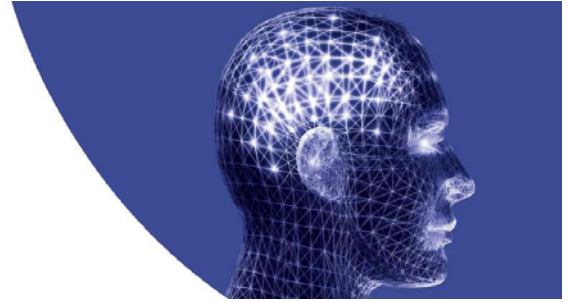


Rethinking

Mental Health Laws



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Anniversary
Public Lecture**

***Opening minds not locking
doors***

***Professor Bernadette McSherry
Federation Fellow, Faculty of Law***

9th October 2008



MONASH University
Law

Educate 08 Public Lecture

Opening Minds, Not Closing Doors: Rethinking Mental Health Laws

*Professor Bernadette McSherry
Australian Research Council Federation Fellow*

Introduction

Scott Jeffrey Schutzman was born in Brooklyn New York on the 13th January 1956.¹ His father, Howard Schutzman was a musician who had met Jeanne Stevens, Scott's mother, at a show in Fort Dix, New Jersey where he performed under the name Buddy Howard, the Silver Trumpeteer.

When Scott was six months old, Howard and Jeanne moved to Miami where another son, Brad was born. Howard and Jeanne divorced when Scott was 9 and, four years later, Jeanne remarried and moved to Toronto with her sons to live with her Canadian husband.²

Scott showed an early aptitude for science and mathematics and skipped grades 2, 8 and 13. He graduated from Ryerson Polytechnical Institute in 1976 with a degree in electrical engineering and found a job in the Toronto offices of an American engineering firm. When he was 23, he met Betsy Palmer and they eventually moved in together.

Scott was described by various friends as being obsessed by his appearance, eccentric, needing little sleep and having an incredibly quick mind. He worked at the engineering firm for three years and because his technical and sales skills were valued highly, when his hyperactivity veered into shouting or inexplicable laughter, his employers gave him leeway...for a while.

From his late 20s onwards, Scott found himself in and out of mental health institutions in Canada and the United States. His first admission to the Queen Street Mental Health Centre in Toronto took place after he had been found huddling under a boardroom table. Subsequently, he lost his job, his expensive apartment and his girlfriend, Betsy.

¹ Scott's story is gleaned from the following sources: Tracey Tyler, 'Fight for a Mind: Manic "Genius" Demands Right to Settle Own Fate', *Toronto Star*, 16 December 2001; *Starson v Swayze*, Ontario Supreme Court, Molloy J, 26 November 1999; *Starson v Swayze and Posner*, Court of Appeal for Ontario, Carthy, Laskin and Goudge JJA, 14 June 2001; *Starson v Swayze* [2003] 1 SCR 722; Justine O'Neill and Doug Fischer, 'Fighting for the Right to Refuse Treatment', *The Ottawa Citizen*, 11 June 2005; *Scott Starson*, Ontario Review Board Reasons for Disposition, 22 October 2007, ORB File No 2852. My thanks to Justice Richard Schneider and counsel to the Ontario Review Board, Joe Wright, for their assistance in providing legal documentation.

² Jeanne's second husband has since died.

Some time after he was released from the Queen Street Health Centre, he was charged with making telephone threats to a female friend's ex-boyfriend and that marked the start of a number of arrests for making threats, trespassing and causing a disturbance. He became obsessed with the comedian Joan Rivers and at one stage was charged with creating a disturbance when he appeared at a bookstore in Florida where Rivers was signing her book. One hospital report referred to six convictions in Canada for minor crimes such as causing a disturbance, causing mischief, harassing phone calls and uttering threats.³

During his 30s, Scott became obsessed with physics and at one stage gave a paper at a conference hosted by the British Society for the Philosophy of Science called 'The Only Logical Alternative to Relativity'. Pierre Noyes, an emeritus professor of physics at Stanford University was so impressed with some of Scott's ideas, that he used them as a basis for a scientific paper entitled 'Discrete Anti-Gravity' in which he credited Scott with co-authorship.

When he was 37, Scott changed his surname to Starson to signify that he was the son of the stars, which tied in with his quest to build a starship based on his theory of antigravity.

In July 1998, Scott was back in Toronto. On the 31st July, the owner of the townhouse where Scott was living phoned the police about Scott's behaviour. Scott was heard shouting at one of the tenants 'I'm going to kill all of you' and then said to one of the police officers 'You don't know who you're dealing with – I'm with the Starsons. I'm going to kill you'.⁴

Scott was charged with making two death threats and was eventually found 'not criminally responsible' on account of mental disorder. Under the Canadian *Criminal Code* such a finding usually results in a direction that the accused be detained in custody in a hospital until such time that he or she is no longer considered a significant threat to the safety of the public.⁵ There is no power to order compulsory or involuntary treatment under the *Criminal Code*.⁶

Scott was detained once more at the Queen Street Mental Health Centre. His psychiatrist at Queen Street, Dr Paul Posner, diagnosed Scott as suffering from bipolar

³ *Scott Starson*, Ontario Review Board Reasons for Disposition, 22 October 2007, ORB File No 2852. These prior convictions were not referred to by the Court of Appeal for Ontario or the Supreme Court.

⁴ *Scott Schutzman aka Starson*, Ontario Review Board Reasons for Disposition, 6 March 2008, ORB File 2852, p 2.

⁵ S 672.54 *Criminal Code* (Can).

⁶ S 672.55 *Criminal Code* (Can).

disorder and wanted to treat him with anti-psychotic medication, mood stabilizers, anti-anxiety medication and anti-parkinsonian medication. Scott refused any such drugs.

Another psychiatrist at Queen Street, Dr Ian Swayze declared Scott incapable of consenting to treatment under the *Health Care Consent Act 1996 (Ont)* which then enables involuntary treatment to occur. Scott appealed to the Ontario Consent and Capacity Board. A number of appeals then ensued.

The Importance of Scott's Story

Before I recount what happened once the lawyers became involved, I want to pause here for a moment and explain why I believe Scott's story is significant in educating both lawyers and non-lawyers in how the law authorizes involuntary treatment of those with very serious mental illnesses.

There is a quotation that says 'listening to both sides of a story will convince you that there is more to a story than both sides'.⁷

Education through the use of personal histories is I believe one of the most important methods of thinking about complex issues in general. Statistics, such as 'one in four people have a mental illness', are unable to capture the multifaceted problems and challenges that occur for individuals with mental illnesses, their family members and carers. The use of individual stories to raise issues is not new and Jill Peay has taken this approach in her stimulating book, *Decisions and Dilemmas: Working with Mental Health Law*.⁸ The use of case studies is a familiar method of teaching health professionals, and lawyers are used to gleaning facts from clients to argue their side of the story.

But more fundamentally, humans learn through stories whether culturally specific or broader in compass. While some have argued that the 'sound-bite, the video clip, the news flash' are challenging traditional approaches to story-telling, I think there is still very much a place for narratives in teaching.⁹

Scott's story is a familiar one to those who have experienced and who care for individuals with very serious mental illnesses. But I should point out that millions of individuals in this country experience mental illness, get through that experience and continue on with their lives.¹⁰

⁷ Attributed to 'Frank Tyger' on 'The Quotations Page', <<http://www.quotationspage.com/quote/38701.html>> accessed 8 October 2008.

⁸ Jill Peay, *Decisions and Dilemmas: Working with Mental Health Law* (Oxford: Hart Publishing, 2003).

⁹ On this point, see in general Richard Kearney, 'The Crisis of Narrative in Contemporary Culture' (1997) 28(3) *Metaphilosophy* 183.

¹⁰ Senate Select Committee on Mental Health, *A National Approach to Mental Health – From Crisis to Community, First Report* (Canberra: Commonwealth of Australia, March 2006) p 1.

Enter the Law

But where does the law come into all this? Clive Unsworth has made the point that '[l]aw actually constitutes the mental health system, in the sense that it authoritatively constructs, empowers, and regulates the relationship between the agents who perform mental health functions'.¹¹

Australian mental health legislation is currently geared toward the involuntary treatment of individuals with low prevalence serious mental illnesses such as schizophrenia and bipolar disorder, but there is an obvious need for laws to ensure proper access to treatment for individuals with the high prevalence mental disorders such as depression and anxiety.

The *Not for Service* Report prepared by the Mental Health Council of Australia and the Brain and Mind Research Institute in association with the Human Rights and Equal Opportunity Commission identified a number of problems for individuals with mental illnesses getting access to treatment. The report found that there is poor access to psychiatrists outside major metropolitan centres, poor access to psychologists due to a general lack of government or private insurance rebates and limited access to new medications in outpatient settings, partly because of restrictions on the provision of scripts under the Pharmaceutical Benefits Scheme.¹² It also identified a number of issues relating to state mental health services including the lack of acute care beds, premature discharge from hospitals of unwell persons and difficulties in getting access to professional care during onset and to prevent the deterioration of illness.¹³

The report also measured the data collected against the *National Standards for Mental Health Services* which were endorsed by the National Mental Health Working Group in December 1996.¹⁴ Standard 11.1 sets out that the relevant mental health service should be accessible to the defined community. The Report found that standard 11.1.4 which requires that the mental health service should be available on a 24 hour basis and standard 11.1.2 which requires that '[t]he community to be served is defined, its needs regularly identified and services are planned and delivered to meet those needs' are not

¹¹ Clive Unsworth, *The Politics of Mental Health Legislation* (Oxford: Clarendon Press, 1987) p 5.

¹² Mental Health Council of Australia, Brain and Mind Research Institute and the Human Rights and Equal Opportunity Commission, *Not for Service* (Canberra: Mental Health Council of Australia, 2005) p 45.

¹³ *Ibid*, p 46.

¹⁴ Australian Health Ministers Advisory Council, National Mental Health Working Group, *National Standards for Mental Health Services* (December 1996)

<<http://www.mhca.org.au/Resources/NoCCS/documents/NationalMentalHealthStandards.pdf>> accessed 7 July 2008.

being met in many Australian states.¹⁵ Instead, because of ‘the inability of consumers and carers to access mental health services during times of crisis, police are increasingly being called to assist as they are available 24 hours a day 7 days a week’.¹⁶

A similar picture was presented to the Senate Select Committee on Mental Health. Its First Report found that ‘most people with mental illness do not currently have access to an integrated, specialised mental health service that meets their needs’.¹⁷

I believe the law has a role to play in regulating access to good quality mental health care for *all* individuals with mental illnesses, but as I pointed out before, our current laws are very much geared towards involuntary detention and treatment of those with very serious mental illnesses. Laws regulating access to services and voluntary treatment warrant more attention.

John Lesser, the President of the Victorian Mental Health Review Board, which conducts reviews and appeals from decisions to involuntarily treat individuals with mental illnesses, has pointed out that we don’t have a Cancer Act or an Epilepsy Act or a Diabetes Act, yet we do have a Mental Health Act.¹⁸ That in itself is discriminatory, but such mental health laws are generally justified on the basis of the protection of the individual concerned, the protection of others and the provision of access to health care.¹⁹ How those laws should be framed is of course subject to debate. Currently, the Victorian *Mental Health Act 1986* is under review and I think it’s timely to consider what happened to Scott Starson in Ontario in order to learn from his experience.

Scott’s Story (continued)

Let me return to Scott’s view of his circumstances. Scott told the Ontario Consent and Capacity Board that he may have had mental problems, but that they were ‘100 per cent manageable’.²⁰ He did not agree with the labels given by psychiatrists, but said that he had ‘exhibited things that would be considered manic’.²¹ One of his desires was to

¹⁵ Mental Health Council of Australia, Brain and Mind Research Institute and the Human Rights and Equal Opportunity Commission, above n 12, p 498 (dealing with Queensland).

¹⁶ Ibid, p 499 (dealing with Queensland). See also p 833 for a national overview.

¹⁷ Senate Select Committee on Mental Health, above n 10, p 148.

¹⁸ John Lesser, *Lecture on Civil Commitment Laws*, Monash University Law Chambers, 5th August 2008; See also John Lesser, *Review and Decision Making for Persons with a Serious Mental Illness: Achieving Best Practice*, Report for the Winston Churchill Memorial Trust of Australia (28 September 2007) <<http://www.mhrb.vic.gov.au/documents/CHURCHILLFINAL28.09.07.pdf>> accessed 8 October 2008.

¹⁹ Genevra Richardson, ‘Balancing Autonomy and Risk: A Failure of Nerve in England and Wales?’ (2007)

³⁰ *International Journal of Law and Psychiatry* 71.

²⁰ *Starson v Swayze*, Ontario Supreme Court, Molloy J, 26 November 1999, para 29.

²¹ Ibid, para 30.

'harvest the hypermanicness without being out of control'²² and he wanted to explore the cause of his problems with Dr Posner.²³

Scott said that any threats that he'd made resulted from provocation or were made in self-defence.²⁴ He acknowledged there was one time when he had struggled violently when hospital staff had put him in physical restraints to inject him with a neuroleptic drug, but otherwise he had never injured anybody.²⁵

Scott said that he had been treated in New York and Florida with antipsychotic drugs and mood stabilizers for a period of eighteen months²⁶ and that this treatment had not worked. He described the effect as a 'foggy, pounding feeling' which made it impossible for him to work.²⁷ He refused the proposed medication which was designed to slow down his brain on the basis that 'it would be worse than death for me, because I have always considered normal to be a term so boring it would be like death'.²⁸ When asked if any of the medication had helped him, he said:

Not in any way whatsoever. They have always been the most horrible experiences of my life. When I keep hearing I suffer from mental illness, I suffer from being treated with those medications. And as soon as those medications are over, I work my way back up the academic ladder.²⁹

When asked at the Board hearing by his doctor whether he thought the proposed medication could be at all beneficial, he said:

Well it has no effect – Dr. – has no effect on what I think about the universe, and reality, and people, and day to day activity. It has no effect on me whatsoever with regard to that. It makes me angry. It makes me frustrated. It makes me so that I cannot communicate with my loved ones. I can't communicate with my colleagues so I can't do my job. That's what it does to me, okay? But it has no effect on those things that you hope to improve, because that's part of your perceived reality.³⁰

Scott's story raises issues that may be familiar to other consumers of psychiatric services – the side effects, the dulling feeling, the inability to communicate the difference between one's own reality and the psychiatrists' perception of it.

David Webb has made the point that what has been termed the 'consumer voice' is too often 'pathologised, dismissed and disregarded by an objective voice that strives only to reduce observable, negative symptoms, rather than address the lived experience.'³¹ He

²² Ibid, para 30.

²³ Ibid, para 29.

²⁴ Ibid, para 29.

²⁵ Ibid, para 39.

²⁶ Ibid, paras 51, 52.

²⁷ Ibid, para 54.

²⁸ Ibid, para 54.

²⁹ Ibid, para 55.

³⁰ Ibid, para 57.

³¹ David Webb, 'Bridging the Spirituality Gap' (2005) 4(1) *Australian e-Journal for the Advancement of Mental Health* 1, 8.

calls for the first-person methods to come to the forefront.

I am acutely aware that I am telling a story in the third person and there are enormous limitations in doing so. I am portraying what is on the public record, not a lived experience, but nevertheless, I believe that hearing a fraction of the whole³² of Scott's viewpoint is an important starting point for rethinking the way in which mental health laws should regulate the detention and treatment of those with severe mental illnesses.

Let me turn now to some of the other perspectives on Scott's story.

The Psychiatrists' Story

The treating psychiatrists had a very different view of Scott's reality. They were of the opinion that Scott was living in a delusional world characterised by grandiose ideas and intellectual posturing.³³ They recognised that they couldn't use some of the newer milder antipsychotic drugs that have fewer side effects because they have to be taken orally and Scott would not consent to that. What they proposed was to put Scott in physical restraints and inject him with long-acting drugs which might then lead to the use of milder drugs 'if his psychosis would remit sufficiently'.³⁴

Dr Posner thought that because Scott's publications had stopped in 1995, this showed that 'the illness has progressed from a hypomanic state in which he was increasingly productive, to a point at which he had crossed the line and became too irritable to function out in the community'.³⁵

Both Dr Posner and Dr Swayze concluded that Scott was in denial about his mental illness. During the initial Board hearing, Dr Swayze testified that Scott's 'understanding was that indeed, he did not and has not suffered from any psychiatric disorder, particularly not from psychotic disorder' and Dr Posner stated that Scott 'did not understand in any way, shape or form that he had a mental illness'.³⁶

Sometimes, psychiatrists will refer to such a lack of understanding as a lack of 'insight'. While this is a rather vague term (particularly for lawyers), insight is generally taken to refer to a person's self-awareness that there is a problem or an illness and an

³² I borrow the title here of Steve Toltz's wonderful novel, *A Fraction of the Whole* (Melbourne: Hamish Hamilton, 2008) which in turn is taken from Ralph Waldo Emerson's quotation: 'The moment we meet with anybody, each becomes a fraction' in 'Solitude and Society' (December 1857) *The Atlantic Monthly* <<http://www.theatlantic.com/issues/1857dec/emerson.htm>> accessed 8 October 2008.

³³ *Starson v Swayze*, Ontario Supreme Court, Molloy J, 26 November 1999, para 42.

³⁴ *Ibid*, para 48.

³⁵ *Ibid*, para 63.

³⁶ *Starson v Swayze* [2003] 1 SCR 722 at 740-741 per McLachlin CJ.

understanding of its cause or meaning.³⁷ A lack of insight or ‘poor’ insight has been associated with the most serious mental illnesses such as schizophrenia and bipolar disorder and while theories of the cause of this have ranged from ‘denial’ to a preference for psychosis, there is a growing literature suggesting that damage to frontal lobe areas may lead to an unawareness of the illness. This is sometimes referred to as anosognosia.³⁸

From a psychiatric perspective, if a person is unaware of or only partially aware that he or she has an illness, it is in that person’s best interests to go ahead with treatment with the aim of improving ‘insight’. Many psychiatrists would argue that the ends justify the means in relation to involuntary treatment.

Recently, however, the Interim Report of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment³⁹ has pointed out that ‘in the context of medical treatment of persons with disabilities...serious violations and discrimination may be masked as ‘good intentions’ on the part of health professionals.⁴⁰

It is thus important to ensure that there are appropriate legal restrictions on certain involuntary treatments and practices and I will return to this point a little later.

The Judges’ Story

The central legal issue before the Ontario Consent and Capacity Board and the appeal courts was whether Scott had the capacity to refuse treatment.

Outside the mental health context, the law has generally recognised the right to consent to, or refuse, medical treatment.⁴¹ Here, in Victoria, this is recognised by the *Medical Treatment Act 1988* (Vic). However, in the mental health context, legislation has limited this right.

For example, under the *Mental Health Act 1986* (Vic), one of the bases for involuntary admission to an approved mental health service is that the person has refused or is **unable to consent** to the necessary treatment.⁴² There is no definition of the inability

³⁷ GD Strauss, ‘Diagnosis and Psychiatry: Examination of the Psychiatric Patient’ in Harold I Kaplan and Benjamin J Sadock (eds), *Comprehensive Textbook of Psychiatry* (Baltimore: William and Wilkins, 1995, 6th ed) Vol 1, p 528.

³⁸ See, for example, Lorenzo Pia and Marco Tamietto, ‘Unawareness in Schizophrenia: Neuropsychological and Neuroanatomical Findings’ (2006) 60 *Psychiatry and Clinical Neurosciences* 531; Mujeeb U Shad et al, ‘Insight and Frontal Cortical Function in Schizophrenia: A Review’ (2006) 86 *Schizophrenia Research* 54.

³⁹ United Nations General Assembly, *Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment: Note by the Secretary-General*, UN Doc A/63/175, 28 July 2008, <<http://www2.ohchr.org/english/issues/disability/torture.htm>> accessed 8 October 2008.

⁴⁰ *Ibid*, p 11.

⁴¹ This is usually traced back to the case of *Schloendorff v Society of New York Hospital* (1914) 211 NY 125, although there may have been earlier decisions of relevance.

⁴² S 8(d) *Mental Health Act 1986* (Vic).

to consent requirement, but the Mental Health Review Board has referred to various tests in its decisions such as:

- Does the individual understand the broad nature and effects of the necessary treatment?
- Can the individual provide an accurate forecast of his or her future actions?
- Is the individual aware of the extent of the illness and can s/he recognise those aspects of behaviour symptomatic of its existence?⁴³

Similarly, in Ontario, where Scott Starson was living, the *Mental Health Act 1990* (Ont) enables involuntary treatment where the person has been ‘found incapable...of consenting to his or her treatment...’⁴⁴ Section 4(1) of the *Health Care Consent Act 1996* (Ont) refers to the assessment of capacity as being based on the individual’s ‘ability to understand the information that is relevant to making a decision about the treatment...and [the ability] to appreciate the reasonably foreseeable consequences of a decision or lack of decision’.⁴⁵

Scott Starson referred to this issue of capacity as a Catch 22. This was summarised by Justice Molloy:

[Scott] said that if he admitted having a mental illness, then the psychiatrists would insist on treating him with medications that he did not want to take. On the other hand, if he did not admit it, then the psychiatrists would say he ‘lacked insight’ into his illness and use that as an indication of incompetence and then force treatment upon him.⁴⁶

The decision as to whether or not Scott was capable of consenting to treatment (and thus capable of refusing treatment) obviously presented a conundrum to the courts.

Most of the judges involved in hearing the appeals decided Scott **did** have the capacity to consent to and refuse treatment. In the Ontario Supreme Court of Justice, Molloy J said on judicial review that ‘a finding of incapacity cannot be based simply on a patient’s failure to acknowledge an illness.’⁴⁷ Rather, it had to be shown that any refusal to acknowledge an illness was caused by or affected by the illness itself. She also stated that ‘the mere fact that an individual is shown to have some delusional ideas is not sufficient to

⁴³ *Re the Review of AB* (1988) 1 MHRBD (Vic) 40 at 57; *Re the Review of RG* (1993) 2 MHRBD (Vic) 104 at 114; *Re the Review of 99-467* [1998] VMHRB 15.

⁴⁴ S 20(1.1)(e).

⁴⁵ While Victoria and Ontario are thus similar in their approach to enabling involuntary treatment where the individual is unable to consent to treatment, other states do not require an assessment of the ability to consent. In New South Wales and South Australia, for example, there is the power to involuntarily treat a person regardless of their capacity to consent or refuse treatment: Ch 3, Part 1 *Mental Health Act 2007* (NSW); Parts 3 and 4 *Mental Health Act 1993* (SA).

⁴⁶ *Starson v Swayze*, Ontario Supreme Court, Molloy J, 26 November 1999, para 29.

⁴⁷ *Ibid*, para 34.

support a finding that the person is not capable of decision making in respect of his treatment'.⁴⁸

Justice Molloy found that the Consent and Capacity Board had placed too much emphasis on hearsay and conjecture and failed to consider Scott's stated reasons for not wanting the proposed treatment and the evidence of his friends and colleagues. She therefore overturned the Board's decision.

On appeal, the three Justices of the Court of Appeal for Ontario all agreed with Justice Molloy that Scott was capable of consenting to and thus, refusing treatment. They said:

[W]e conclude that Professor Starson understood, through the screen of his mental illness, all aspects of the decision whether to be treated. He understands the information relevant to that decision and its reasonably foreseeable consequences. He has made a decision that may cost him his freedom and accelerate his illness. Many would agree...that it is a decision that is against his best interests. But for Professor Starson, it is a rational decision, and not one that reflects a lack of capacity.⁴⁹

A further appeal was made to the Supreme Court of Canada and here the judges were split six justices to three in holding that Scott did have capacity to consent to and therefore to refuse treatment. The judgment of the majority was delivered by Major J who emphasized the importance of human rights. He stated:

Few medical procedures can be more intrusive than the forcible injection of powerful mind-altering drugs which are accompanied by severe and sometimes irreversible adverse side effects. Unwarranted findings of incapacity severely infringe upon a person's right to self-determination.⁵⁰

Justice Major stated that the justices in the minority (and by implication the members of the Consent and Capacity Board) ignored Scott's acknowledgment that he had 'mental problems, his obvious appreciation of the intended purpose of the medication, the admitted uncertainty by the doctors that treatment would improve Professor Starson, the failure in the past of mood stabilizers...and his rationale for refusing the medication'.⁵¹

The majority of judges in all the appeals therefore gave preference to Scott's story in the context of a strong human rights discourse. It is worth noting here that the Canadian Charter of Rights and Freedoms came into force on the 17th April 1982 and the Supreme Court of Canada is thus well versed in the jurisprudence of human rights. The Supreme

⁴⁸ Ibid, para 47.

⁴⁹ *Starson v Swayze and Posner*, Court of Appeal for Ontario, Carthy, Laskin and Goudge JJA, 24 August 2000, para [14].

⁵⁰ *Starson v Swayze* [2003] 1 SCR 722 at 759 per Major J.

⁵¹ Ibid at 772-773 per Major J.

Court decision in *Starson v Swayze* has given rise to academic debate⁵² and has greatly influenced subsequent decisions by the Consent and Capacity Board.⁵³

The ultimate result of all these hearings was that Scott was not treated with drugs against his will. However, he still remained in detention because of the initial finding that he was not criminally responsible for making death threats. I'll return to what has happened to Scott since the Supreme Court case a little later.

There's another story in all this that needs telling.

The Family and Friends' Story

Jeanne Stevens, Scott's mother, has said that she thought Scott was ill from his teens, perhaps even earlier.⁵⁴ At college, he often complained of headaches and had difficulty in concentrating. She consistently wanted him to have treatment and tried to become his substitute decision-maker to ensure he was able to get the treatment she thought he needed. Unfortunately, that caused a break down in their relationship such that Scott refused to see her for some time. More recently, Scott has had regular contact with Jeanne but the relationship has been described as 'strained'.⁵⁵ Scott's brother, Brad has no contact with him.

Scott has kept in touch with his ex-girlfriend, Betsy, who lives in the United States and they regularly speak on the telephone. He also keeps in touch with some physics colleagues and a lawyer friend, Dennis Daoust. Many of these friends have given evidence during the various legal hearings.

The role of family members and carers is a very difficult one. Too often they are left out of discussions with treatment teams and have to pick up the pieces when things go wrong. They are the ones who are the first to see the warning signs and a lack of access to treatment can lead to a breakdown in family relationships and friendships.

Does the law have any role here? I think it does and I'll say a bit more about this shortly. I want now to turn to a consideration of what lawmakers can learn from Scott's story and the stories of his mother and friends.

⁵² See for example Ronald Sklar, 'Starson v Swayze: The Supreme Court Speaks Out (Not All That Clearly) on the Question of "Capacity"' (2007) 52(6) *Canadian Journal of Psychiatry* 390; Ari Greenwald, 'Law and Ethics in Medicine: Competency and Mental Illness' (2003) 81(1) *University of Toronto Medical Journal* 16.

⁵³ A check of the database CanLII on the 8th October 2008 found the Supreme Court case had been cited 403 times in subsequent decisions.

⁵⁴ O'Neill and Fischer, above n 1.

⁵⁵ *Scott Starson*, Ontario Review Board Reasons for Disposition, 22 October 2007, ORB File No 2852, p 4.

Stories for Politicians and Policymakers

One of the clear themes emerging from Scott's perspective is his inability to get his own story heard. There is a growing international trend towards supported decision-making processes for those with disabilities in general, which may assist in ensuring the wishes and preferences of the individual concerned are given priority.

On the 3rd May 2008, the *Convention on the Rights of Persons with Disabilities* (CRPD) came into force. Australia signed the Convention on 30 March 2007 and ratified it on 17 July 2008. This Convention is of great significance in that it clarifies the obligations of States Parties to promote and ensure the rights of person with disabilities and sets out the steps that should be taken to ensure equality of treatment. It goes into much more detail than previous general human rights conventions concerning what action needs to be taken to prohibit discrimination.⁵⁶

In particular, Article 12 of the CRPD deals with the legal capacity of persons with disabilities. It starts with the presumption that people with disabilities, including mental illnesses, are capable of making their own decisions and any other form of decision-making must be seen as a measure of last resort.⁵⁷ Anna Lawson has argued that Article 12 shifts the focus from substituted decision-making to supported decision-making.⁵⁸

This means that attention will need to be paid to what is meant by the capacity to consent to or refuse medical treatment. As pointed out earlier, there is no legal definition of this in the current Victorian Mental Health Act whereas many countries have a definition of capacity in a separate Act specifically dealing with health care and capacity in general.

On this point, some authors have argued for the fusion of mental health and guardianship legislation in order to help combat the discrimination inherent in mental health acts,⁵⁹ but such a fusion is dependent on a substitute decision-making model that does not fall within the tenor of the CRPD, which instead endorses supported decision-making.

Article 12 of the CRPD provides added impetus for the movement to include provisions for advance directives or statements into mental health laws.⁶⁰ In Victoria,

⁵⁶ See in general Annegret Kämpf, 'The Disabilities Convention and its Consequences for Mental Health Laws in Australia' (2008) *Law in Context* [Forthcoming].

⁵⁷ Rosemary Kayess and Ben Fogarty, 'The Rights and Dignity of Persons with Disabilities: A United Nations Convention', (2007) 32(1) *Alternative Law Journal* 22, 23.

⁵⁸ Anna Lawson, 'The United Nations Convention on the Rights of Persons with Disabilities: New Era or False Dawn?' (2007) 34(2) *Syracuse Journal of International Law and Commerce* 563, 597.

⁵⁹ John Dawson and George Szmukler, 'Fusion of Mental Health and Incapacity Legislation' (2006) 188 *British Journal of Psychiatry* 504; Stephen Rosenman, 'Mental Health Law: An Idea Whose Time Has Passed' (1994) 28 *Australian and New Zealand Journal of Psychiatry* 560.

⁶⁰ Penny Weller, 'Supported Decision-Making and the Achievement of Non-Discrimination: The Promise and Paradox of the Disabilities Convention' (2008) *Law in Context* [forthcoming].

treatment plans have been introduced in an attempt to take into account the views of those with mental illnesses, but these have not resulted in any major changes to practice. It is my impression from sitting on the Mental Health Review Board, that treatment plans have been largely viewed as an extra paperwork hurdle and it is uncommon to see the signature of the person concerned on them.

An advance directive emphasises the wishes and preferences of the individual concerning treatment options and thus enables his or her perspective to be taken into account. Provisions for advance directives have been introduced, albeit with mixed degrees of success, in other countries and should be seriously considered in Australia.

How to include carers' perspectives in mental health laws is also an important issue. The *Mental Health (Care and Treatment) (Scotland) Act 2003* came into effect on 1 October 2005. This is one of the most progressive and comprehensive mental health acts to date and it includes a process for consumers to nominate a 'Named Person' such as a relative or friend with rights to be involved in any legal hearings. The Named Person has the same rights as the individual concerned to be notified of, appear, and be represented at hearings of the Mental Health Tribunal. The Named Person has the right to initiate appeals against the renewal of compulsory treatment measures and the right to appeal decisions of the Tribunal. Families of individuals with mental illnesses also have rights to trigger assessments when needed. The Scottish Act is detailed and complex, but the Scottish Executive has also issued a comprehensive Code of Practice in three volumes, together with specific training manuals for staff and information for patients and families, to assist in the implementation and interpretation of the Act. The Code of Practice sets out processes for ensuring that carers are given appropriate information in relation to measures taken under the Act.

The right of access to advocates, not necessarily lawyers, for those individuals with mental illnesses is also of growing concern internationally.⁶¹ There is a provision in the Scottish Act setting out that individuals with mental illnesses have a right of access to independent advocacy and the onus is placed on each local authority and each Health Board to secure the availability of independent advocacy services and to ensure the individual concerned has access to them.⁶² This again, is an area worth investigating here in Victoria where usually only around 5% of hearings before the Mental Health Review Board involve legal representation.

⁶¹ Terry Carney et al, 'Advocacy and Participation in Mental Health Cases: Realisable Rights or Pipe-dreams?' (2008) *Law in Context* [Forthcoming].

⁶² S 259 *Mental Health (Care and Treatment) (Scotland) Act 2003*.

There is another Article in the CRPD which will undoubtedly have repercussions for invasive medical treatments and procedures. Article 17 of the CRPD which is entitled 'Protecting the Integrity of the Person' states:

Every person with disabilities has a right to respect for his or her physical and mental integrity on an equal basis with others.

There has been some debate about the scope of this Article, with Tina Minkowitz arguing that when read with the prohibition against torture or cruel, inhuman and degrading treatment or punishment in Article 15, Article 17 provides the basis for understanding forced psychiatric interventions as a violation of human rights.⁶³ I have argued in a forthcoming paper that from a practical perspective, States will continue to have legislation and programs that enable involuntary treatment and what Article 17 will do is severely limit treatments such as electro-convulsive therapy and psychosurgery and practices such as seclusion and restraint.⁶⁴

It is significant in this regard that the Interim Report of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment⁶⁵ has stated that '[t]he more intrusive and irreversible the treatment, the greater the obligation on States to ensure that health professionals provide care to persons with disabilities only on the basis of their free and informed consent.'⁶⁶

Further, the Report states that 'ECT be administered only with the free and informed consent of the person concerned'⁶⁷ and that 'forced and non-consensual administration of psychiatric drugs, and in particular neuroleptics, for the treatment of a mental condition needs to be constantly scrutinized'.⁶⁸ The Report goes on to point out that 'the suffering inflicted (by psychiatric drugs) and the effects upon the individual's health may constitute a form of torture or ill-treatment'.⁶⁹

In summary then, law reform endeavours need to take into account the provisions of the CRPD in introducing measures for supported decision-making and for limiting invasive treatments and practices. Some authors such as Minkowitz argue that *all* involuntary detention and treatment is unjustifiable under the CRPD, but I think a close reading of the

⁶³ Tina Minkowitz, 'The United Nations Convention on the Rights of Persons with Disabilities and the Right to be Free from Nonconsensual Psychiatric Interventions' (2007) 34(2) *Syracuse Journal of International Law and Commerce* 405.

⁶⁴ B McSherry, 'Protecting the Integrity of the Person: Developing Limitations on Involuntary Treatment' (2008) *Law in Context* [forthcoming].

⁶⁵ United Nations General Assembly, above n 39.

⁶⁶ *Ibid*, p 14.

⁶⁷ *Ibid*, p 15.

⁶⁸ *Ibid*, p 16.

⁶⁹ *Ibid*.

provisions means that involuntary commitment laws can exist subject to important limitations.

The Scottish Act provides a model for the inclusion of advocates and named persons to assist decision-making and should be the first port of call for policy makers seeking to review mental health acts.

The important thing to remember is that the law needs to support processes for individuals to have their stories, their preferences and their wishes to be heard.

Further Research: The Rethinking Mental Health Laws Project

In December 2007, the Australian Research Council commenced funding a five-year Federation Fellowship project entitled: *Rethinking Mental Health Laws: An Integrated Approach* which is based at the Faculty of Law, Monash University. The project provides a wonderful opportunity to explore some of the international trends listed above in relation to civil commitment laws as well as consider treatment options for mentally ill offenders. It is also focussing on the role of the law in helping increase access to optimal mental health services.

The research team at present includes myself, Professor Ian Freckelton who is a part-time Professor of Law at Monash University, Dr Penny Weller, a postdoctoral research fellow, four doctoral students, Annegret Kämpf, Ronli Sifris, Jamie Walvisch and Liz Richardson with hopefully another one joining us next year, two research fellows, Joanna Kyriakakis and Steven Yannoulidis, an executive officer, Kathleen Patterson and various sessional research assistants. It is the first time such a project has been established in Australia and if you would like further information about each person's research topics, please have a look at our website: www.law.monash.edu.au/rmhl.

The Cycle Continues

So what has happened to Scott Starson? He is now 52 and he has now been diagnosed with 'schizoaffective disorder'. Since being charged and found not criminally responsible for making threats to kill in 1998, he has been detained in various institutions on the basis that he still poses a risk to public safety. He did appeal a decision of the Ontario Review Board made on 28 August 2003 that he continue to be detained, but to no avail.⁷⁰ The Court of Appeal for Ontario found that Scott 'continued to represent a real risk

⁷⁰ *R v Starson* (2004) 183 CCC (3d) 538.

of serious psychological harm to members of the public by his threatening behaviour, which in the past has included threats of death'.⁷¹

It is important to note that if Scott had been found guilty under the Canadian *Criminal Code*, his sentence would have been no more than five years in prison,⁷² yet because of the finding that he was not criminally responsible he has been detained in mental health institutions for ten years. This raises a number of issues for the interplay between the civil and criminal justice systems when it comes to individuals with mental illnesses and the rethinking mental health laws project is keen to explore this further.

In 2005, Scott refused most hospital food and drinks on the basis that he thought the hospital staff were trying to poison him. He became so frail that he had difficulty walking.

His doctors went back to the Ontario Consent and Capacity Board and once again an order was made that Scott was incapable of consenting to his treatment. Once more, Scott appealed this decision, but this time the Ontario Superior Court of Justice upheld the Board's finding.⁷³ This meant that Scott could be treated against his will.

Since then, Scott has responded to some extent to medical treatment in the sense that he is calmer and, according to the Ontario Review Board, 'has not posed any management difficulties'.⁷⁴ He keeps to himself and spends his time working on physics equations, but he has described his mood as 'low' because of a 'sense of loss of status from his previous level of achievement'.⁷⁵

In 2006 Scott was transferred to a medium secure forensic unit in Toronto. By this stage, Scott's mother had been appointed his substitute decision maker under section 20 of the *Health Care Consent Act 1996 (Ont)* and she consented on his behalf to injections of the antipsychotic drug risperidal consta.

In July 2007, while still subject to the powers of the Ontario Review Board, Scott moved to an apartment in Toronto which was subsidised by the Mental Health and Justice program. On the 1st October 2007, Scott was readmitted to the Queen Street Centre for Addiction and Mental Health on the basis that he had become withdrawn, was refusing to eat and was extremely depressed. The police were called to bring Scott into hospital after his mother contacted his doctors.

Scott was treated with an antidepressant and was discharged back into the community on the 11th December 2007. On 6th March 2008, the Ontario Review Board decided that Scott still needed monitoring and ordered that he report to the hospital at

⁷¹ Ibid, para 24.

⁷² S 264.1(2) *Criminal Code* (Can).

⁷³ These decisions are mentioned in O'Neill and Fischer, above n 1, but they are not publicly available.

⁷⁴ *Scott Starson*, Ontario Review Board Reasons for Disposition, 22 October 2007, ORB File No 2852, p 4.

⁷⁵ Ibid, p 3.

least once a week. Unfortunately, one week later, on the 13th March, Scott was brought back into the Queen Street Centre once again as he failed to come into the hospital as required and did not respond to any phone calls. Once more the police were called to bring him back into hospital: once more he was given medication and released back into the community on 17th April.

The latest decision of the Ontario Review Board I have been able to obtain was made on 15 July 2008 and this confirms the decision of the hospital to significantly increase the restrictions on Scott's liberty.⁷⁶ It would seem that Scott's reintegration into the community will not be easy given the ten years he has spent detained and the cycle of hospital admissions may very well continue for some time.

Conclusion

Scott's story has hopefully set out some of the difficult issues with which mental health laws must grapple. Every person's story is different and we all bring very different perspectives to the issues. What I think is important is that we do address the concerns of those whose voices are too often unheard whether this be through, for example, advance directives, the use of advocacy or through more attention being paid to the wishes of carers.

While it remains the case that legal provisions alone do not lead to the development of new services,⁷⁷ any endeavour to provide proper treatment for individuals with mental illnesses will only work if there are appropriate laws in existence shaping the way in which individuals with mental illnesses can gain access to the highest attainable standard of mental health care.

Ultimately, proper care will only be achieved for those with mental illnesses not only through rethinking mental health laws but also through raising awareness of discrimination and curbing indifference and neglect. As Sir William Deane has pointed out, 'the ultimate test of our worth as individuals and as a nation is how we treat the most disadvantaged and vulnerable of our fellow human beings'.⁷⁸

⁷⁶ *Scott Starson*, Ontario Review Board, Decision, 15 July 2008, ORB File 2852.

⁷⁷ Bernadette McSherry, 'Human Rights and Mental Illness: The Legal Framework' (1994) 1 *Journal of Law and Medicine* 205.

⁷⁸ Sir William Deane, 'Address on the Occasion of the Jesuit Refugee Service Dinner, Sydney, 19th June 2004 <http://jrs.org.au/component?option=com_docman/task,doc_view/gid,25/Itemid,47/> accessed 8 October 2008.

