2004 AMA Code of Ethics states that exceptions must be taken very seriously, and gives as examples where there is a serious risk to the patient or another person, where required by law, where part of approved research, or where there are overwhelming societal interests.

The provision in the Mental Health Act originally duplicated that in the Health Services Act. It was amended pursuant to lobbying by carers concerned that those responsible for caring for people with mental illness found it too difficult to get information from mental health services about those for whom they cared.

There is no doubt that this provision treats people receiving treatment for mental illness less favourably than those receiving general public health services where confidentiality is concerned, and, indeed amounts to a condition that people will only get the greater protection if accessing services from general health services. The question is whether it could be said to be “reasonable”, whether in the sense of section 80, or the requirements of indirect discrimination.

In our view the provision is unreasonable in that underlying it is an assumption that people with mental illness are more in need of care by others and less able to make reasonable decisions about disclosing information about their illness than users of general health services.

Confidentiality is of utmost importance to users of mental health services, as is the ability to exercise one’s own judgment as to who receives information. It can be therapeutically destructive for a person to know or fear that others will be passing on sensitive information about their illness, in terms of their relationships with both therapists and carers. Where relationships with carers are sufficiently supportive to justify information sharing then patients will be willing and able to disclose information themselves.

At the very least, to be rendered reasonable, this provision should require consideration of whether the patient is able to make reasonable decisions about disclosure of information

themselves. It is unreasonably discriminatory to assume people with mental illness are less able to do this.

Immunity from Suit

Section 122 of the Mental Health Act provides:

No civil or criminal proceedings lies against any person for anything done in good faith and with reasonable care in reliance on any authority or document apparently given or made in accordance with the requirement of this Act.

We urge serious consideration be given to whether this amounts to a discriminatory provision. There is no comparable provision in the Health Services Act 1988. It may be thought that this is because it is a provision relevant exclusively to a regime such as that under the Mental Health Act. Under it people can be given a status which justifies treatment without consent, and anyone who acts in good faith on the assumption that such status has been legitimately conferred is protected.

However, it may be that users of general health services have greater entitlement to remedies where clinicians take action assuming they have consented where they in fact have not. That would seem to be the comparable situation – the involuntary status under the Mental Health Act stands in the place of a general patient’s own consent. It certainly does not seem reasonable that people treated when they have not in fact consented have greater access to legal redress than people with mental illness treated on the assumption that illegitimate authorisation of involuntary treatment is in fact legitimate.

Involvement of Police in Mental Health Treatment

Under sections 9A, 9B, 10 and 11 of the Mental Health Act police are authorised to transport people to mental health services and use whatever force is reasonably necessary. People being treated for other sorts of health problems are not subject to police involvement in their health service provision.

Many people with mental illness report experiencing involvement of police as distressing, stigmatising and something which exacerbates their mental health problems. There is a great deal of fear amongst users of mental health services of police involvement, to the extent that there is a concept of “suicide by cop” within Consumer parlance.

The Centre has long held the view that it is inappropriate, counter therapeutic and unnecessary for police to perform this role. Our understanding from senior police personnel is that Victoria Police does not consider it to be an appropriate role. The removal of this power from police (subject perhaps to an exception for extreme situations) would certainly require a redistribution of resources between police and mental health services. However, there is absolutely no reason why mental health workers could not be equipped and resourced to deal even with challenging

situations, and it would ultimately much better serve the interests of mental health service users and the broader community.

It is not adequate to argue that this is more a matter of service provision practice than legislative provision. The involuntary apprehension and transport of people with mental illness is a grave matter about which legislation is required to ensure that fundamental rights and optimum service quality are delivered in practice.

Mental Health Act 1986/Medical Treatment Act 1988

The interaction between the Mental Health Act and Medical Treatment Act, as far as Refusal of Treatment Certificates is concerned, amounts to discrimination.

In relation to a presently existing medical condition, a competent person can execute a Refusal of Treatment Certificate and know it will be respected if and when they lose capacity. However, (though it is untested in court to date) if the illness is a mental illness and a person becomes unwell and meets the criteria for involuntary treatment under the Mental Health Act their previously expressed refusal is unlikely to be respected. It appears from section 4(3)(b) of the Medical Treatment Act that the involuntary treatment provisions of the Mental Health Act would prevail. Section 4(3)(b) relevantly states “This Act does not limit the operation of any other law”. There is no comparable section to section 41 of the Guardianship and Administration Act 1986 in the Mental Health Act. That section provides that the consent of a “Person Responsible” cannot justify treatment without the person’s consent where they have executed a Refusal of Treatment Certificate.

In the Centre’s view, the Mental Health Act should be amended to make it clear that, if a valid Refusal of Treatment Certificate has been executed, involuntary treatment cannot be imposed on that person.

There can be no justification for treating those with mental illness and those with other conditions differently when a Certificate’s validity depends on the person having had a high level of understanding of their illness and treatment at the time of execution. Indeed, given the dynamic and often episodic or cyclical nature of many mental illnesses people will often be particularly well informed on the basis of experience as to the implications of their illness and treatment.

Crimes (Mental Impairment and Unfitness to be Tried) Act 1997

Limiting Terms

The regime governing those found unfit to be tried or not guilty of offences because of mental illness (“forensic patients”) discriminates as between those people and those convicted of the same offences.

A key feature of this regime is that those with a mental illness are placed under Supervision Orders. These are generally custodial, requiring the person to reside at Thomas Embling, a secure forensic mental health facility, and may be varied to non-custodial supervision orders, then to extended leave and ultimately revoked. Under the C(MIUT) Act, Supervision Orders are of indefinite duration, though a Major Review must take place at the “Nominal Term” – a period equal to 25 years for murder, the maximum period of imprisonment applicable for other serious offences and half the maximum for others (sections 27 and 28). Those under the Act can also apply to work their way through the hierarchy of orders at any time.

The guiding principles for reduction of restrictions are the person’s need for treatment and community safety (sections 39 and 40).

The Act discriminates against “offenders” with mental illness in that it does not impose a finite limit on these orders. People convicted of the same offences have finite sentences, generally much shorter than the Nominal Terms under the Act. The Commonwealth Criminal Code Officers’ Committee developed a Model Mental Impairment Bill⁵ which has been the blueprint for reform to the “Governor’s Pleasure” system in Australian states and territories. It provides for a finite “limiting term”. In South Australia⁶ and the ACT⁷, and New South Wales where a person is unfit to stand trial⁸, there are limiting terms in the comparable regimes.

Given the stigma and restriction experienced by people subject to these orders, this is clearly less favourable treatment for “offenders” with mental illness. Moreover, it could not be said to be reasonably necessary for health or safety. The key justification of the Government for not providing a limiting term was the difficulty of calculating the time required for treatment. This is no justification where there exists a mental health system the focus of which is the provision of treatment, on an involuntary basis where there is any serious risk to the person themselves or the community.

⁵ Criminal Code Officers’ Committee *Model Mental Impairment Bill* 1994

⁶ Criminal Law Consolidation (Mental Impairment) Amendment Act 1995 section 269O

⁷ Criminal Code 1900 section 428C

⁸ Mental Health (Criminal Proceedings) Act 1990 section 23

Victim Notification and Reports

Another significant respect in which forensic patients are treated less favourably than people convicted of the same offences is in terms of victim notification and reports.

Under section 38C of the C(MIUT) Act victims of offences must be notified of any hearing and their reports considered where the Court is reviewing a forensic patient's Supervision Order with the possible consequence of a reduction of the level of supervision or release of the person from the Order, unless the victim has indicated they do not wish to be notified or reasonable efforts to locate them have been fruitless.

People convicted of offences are treated more favourably in that there is no mandatory requirement that victims be notified or their views considered when the Parole Board is considering parole applications. The Parole Board exercises its discretion as to whether to notify victims. We fully recognise the place of victims in the criminal justice system, and it is crucial that their experience be recognised and needs met. However, in many cases processes other than awareness of or involvement in management decisions will be more appropriate. Appropriate counseling is an example.

Victim notification and involvement in hearings will sometimes exacerbate a person's illness. Since the C(MIUT) Act came into operation there have been cases where victim presence has created extreme tension. Forensic patients should not be exposed to a greater risk of distressing or inappropriate involvement of victims, or infringements of their privacy, than ordinary convicted offenders. This different treatment could not be said to be reasonably necessary for health or safety or reasonable generally. It may in fact exacerbate forensic patients' health problems. Community safety is the key consideration at the heart of all decisions about forensic patients and there is no sense in which victim awareness of people's status would increase safety – and in some cases victim awareness may put a forensic patient's safety at risk.

Section 38C should be amended to make victim notification discretionary, with the advice of those treating the person to guide exercise of that discretion.

Residential Tenancies Act 1997

Section 23 of the Residential Tenancies Act discriminates by excluding from coverage under that Act "health or residential services". Relevant to people with mental illness, "health or residential services", as defined in section 3 includes supported residential services ("SRSs") under the Health Services Act 1988 and community care units ("CCUs" – residential services for people receiving services under the Mental Health Act 1986).

CCUs are exclusively occupied by people with mental illness. Every area mental health service includes a CCU. Whilst a small number of residents stay much longer term, the average length of stay is now around 12 – 18 months. A significant number of people with mental illness, along with people with a range of other support needs, reside in SRSs.

In both of these types of services residents pay rent. Apart from the support or treatment they receive, their residential situations are similar to those of tenants who are covered by the Residential Tenancies Act. Their rental situations are closely comparable to those of people in rooming houses, in that they pay rent for exclusive use of their own room and use of some shared facilities. However, exclusion from that Act's coverage means they have no clear mechanism by which they can pursue rooming house rights such as the following, protected under Part 3 of the Residential Tenancies Act:

- that maintenance and repairs are carried out on the rented premises;
- a right to privacy and quiet enjoyment of their room and the rented premises;
- a right to challenge a rent increase;
- a right to formal notice to vacate where a resident is required to move;
- a right to formally challenge an eviction.

People in rooming houses have access to the Residential Tenancies List of VCAT to resolve disputes about such matters. For SRSs, the Health Services Act In Part 4 Division 5 and the Health Services (Supported Residential Services) 2001 articulate a range of resident rights in some detail. However, there is no provision for access to an independent external complaints or dispute resolution mechanism. In the case of CCUs there is no legislative articulation of rights at all and no appropriate complaints mechanism.

In our view it could not be said to be either reasonably necessary for health or safety, or reasonable more generally, for these tenants to be excluded from the protection of the rights applying to rooming houses under the Residential Tenancies Act. It is indeed likely to be conducive to better mental health, if anything, for people to have greater clarity about their rights and how they may be enforced. Many such residents will be vulnerable and marginalised at a number of levels and secure, appropriate accommodation will be crucial to their well-being.

Accordingly, section 23 should be amended to make it clear that the Act does apply to SRSs and CCUs (with whatever modifications may be considered reasonably necessary) – and, indeed to the range of other disability accommodation types currently excluded.

Children, Youth and Families Act 2005

In our experience acting for parents in relation to child protection applications, there is extensive discrimination on the basis of any mental illness parents may have – indeed on the basis of disabilities generally. This generally falls into two broad categories - inaccurate and prejudicial assumptions about lack of parenting ability, or inadequate access to the support services that would augment people's parenting skills. The child protection system discriminates more broadly against people marginalised by a range of factors including poverty and lack of educational opportunity.

With the introduction of the new Act in 2006 we are concerned that intervention by child protection services has increased without concurrent increased provision of support services to parents with disabilities. The new provisions for fast tracking permanent care discriminates against parents with disabilities, who may take 6 months to recover from an episode of illness, by which time they are at risk of having their children permanently removed.

The bulk of this discrimination is not legislatively based, but occurs in the context of practices and exercises of discretion by protective workers. We do, however, wish to highlight one area in particular in which the legislation itself can be said to discriminate.

For example a person interviewing a parent in relation to an application to warn them that the information they give may go into a report. In our view parents with disabilities are significantly disadvantaged in relation to the protection process if they do not have the assistance of an advocate to ensure they understand the implications of these warnings.

There is a model for this in terms of the Independent Third Persons who must be present when people with mental impairments are interviewed by police. Given the potentially weighty consequences of investigation by protective workers, it is just as important that such assistance be available here. It is crucial that people who may be vulnerable and unaware in such processes have such warnings clearly explained, be given a clear sense of where such interventions may lead, and informed of their rights. We recommend that the assistance go beyond what is provided under the ITP program, where the role is not one of advocacy but to ensure the person has understood the police caution and that communication during the interview is clear and appropriate. We believe the assistance should include advocacy from people with experience of the child protection system and working with people with disabilities.

Summary Offences Act 1966/Vagrancy Act 1966

Public drunkenness offences should be abolished. There is increasing awareness of the links between mental illness, homelessness and abuse of substances such as alcohol – again people with mental illness are over-represented and inappropriately penalised for what is largely a manifestation of an illness and inadequate support. In this context, we hope that priority is given to the establishment of alcohol treatment facilities so that such offences can be abolished.

Juries Act 2000

The ineligibility for jury duty of “patients” within the meaning of the Mental Health Act is a particularly blatantly discriminatory legislative provision.

Schedule 2 of that Act provides that the following people, amongst others, are ineligible for jury service:

- (a) A person who has a physical disability that renders them incapable of performing the duties of jury service
- (b) A patient within the meaning of the Mental Health Act 1986
- (c) A person who has an intellectual disability within the meaning of the Intellectually Disabled Persons Services Act 1986
- (d) A person who is a represented person within the meaning of the Guardianship and Administration Act 1986
- (e) A person who is subject to a Supervision Order under the Crimes (Mental Impairment and Unfitness to be Tried) Act 1997.

The term “patient” includes people who are on involuntary treatment orders, forensic patients (subject to a Supervision Order under the Crimes (Mental Impairment and Unfitness to be Tried)

Act 1997) and security patients (people who have been found guilty of offences but are serving part of their sentence in hospital).

What is most objectionably discriminatory about this provision is that it assumes that all involuntary patients will not have capacity to perform jury service. This is extremely misguided. Mental illness often manifests in a way that would not in the least impact on a person's capacity in this regard. Indeed, it is when a person is an involuntary patient and receiving treatment that they may be at their most "well". It may be that some involuntary inpatients cannot perform jury service for the practical reason that they cannot get adequate leave from the service – but, equally, some people will be able to get such leave. And people subject to community treatment orders are subject to no such practical limitation. The only restriction on them is that they receive treatment from a community mental health service, and, in a very few cases, reside at a particular address.

What is required is a provision more like (a) – that a person with any disability or condition that renders them incapable of performing jury duty is ineligible. Mental health professionals are well qualified to provide such opinions. Such a formulation would obviate the need for exclusions (a) – (d) – both (c) and (d) are similarly discriminatory in that they assume all people of a particular status will be incapacitated in the relevant sense. A represented person under the Guardianship and Administration Act, for example, may have a very specifically limited incapacity which does not impede ability to be a juror.

It is ironic that the objective of the rewrite of the Juries Act 1967 which produced the current regime was to increase the representativeness of juries and narrow the categories of ineligibility⁹. The Law Reform Committee in fact recommended what we are advocating – a general category of those with a physical, intellectual or mental disability creating incapacity to effectively perform the functions of a juror.

In terms of security patients and people subject to Supervision Orders, it may be that the exclusion is based not on assumptions about capacity but the fact that they are on criminal justice system orders having been charged with offences, in the same way people with particular criminal histories are ineligible. This may possibly be a more legitimate basis for ineligibility.

Sentencing Act 1991

There are many ways in which the Sentencing Act could be said to discriminate against a range of people protected by the Equal Opportunity Act by not providing for dispositions which

⁹ Law Reform Committee Parliament of Victoria *Jury Service in Victoria Final Report Volume 1* 1996.

adequately recognise the relevance of their attributes to offending and impact of a sentence. We give two examples particularly relevant to our client group which are in no way exhaustive.

One example is the need for a non-custodial disposition option tailored specifically for people with mental illness. The Act provides for a specialised non-custodial disposition for people with intellectual disability – Justice Plans under Division 6 of Part 3. We do not suggest a specialised mental illness order should be necessarily modelled on these, but there is a great need to introduce tailored sentencing options to reduce the number of people with mental illness in prison. There is increasing awareness of the large numbers of such people in prison and the inadequacy of prison resources for that population. As it stands the only mental health specific sentencing orders for people found guilty are custodial.

The second example is the need for Magistrates and Judges to have discretion to dismiss charges without a finding of guilt in appropriate cases. In many situations offending behaviour is entirely the product of an illness which is quickly brought under effective treatment and any lengthy involvement in the court system - including that required for a finding of not guilty due to mental impairment – is inappropriate. Magistrates themselves have expressed the view that they should have this power and not be reliant on police to withdraw charges in relevant cases. We are aware that such power exists in relation to summary offences under the Commonwealth Crimes Act 1914 (section 20BQ). It is a particularly compelling need for reform given its relevance to people with needs for accommodation beyond mental illness.

Wrongs Act 1958

Changes made in 2003 limiting access to damages in civil actions for non-economic loss may discriminate against people with psychiatric disability. Under section 28LB the threshold for non-psychiatric injury is an impairment level of more than 5%, and for psychiatric injury it is a level of more than 10%.

At the time these changes were made there were conflicting views expressed in public debate as to whether this in fact amounts to discrimination. Psychiatrists with experience of using the relevant impairment tables expressed the view publicly that it was discriminatory, then one of them retracted that view the next day. Government representatives argued it was accepted that a psychiatric impairment of 10% in fact equated with a non-psychiatric impairment of 5%. Personal injuries lawyers we spoke to expressed the view that the levels are not equivalent.

We understand that it may be that there is a similar discrepancy in relation to certain compensation entitlements under either the Accident Compensation Act 1985 or the Transport Accident Act 1986. It may well be that that provision is discriminatory also.

Health Services (Conciliation and Review) Act 1987

We are very concerned about the interaction between section 31 of this Act and the Equal Opportunity Act 1995. Section 31 is not discriminatory in the same way as the provisions we have identified above. However, it is of relevance to this review in that it exempts the Health Services Commissioner and officers from the provisions of the Equal Opportunity Act. This is in our view an inappropriate and unacceptable exemption.

Section 31 confers on the Health Services Commissioner the same immunity from suit that applies under section 21A of the Evidence Act to boards appointed or commissions issued by the Governor in Council. That immunity is the same one applying at common law to the judiciary.

It was determined in the case of Taylor v HSC (2000 VCAT) that this means the Health Services Commissioner cannot be liable under the Equal Opportunity Act. Taylor was in fact a case where a complainant with a mental illness alleged she had been discriminated against because of that disability in the way her complaint to the Health Services Commissioner was handled. We have considerable experience assisting people make complaints to the Commissioner and believe discrimination has occurred in relation to some of our clients. That discrimination takes the form of a less rigorous, rights based approach to complaints resolution for people with mental illness than seems to take place for other health service users. It is a widely held view and experience amongst people with mental illness that their rights around complaints and grievance processes generally are not treated as seriously as those of people with no such illness. Whilst this is usually a matter not so much of legislative provision as exercise of discretion, unreasonable immunities from suit, and particularly from discrimination law regimes, are particularly concerning in this context.

This immunity came to our attention when a complainant to the Commissioner filed a complaint with the assistance of the Equal Opportunity Commission about, amongst other things, a decision by the Health Services Commissioner that they would in future not accept any complaints from this person that related to matters arising more than 12 months from the date of complaint. This was in a context where the Commissioner rarely exercises the discretion to decline complaints more than 12 months old, accompanied by advice to “let go” of his concerns about past medical treatment and with reference to a psychiatric report in relation to this complainant.

We understand that the concept of judicial immunity is well established, but we can see no justification for a body such as the Health Services Commissioner to be immune from action under the Equal Opportunity Act. The Health Commissioner’s role is vastly different from that

of courts, or, indeed, many Governor established boards and commissions. The Health Services Commissioner has no power to make binding determinations. Not all of the powers conferred on boards and commissions under Division 5 of the Evidence Act reside in the Health Services Commissioner. There are no appeal rights from decisions of the Health Services Commissioner – there is not even access to VCAT for determination of complaints not satisfactorily resolved through the Health Services Commissioner’s processes, except in the case of complaints under the Health Records Act 2001.

Indeed, it is timely to consider the legitimacy of such immunity in relation to a range of bodies – especially when it comes to such crucial principles as freedom from discrimination. Insurance policies mean that individuals performing important and complex roles need not be unduly distracted from their task by fear of litigation in a range of other contexts. There is no reason why those such as the Health Services Commissioner and their staff cannot be adequately protected in this way.

We do not believe that a mechanism to prescribe certain Acts under the Equal Opportunity Act necessary.

We do not believe that a three year sunset period for the repeal of the statutory authority exception is appropriate.

The Victoria *Charter of Rights and Responsibilities* has been in operation for 12 months ample time for statutory authorities to comply with its provisions. *Charter* section 8, that everyone has a right to human rights without discrimination is now in operation, a sunset period would be in contravention of this provision. Section 7 of the *Charter* allows for limitations, we recommend that any exception be subject to this test.