



OFFICE OF THE
PUBLIC ADVOCATE

Submission to the Review of the *Health Act (1958)*
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Summary

The focus of this submission is the issues raised in two subsections of the discussion paper *Review of the Health Act 1958* (Department of Human Services, 2004): These are:

- sub-section 8.4. *Incident Involving care giver* (p. 66) and
- sub-section 8.5. Public health orders and the management of infected persons (pp. 66-70).

Introduction

This submission from the Public Advocate in Victoria to the *Review of the Health Act 1958* (Department of Human Services Public Health, 2004) will discuss proposals in the discussion paper as they affect people with cognitive disabilities. The topics to be discussed are:

1. The key theme of the discussion paper (p. iii)
2. Addressing health inequalities (p. 11);
3. Sub-section 8.4. *Incident Involving care giver* (p. 66);
4. Sub-section 8.5. *Public health orders and the management of infected persons* (pp. 66-70).

About the Public Advocate

The Public Advocate in Victoria is appointed by the Governor in Council pursuant to the *Guardianship and Administration Act 1986* (Vic). The Office of the Public Advocate (OPA) represents the interests of people with a disability, aiming to promote their rights and dignity and to strengthen their position in society. It is a statutory office, independent of government and government services, and can highlight situations in which people with disabilities are exploited, neglected or abused. Further material on the role of the Office can be provided if required by consulting OPA's website: www.publicadvocate.vic.gov.au.

1. The key theme of the discussion paper (p. iii)

It is noted that the discussion paper acknowledges that: *Many of the proposals challenge a range of ... social values, particularly the right to individual autonomy. We need to address these issues and decide, as a society, the appropriate balance between individual rights and community good* (p. iii).

As a general principle the Public Advocate believes that people with disabilities must accept the same responsibility to their fellow citizens for maintaining public health as other members of the community **to the extent that they are able to do so**. At the same time, the Public Advocate believes that it is particularly important that the rights of people with cognitive disabilities, who may not be able to give consent to treatment or medical tests and/or to change behaviour that may pose a risk to others, are upheld and protected. The need to protect the community need not be at the expense of the rights of people who because of their cognitive disability are vulnerable and at greater risk of having their rights abused or neglected than other people in the community. The comments on subsections 8.4 and 8.5 below make clear, the appropriate balance between individual rights and community good, would not be achieved with some of the current proposals regarding enforced testing and detention in relation to people with cognitive disabilities in their present form. More effective ways of working with people with cognitive disabilities are available which protect the rights of people with disabilities and the general community.

2. Addressing health inequalities (p. 11)

The discussion paper acknowledges that *'People with a disability have poorer health outcomes than other members of the community [and that] prisoners suffer higher rates of infectious diseases, ... mental illness and life trauma than the general population.*

The particular disadvantages faced by people with disabilities in accessing adequate healthcare appropriate to their needs is certainly of concern to OPA and the *Health Act* should recognise the need to address inequalities in the health and well being of people with disabilities. One way of achieving this is through a recognition of the inability of some people with cognitive disabilities to meet public health requirements. Consequently a punitive approach to managing public health risks is not always appropriate in their case.

OPA's experience is that people with cognitive disabilities are both over-represented and extremely disadvantaged in the prison system (Office of the Public Advocate, 2003) and that a proactive and co-ordinated approach to addressing their particular health needs is required. This approach needs to be non-punitive, seeking to benefit the individual as much as it seeks to protect the health and safety of the general community. Such an approach does not seem to be evident in the proposals put forward in sub-sections 8.4 and 8.5 of the discussion paper, where containment of risk rather than beneficial treatment of infected persons appears to be paramount.

3. Sub-section 8.4. *Incident Involving care giver* (p. 66);

Where someone refuses consent to testing and the person has a cognitive disability then it must be recognised that the person concerned may also lack the capacity to consent rather than be choosing not to comply with a request to be tested..

The common law recognises a person's right to personal autonomy. The taking of a blood sample without the consent of the person is, on the face of it, a breach of that person's autonomy and an assault. However, the common law right has been modified by section 120A of the Health Act.

The United Nations Declaration on the Rights of Disabled Persons (1975) states:

Disabled persons have the same civil and political rights as other human beings: paragraph 7 of the Declaration on the Rights of Mentally Retarded Persons applies to any possible limitation or suppression of those rights for mentally disabled persons.

Paragraph 7 of the Declaration on the Rights of Mentally Retarded Persons states:

Whenever mentally retarded persons are unable, because of the severity of their handicap, to exercise all their rights in a meaningful way or it should become necessary to restrict or deny some or all of these rights, the procedure used for that restriction or denial of rights must contain proper legal safeguards against every form of abuse. This procedure must be based on an evaluation of the social capability of the mentally retarded person by qualified experts and must be subject to periodic review and to the rights of appeal to higher authorities.

These Declarations raise the issue whether the removal of the right to personal autonomy enshrined in the common law is a breach of the human rights of people who have a disability. If so, does the Health Act provide the protections set out in these Declarations?

Whilst section 120A removes the rights of people who have a disability, it also removes the same right for people who do not have a disability. A person who is competent is asked to consent to the test, but if that person refuses the Secretary can order that their blood be tested. There is a penalty for refusing. Accordingly it is submitted that there is no real right to refuse, and that really section 120A enacts a courtesy to people to accede to testing without an order being made.

Therefore it is submitted that people who cannot give informed consent are not being treated less favourably than people who are able to give informed consent through a provision such as s120A. It is submitted that there is no breach of the Equal Opportunity Act or Disability Discrimination Act by virtue of this provision.

The Public Advocate is concerned that the proposals for the provision of information and counselling to facilitate a person to make an informed decision to consent to the test ensure that people who have an impairment receive that information in accessible formats and that the counselling has regard to the person's disability.

There may be a suggestion that where a person is unable to consent to a test that the person responsible for them (as set out in Part 4A of the *Guardianship and Administration Act 1986*) could consent on the person's behalf. A person responsible is required to act in the best interests of the person for whom they are responsible. Section 38 sets out various matters to be considered by the person responsible when consenting to treatment:

- (a) the wishes of the patient, so far as they can be ascertained; and
- (b) the wishes of any nearest relative or any other family members of the patient; and
- (c) the consequences to the patient if the treatment is not carried out; and
- (d) any alternative treatment available; and
- (e) the nature and degree of any significant risks associated with the treatment or any alternative treatment; and
- (f) whether the treatment to be carried out is only to promote and maintain the health and well-being of the patient; and
- (g) any other matters prescribed by the regulations.

None of these matters relates to consenting to a procedure to benefit a third party. Whilst consenting to a procedure to benefit a third party is not contrary to the best interests of a person, it is submitted that it is not contemplated by the legislated terms in the *Guardianship and Administration Act* and persons responsible may be reticent about exercising authority in relation to such a request.

4. Sub-section 8.5. Public health orders and the management of infected persons (pp. 66-70).

Information or education provided to people subject to the *Health Act* must be targeted appropriately for people with cognitive disabilities and there be recognition of the role for an advocate/case worker to assist with the process. Others, such as public health workers/contact tracers and HIV advocacy groups should also be involved in the education/information process.

8.5.3. Orders for Counselling.

The object of counselling is to achieve appropriate and responsible behavioural change. It is submitted that the Act be more explicit about what is meant by 'appropriate and responsible behaviour' as this expression is too amorphous and difficult for people who have a cognitive disability to comprehend. .

A number of issues in relation to people with disabilities and counselling need to be addressed:

- Any counselling needs to be appropriate to the needs of the person with a cognitive disability and where appropriate HIV advocacy groups should be involved with the person.

- It should be recognised that there will be a group of people who, due to their cognitive disability, cannot change their behaviour.

It is unclear why there is reference to the *Mental Health Act 1986*. The provisions in the *Mental Health Act (1986)* relating to involuntary psychiatric treatments can only be invoked if treatment is possible. Treatment is defined as things done in the course of the exercise of professional skills to—

- (a) remedy the mental disorder; or
- (b) lessen its ill effects or the pain and suffering which it causes.

Where the treatment is not to benefit the patient but for the benefit of others it is inappropriate to use the *Mental Health Act 1986* to achieve this.

8.5.4. *Orders for restriction, (treatment) isolation and detention*

OPA supports the proposition that the Act contains an explicit list of restrictions which may be imposed by order of the Secretary.

The Public Advocate does not consider that it is appropriate to appoint a guardian to detain a person who has a cognitive disability where that person is unable to understand their situation that they have an infectious disease and that their behaviour may be a risk to others. The use of guardianship to detain a person where such detention is not for the benefit of the person but to protect the public is contrary to the provisions of the *Guardianship and Administration Act 1986* under which a guardian is required to act in the best interests of the represented person. Whilst guardianship is not appropriate, the Public Advocate considers that if a person who has a disability is to be detained, restricted, treated or isolated, the proper processes for protection of their human rights must be incorporated in the legislation. Reference was made above to the requirements of the United Nations Declarations in relation to the removal or restriction of rights and it is submitted that this must be adhered to in relation to such orders under the *Health Act*.

Subject to the caveat set out in the previous paragraph, the Public Advocate supports provisions which could order that a person undergo therapeutic treatment notwithstanding their refusal. This may also require the “reasonable use of force”. In both these circumstances, we would support confirmation by a court or tribunal before treatment proceeds. It should be necessary to demonstrate that the treatment is in the best interests of the person as well as protecting public health.

We note that the current provisions of the *Health Act* do not allow for the return of a person who absconds from a facility where they have been directed to remain by the Secretary. (see Issue 92). In the case of a person with a cognitive disability who meets the criteria under the *Guardianship and Administration Act 1986*, it would be possible to enforce detention under s26 of that Act. However, in such cases OPA considers that it is more appropriate to give health services these powers rather than to use guardianship legislation as the detention is not necessarily in the best interests of the represented person.

The suggestion that VCAT’s Guardianship List review of decisions made to restrict, treat, isolate or detain a person is understandable as that List has experience of civil restrictions through guardianship and administration. However, there is a significant difference between the restriction of liberty on grounds of a person’s best interests and the best interests of the community. It is submitted that a preferred option would be to establish a new List within the

Human Rights Division of VCAT to deal with such matters. As it is not anticipated that the List would sit often, its administration could be shared with that of the Guardianship List.

8.5.6 Offences

The use of offence provisions to exhort compliance with the law is a legitimate tool. However, the Public Advocate fears that the provision could be used where a person lacks capacity to make informed decisions. The Public Advocate recommends that a defence be incorporated into the Act where a person is unable to understand or adhere to orders by reason of their disability.

8.5.7. Appeals and review

OPA considers that a workable, responsive and accessible appeals process will be essential if the new Act is to be successful. We understand that there have been very few requests for the Secretary to review an order under the current legislation. Is this because those affected do not know that this is possible? An appeal to the Supreme Court may be perceived by persons to be a costly, time-consuming and therefore possibly ineffective means of providing an avenue of appeal for those under a *Health Act* order. The Public Advocate agrees with the proposal in the discussion paper that VCAT would be an appropriate forum for review and appeal in its Human Rights Division. As noted above, it is preferred that a new List be created to deal with such cases.

The Department of Human Services Disability Services Division and the Intellectual Disability Review Panel have developed a protocol pertaining to hearings of matters relating to the residents of the Statewide Forensic Service's (SFS) Intensive Residential Treatment Program (IRTP), which documents procedures for appeal and reviews of admissions to this program (June 2004). The SFS is a secure facility for people with intellectual disabilities involved with the criminal justice system who exhibit a range of dangerous and anti social behaviours. The procedures set out in the protocol were suggested by OPA to overcome the current deficiencies in the law and practice which in effect allow civil detention to occur unlawfully. It is proposed that this will be remedied in new disability services legislation proposed for Autumn 2005. It would be appropriate to consult the procedures when developing appropriate independent and accessible appeals and review mechanisms under the *Health Act*.

Conclusion

It is difficult to weigh up the competing rights of those who need protection and the rights of those who are unable to make informed decisions or give effect to those decisions because of their disability. The Public Advocate considers that the *Health Act* should cover the field in relation to such decisions and that it is not appropriate to use guardianship to make such decisions. However, there must be appropriate measures in place

- to protect people who have a disability from abuse;
- to review and appeal decisions, and
- to ensure that orders are the least restrictive means to achieve the outcome required by the legislation and that such orders are used as the last resort.

References

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