



# EQUALITY, CAPACITY AND DISABILITY

Joint submission to the Australian Law Reform Commission (ALRC) – Issues Paper 44 *Equality, Capacity and Disability in Commonwealth Laws*

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## INTRODUCTION

The National Mental Health Consumer and Carer Forum (NMHCCF) is the combined national voice for consumers and carers participating in the development of mental health policy and sector development in Australia. Through its membership, the NMHCCF gives mental health consumers and carers the opportunity to meet, form partnerships and be involved in the development and implementation of mental health reform.

The MHCA is the peak, national non-government organisation representing and promoting the interests of the Australian mental health sector, committed to achieving better mental health for all Australians. As an independent peak body with no service delivery role, the MHCA seeks to ensure that the needs of people with experience of mental illness and their carers are met to the maximum extent possible.

Thank you for the opportunity to respond to the ALRC Issues Paper 44, *Equality, Capacity and Disability in Commonwealth Laws*. We have focused on seven questions listed in the Issues Paper, as outlined below.

## RESPONSES TO QUESTIONS

### QUESTION: 1

Australia has an Interpretative Declaration in relation to Article 12 of the *United Nations Convention on the Rights of Persons with Disabilities*. What impact does this have in Australia on:

- (a) provision for supported or substitute decision-making arrangements; and
- (b) the recognition of people with disability before the law and their ability to exercise legal capacity.

The MHCA and the NMHCCF believe it is a fundamental human right for all persons to be assumed to have the capacity to make decisions and that they must be given full support in their decision-making, as required.

We are concerned about the traditional lack of focus on supported decision-making and current reliance on the use of substituted decision-making in the disability and mental health sectors in Australia.

This particularly disadvantages people with a mental illness and psychosocial disability, who are amongst the most vulnerable in our community and may not have effective decision-making supports that other members of the community have. People with a psychosocial disability often have difficulty with conceptual understanding, communicating, and interacting with people outside their home and face challenges resulting from being socially isolated and without supportive networks.

We contend that Australia's Interpretative Declaration in relation to Article 12 of the *United Nations Convention on the Rights of Persons with Disabilities* (CRPD) not only puts those with a disability at a disadvantage but is in breach of their human rights.

The ALRC Issues Paper paragraph numbers 23 to 26, relating to Australia's Interpretive Declaration, draws attention to the concluding observations of the Committee on the Rights of Persons with Disabilities. Australia is not fulfilling its obligation under Article 12 whilst this Interpretation remains in place and we submit that Australia rescind the said Interpretive Declaration to accord full legal force to Article 12 of the Convention.

The MHCA and the NMHCCF recommend that Australia:

- withdraw its Interpretive Declaration in relation to Article 12
- develop a nationally consistent supported decision-making framework for the mental health and disability sectors. This framework would comply with article 12 of the CRPD, outlining various support options that give primacy to a person's will and preferences and respect their human rights
- provide training to relevant parties on the recognition of the legal capacity of persons with disabilities and on the primacy of supported decision-making mechanisms in the exercise of legal capacity.<sup>1</sup> This training would require genuine consultation and collaboration with persons with disabilities, their support persons/carers and their representative organisations.

## FRAMING PRINCIPLES

### QUESTION: 3

The ALRC has identified as framing principles: dignity; equality; autonomy; inclusion and participation; and accountability. Are there other key principles that should inform the ALRC's work in this area?

The MHCA and the NMHCCF support these framing principles and believe that they fit well with the preamble of the UN Convention on the Rights of Persons with Disabilities (CRPD):

*Disability results from the interaction between persons with impairments and attitudinal and environmental barriers that hinders their full and effective participation in society on an equal basis with others.*<sup>2</sup>

Further we believe the framing principles should serve to enhance the lives of persons with disabilities as stated in Article 1 of the CRPD.<sup>3</sup>

*Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.*

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<sup>1</sup> Office of the High Commissioner for Human Rights, 10<sup>th</sup> Session of the Committee on the Rights of Persons with Disabilities (12 November 2013).

<sup>2</sup> UN Convention on the Rights of Persons with Disabilities, opened for signature 30 March 2007, 999 UNTS 3 (entered into force 3 May 2008) Preamble.

<sup>3</sup> UN General Assembly, Convention on the Rights of Persons with Disabilities, 13 December 2006, A/RES/61/106, Annex I

## A UNIFORM APPROACH TO LEGAL CAPACITY?

### QUESTION: 4

Should there be a Commonwealth or nationally consistent approach to defining capacity and assessing a person's ability to exercise their legal capacity? If so, what is the most appropriate mechanism and what are the key elements?

The MHCA and the NMHCCF support a nationally consistent approach to capacity and would like to reiterate that it is a fundamental human right for all persons to be assumed to have capacity to make decisions. Further, we recommend that the ALRC be mindful of the cited draft general comment on Article 12 and in particular their comment 21 (reproduced below).

*In order to fully recognize “universal legal capacity”, whereby all persons (regardless of disability or decision-making skills) inherently possess legal capacity, States must abolish denials of legal capacity that are discriminatory on the basis of disability in purpose or effect.<sup>4</sup> Systems that deny legal capacity based on status violate article 12 because they are prima facie discriminatory, as they permit the imposition of substitute decision-making solely on the basis of the person having a particular diagnosis. Similarly, functional tests of mental capacity or outcome-based approaches that lead to denial of legal capacity violate article 12 if they are discriminatory or if they disproportionately affect the right of persons with disabilities to equality before the law.*

We also draw reference to the 2012 Law Council of Australia's<sup>5</sup> recommendation that a nationally consistent approach to the assessment of capacity in the context of substitute decision-making is highly desirable in order to promote greater clarity. Ultimately a nationally consistent approach would provide protection and more effectively foster individual autonomy, as circumstances require. We note that agreement to this recommendation was also cited in the Mental Health Coordinating Council's submission to the ALRC's current inquiry.<sup>6</sup>

However, we believe that in defining a nationally consistent approach to capacity, the context should be aligned with the recommendations of the Committee<sup>1</sup>, i.e. that a nationally consistent approach to the assessment of capacity should apply to and focus on supported decision-making.

## THE ROLE OF FAMILY, CARERS AND SUPPORTERS

### QUESTION: 5

How should the role of family members, carers and others in supporting people with disability to exercise legal capacity be recognised by Commonwealth laws and legal frameworks?

The MHCA and the NMHCCF have a strong interest in ensuring that family, carers and others supporting those with a mental illness or psychosocial disability are included in their care, where

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<sup>4</sup> See Convention on the Rights of Persons with Disabilities, art. 2, in conjunction with art. 5.

<sup>5</sup> The Law Council Australia, 2012, Submission 056, 'Inquiry into Dementia: Early Diagnosis and Intervention', Item 21.

<sup>6</sup> Mental Health Coordinating Council (MHCC), Submission: Australian Law Reform Commission – Issues paper 44 Equality, Capacity and Disability in Commonwealth Laws.

this is appropriate and desired, and that family, carers and supporters be provided with the assistance that allows for this.

Advanced Care Directives (ACD) are used by persons, when they have capacity, to provide health care directives, in the event that they may no longer have capacity. They are helpful instruments for family members, carers and others that allow them to be supportive of the consumers they care for, and advocate for their agreed treatment or care. This form (or similar) can be developed together to assist consumers to exercise their legal capacity during times of distress or when they no longer have capacity.

Over the last few years a number of states and territories have committed to developing uniformity of ACD, and in giving legal standing to them, or similar instruments, and also promoting their use by the public. We believe that the uniform acceptance by the health and legal sectors would enable people with mental illness and psychosocial disability to direct courses of treatment or care if they become unwell. We urge the Commonwealth, and the states and territories, to continue this, and make the necessary legislative changes to give appropriate legal standing to ACD in all settings and in all states and territories.

The MHCA and the NMHCCF recommend the development and implementation of:

- nationally consistent legislation governing the scope and implementation of advanced care directives and plans
- national guidelines to promote good practice in advance care planning. These guidelines should specify the key elements in working through this process with consumers and their carers, where appropriate and always with the consumer's consent
- education and training for primary and specialist health care providers about strategies to engage in advance care planning
- a nationally harmonised system for recording advance care directives and plans, based on best practice evidence from similar programs internationally.

## HEALTH CARE AND AGED CARE

### QUESTION: 34

What issues arise in relation to health care that may affect the equal recognition before the law of people with disability and their ability to exercise legal capacity? What changes, if any, should be made to Commonwealth laws and legal frameworks relating to health care to address these issues?

The MHCA and the NMHCCF have focused on the health care aspects referred to in the ALRC Issues Paper at paragraph numbers 240 and 241.

We support the Commonwealth developing a legal framework for assessing capacity relating to health care, as we do for legal capacity in our response to Questions 4 and 5.

Further we strongly believe that there is an urgent need for the Commonwealth, states and territories to develop a national framework for mental health legislation allowing for consistency across all states and territories, as referred to in the first National Mental Health Plan.<sup>7</sup>

Currently, the inconsistencies of state and territory Mental Health Acts disadvantage people with mental illness and psychosocial disability, resulting in unnecessary hardship. For example, transference and reinstatement from one state to another hinders their full and effective participation in society on an equal basis with others.

We also encourage the ALRC to review the current legislation in the UK<sup>8</sup> and other recent legislation from other EU jurisdictions, as it relates to mental health and capacity law, and in particular those that have been enacted after they have signed the CRPD.

## RESTRICTIVE PRACTICES

### QUESTION: 36

In what ways, if any, should the proposed National Framework for Reducing the Use of Restrictive Practices in the Disability Service Sector be improved?

The MHCA and the NMHCCF welcomed the development of the *National Framework for Reducing the Use of Restrictive Practices in the Disability Service Sector* and hope that the experiences of the mental health sector and their focus on reducing the use of restrictive practices will provide valuable insight in how to instigate change in the disability sector. We also support the recommendations in the *United Nations Convention on the Rights of Persons with Disabilities* to reduce restrictive practices in mental health and disability services.

The MHCA and NMHCCF recommended in their submission on the proposed *National Framework for Reducing the Use of Restrictive Practices in the Disability Service Sector* (July 2013) the following definitional changes and additions to the draft framework section, as follows:

1. With regard to the definition of chemical restraint provided by the Framework:

*'A chemical restraint means the use of medication or chemical substance for the sole and temporary purpose of influencing a person's behaviour. It does not include the use of medication prescribed by a medical practitioner for the treatment of, or to enable the treatment, of a diagnosed mental illness, a physical illness or physical condition.'*<sup>9</sup>

We note that the definition of 'chemical restraint' does not include the use of medication prescribed by a medical practitioner for the treatment of or to enable treatment of a diagnosed mental illness. However it is the experience of mental health consumers and carers that medication used for treatment is often also administered to control behaviour.<sup>10</sup> That is, a medication can be administered for difference purposes at different times for the

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<sup>7</sup> Australian Government (1992) *National Mental Health Plan*, accessed from the Department of Health website on 31 January 2014: <https://www.health.gov.au/internet/main/publishing.nsf/Content/mental-pubs-n-plan92>

<sup>8</sup> *Mental Health Capacity Act 2005*, United Kingdom, <http://www.legislation.gov.uk/ukpga/2005/9/introduction>

<sup>9</sup> Department of Families, Community Services, Housing and Indigenous Affairs. (2013) *Proposed National Framework for Reducing the Use of Restrictive Practices in the Disability Service Sector*. Consultation Version – May 2013.

<sup>10</sup> NMHCCF. (2009) *Ending Seclusion and Restraint in Australian Mental Health Services*. NMHCCF, Canberra (available at [www.nmhccf.org.au](http://www.nmhccf.org.au))

same person. Examples include the transportation of individuals into acute mental health services and in the aged care sector to minimise unsupervised wandering and prevent falls. The framework needs to acknowledge the complexities inherent in how medications are currently used.

2. A definition of 'emotional restraint' should be added:

*'emotional restraint occurs when the individual consumer is conditioned to such an extent that there is a loss of confidence in being able to express their views openly and honestly to staff for fear of the consequences. Emotional restraint can also be coercive and threatening in nature, for example being threatened with seclusion or restraint'.<sup>11</sup>*

Emotional restraint as a practice is often an intrinsic part of workplace cultural practice and can only be addressed as such. This must also be acknowledged by the Framework as an area for priority action.

3. The definition of 'other restrictive interventions' is unclear in the framework. Definitions need to be provided for "psychosocial" and "environmental" restraints and "consequence driven practices"

## QUESTION: 37

What is the most appropriate approach to the regulation, reduction and elimination of restrictive practices used on people with disability at a national or nationally consistent level? What are the key elements any such approach should include?

The MHCA and the NMHCCF recommend that nationally consistent legislation governing restrictive practices, of which seclusion and restraint are included, be developed and adopted across all states and territories. This legislation should include standardised terminology and definitions and set clear and effective practice standards.

We also endorse the National Mental Health Commission's (the Commission) recommendation to target the reduction of 'the use of involuntary practices and work to eliminate seclusion and restraint'. In order to carry out this recommendation, the Commission has called for all states and territories to contribute to a national data collection to provide comparison across states and territories, with public reporting on all involuntary treatments, seclusions and restraints each year from 2013.<sup>12</sup>

In 2009 the NMHCCF released the position statement, *Ending Seclusion and Restraint in Australian Mental Health Services*.<sup>13</sup> This statement highlights that a key element in the reduction and elimination of seclusion and restraint is the provision of support to assist mental health

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<sup>11</sup> Ibid.

<sup>12</sup> National Mental Health Commission, 2013: A Contributing Life, the 2013 National Report Card on Mental Health and Suicide Prevention. Sydney: NMHC

<sup>13</sup> NMHCCF. (2009) *Ending Seclusion and Restraint in Australian Mental Health Services*. NMHCCF, Canberra (available at [www.nmhccf.org.au](http://www.nmhccf.org.au))

professionals implement cultural and clinical practice change. The NMHCCF position statement also recommends a range of changes to state and territory legislation.

The NMHCCF contend that seclusion and restraint:

- are currently used at unacceptably high levels in mental health services
- are avoidable and preventable practices
- highlight a failure in care and treatment when they are used
- are commonly associated with human rights abuse
- are not an evidence-based therapeutic intervention
- are a cause of short and long term emotional damage to consumers and/or their family/carer
- are an inhibitor of developing trust and respect between consumers, carers and clinical staff.<sup>14</sup>

The NMHCCF has identified the following six key strategies to end seclusion and restraint in Australian mental health services:

1. Better accountability
2. Implementation of evidence based approaches to ending seclusion and restraint
3. Adherence to standards and public reporting
4. Support for mental health professionals towards cultural and clinical practice change
5. Better care planning
6. Review relevant mental health legislation

The MHCA and the NMHCCF support, and encourage the ALRC to consider, the recent work undertaken in this area, including the National Mental Health Seclusion and Restraint Project (2007-2009) and the Commission's National Seclusion and Restraint Project.<sup>15</sup>

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<sup>14</sup> NMHCCF (2012) Advocacy Brief - Seclusion and Restraint in Mental Health Services. NMHCCF, Canberra (available at [www.nmhccf.org.au](http://www.nmhccf.org.au))

<sup>15</sup> Information about the Commission's National Seclusion and Restraint Project is available at: <http://www.mentalhealthcommission.gov.au/our-work/national-seclusion-and-restraint-project.aspx>