MENTAL HEALTH LAW CENTRE (WA) Inc.

ABN 40 306 626 287

Our Ref: SB/MDL NCW 1005

8 May 2014

The Executive Director
Australian Law Reform Commission
GPO Box 3708
SYDNEY NSW 2001

By email: privacy@alrc.gov.au ; www.alrc.gov.au/content/privacy-subs-DP80

Dear Madam

ALRC DISCUSSION PAPER 80
SERIOUS INVASIONS OF PRIVACY IN THE DIGITAL ERA
MENTAL HEALTH LAW CENTRE (WA) INC. SUBMISSION

The Mental Health Law Centre is a community legal centre, which specialises in providing free legal advice and representation to people with a mental illness, when their legal problem is causally related to their legal issue. The main focus of our work is assisting patients who are involuntary under the provisions of the *Mental Health Act 1996* (WA) (MHA) and mentally impaired accused persons who are subject to criminal charges, particularly those subject to the *Criminal Law (Mentally Impaired Accused) Act 1996* (WA).

We refer to Discussion Paper 80: *Serious Invasions of Privacy in the Digital Era*, dated March 2014. The Discussion Paper is seeking submissions on 47 proposals for reform, including a new Commonwealth Act that would provide for a statutory cause of action for serious invasions of privacy, and uniform surveillance device laws.

The right to privacy is a fundamental right, supported by Article 17 of the International Covenant of Civil and Political Rights:

> 1. *No one shall be subjected to arbitrary or unlawful interference with his privacy, family, home or correspondence, nor to unlawful attacks on his honour and reputation.*
> 2. *Everyone has the right to the protection of the law against such interference or attacks.*

Health or medical information is of a private nature, and should be protected from misuse or intrusion where it is appropriate and possible. The Mental Health Law Centre acts to protect our client's private information, acknowledging that our clients are among the most vulnerable and disadvantaged members of our community. They suffer from widespread, systemic discrimination and are consistently denied the rights and services to which they are entitled.

Case example

The Mental Health Law Centre has assisted a client, "Jane", in making a complaint to a health service regarding the disclosure of her personal information to third

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parties. Jane was in a relationship with a staff member of the health service, "John", who told her that he had accessed her E-medical records by the hospital computer system, and he had also accessed other people's medical records. Jane later became aware that John was disclosing her personal information to other people, including mutual friends.

As there is no statutory cause of action applicable to Jane's case, civil causes of action have been considered. The following causes of action that are applicable are Negligence (tort and statute), Intentional Infliction of Mental or Emotional Harm (tort); Defamation (tort); Breach of Statutory Duty under the *Mental Health Act 1996* (WA) (tort); Breach of Statutory Duty under the *State Records Act 2000* (WA) (tort); Breach of Privacy (tort); and Breach of Confidence (equity).

Pursuing a civil action is difficult for Jane, given the sizeable amount of resources that would need to be available in order to commence proceedings with sufficient evidentiary material to substantiate the case, the risks of costs orders, and the resilience she would need to find to sustain her during protracted court actions.

Jane's case demonstrates how individuals with a mental illness may benefit from a statutory cause of action by offering a less onerous option than litigation.

SUBMISSIONS

(a) Support for statutory cause of action

The Mental Health Law Centre (WA) supports a Commonwealth statutory cause of action for serious invasion of privacy. We submit that this would address some of the problems that mental health service consumers currently experience with available civil causes of action.

(i) Scope of application

The Mental Health Law Centre acknowledges that a statutory cause of action under a federal statute may only affect some people with a mental illness in Western Australia. We note that the *Privacy Act 1988* (Cth) only applies to the following entities:

(a) All Commonwealth public sector agencies;
(b) Most private sector organisations; and
(c) All private sector organisations which are health care providers.

We confirm that under the current operation of the *Privacy Act 1988* (Cth), the laws only apply to our clients who are mental health patients in private institutions, and involuntary patients detained in Cth. funded psychiatric hostels.

(ii) Difficulty with civil causes of action

Presently, any civil claim for breaches of privacy under the *Mental Health Act 1996* (WA) are dependent upon the tort of breach of statutory obligation and/or negligence. The availability of these causes of action is significantly limited by the lack of positive obligations on health service providers to ensure compliance with the formal requirements of the *Mental Health Act 1996* (WA) and the *Mental Health Bill 2013* currently travelling through the WA parliament. For many of our clients, who are generally impecunious, and do not have the financial resources or resilience to

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expose themselves to witness examination and adverse cost orders even if they find a *pro bono* lawyer, civil litigation is often out of the question.

The civil claims jurisdictions in the WA courts impose onerous regimes, in terms of procedure, evidence and law, on litigants. The onerous requirements of the civil claims jurisdictions in WA are exacerbated for many of our clients, who are often unable to understand or to give effective instructions and may be facing a defendant who is the State government, with all the resources that that brings to the litigation. To exacerbate the problem, mental illness patients may be unable to provide clear evidence of monetary damage arising from breaches of the mental health law, because the damage is often unquantifiable (for example, embarrassment, loss of dignity, disruption to life).

A statutory cause of action would significantly reduce the costs associated with pursuing a civil action. Our clients may be less capable of instigating legal proceedings, acquiring relevant information, and meeting the onerous costs of civil litigation because of the symptoms of their mental illness. A statutory cause of action will facilitate access to justice for our clients, arguably amongst the most vulnerable in our society, involuntary patients.

(b) CCTV surveillance

We refer to the first element of the proposed new tort:

a) *Intrusion upon the plaintiff's seclusion or private affairs (including by unlawful surveillance); or*
b) *Misuse or disclosure of private information about the plaintiff (whether true or not).*

(i) <u>Support for CCTV surveillance</u>
One of the core issues facing mental health services and involuntary patients is the variable standard of care delivered to involuntary patients.
The variable standard of care is due to the absence of clearly defined uniform expected standards of care and service delivery, and where there is such a standard, the lack of independent uniform enforcement of such standards.[1]

In our opinion, one policy decision that is likely to lead to far reaching improvements in the standard of the delivery of service in involuntary hospitals is the introduction of wide ranging closed circuit television (CCTV) with audio recording. This should be implemented in all wards of authorised hospitals and hostels, and in all places where patients are detained on referrals, but <u>without any monitors or screens</u> associated with the recording.

We have submitted to the Western Australian Mental Health Commission that the powers of the Chief Psychiatrist (CP) should be amended to include the power to install CCTV surveillance, as the CP decides is necessary, and to ensure that any existing CCTV surveillance is lawful and not in breach of

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[1] Professor Bryant Stokes, AM, 'Review of the admission or referral to and the discharge to and the discharge and transfer practices of public mental health facilities/services in Western Australia' (Review, Government of Western Australia Mental Health Commission and Department of Health, July 2012) 108.

patient and staff privacy. We **enclose** a copy of our submission to the Mental Health Commission.

(ii) Continuation of section 3 of *Privacy Act 1988* (Cth)
We refer to section 3 of the *Privacy Act 1988* (Cth), which specifically states that it is not intended to affect the operation of a law of a State or of a Territory that makes provision with respect to the collection, holding, use, correction, disclosure or transfer of personal information and is capable of operating concurrently with the *Privacy Act 1988* (Cth).

We submit that the new Act should include a similar provision to section 3 of the *Privacy Act 1988* (Cth), so as not to limit the operation of any change to Western Australian law regarding the powers of the Chief Psychiatrist to install CCTV surveillance. We reaffirm that we understand that the only areas where the Commonwealth and State laws may conflict in this matter are for people with a mental illness in private mental health institutions, or psychiatric hostels.

(iii) Defences and Exemptions
The Mental Health Law Centre supports a defence of lawful authority. If our submission supporting the continuation of section 3 of the *Privacy Act 1988* (Cth) is not adopted, we submit that a defence of lawful authority would accommodate a new power of the Western Australia Chief Psychiatrist to install CCTV surveillance in all wards of all authorised hospitals and hostels subject to Cth laws, and in all places where patients are detained on referrals, which are subject to Cth laws.

We refer to clause10.17 of the Discussion Paper, and note that the ALRC welcomes stakeholder responses on the wording of this defence, with consideration to be given to whether or not the exception should be clarified. We refer to the 'principle of legality', cited in *Coco v R* whereby an abrogation of a fundamental right, freedom or immunity must be expressly authorised.[2]

We support the ALRC's recommendation that a defence of lawful authority would include 'authority under Commonwealth, state and territory acts and delegated legislation; a duty of confidentiality under common law or equity; an order of a court or tribunal; and documents that are given the force of law by an Act, such as industrial awards',[3] and would add a formal policy adopted by an agency and approved by the OIC.

(iv) Surveillance Devices
We refer to Proposal 12-1, which supports uniform surveillance device laws and workplace surveillance laws throughout Australia. The Mental Health Law Centre supports uniform surveillance device laws and workplace surveillance laws throughout Australia, whether by uniform state and territory surveillance laws or Commonwealth legislation that covers the field.

We submit that any uniform surveillance device laws should accommodate our earlier submission that CCTV surveillance should be implemented without any monitors or screens associated with the recording. Where ever

[2] *Coco v The Queen* [1994] HCA 15 [8]-[9].
[3] ALRC, *For Your Information: Australian Privacy Law and Practice*, Report 108 (2008) [13.44].

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appropriate the distinction must be made, as the breach of privacy laws in the interest of safeguarding protected person might be much more palatable in the absence of monitors/screens, which enable voyeuristic viewing and/or as substitute for proper observation. In order to protect the privacy of people who are in private mental health institutions or Cth funded psychiatric facilities, CCTV surveillance should only be available to authorised persons in order to assist investigations or misconduct or criminal activity. We refer you to our **enclosed** submission to the Mental Health Commission for further discussion of this matter.

We **enclose** a copy of our submission to the WA EOC Commissioner, which further expands on the difficulties people with mental illness experience especially in relation to stigma and discrimination, and in ensuring the law and policy distinguish between the needs of people with a mental illness and people with an intellectual disability, by way of providing a background to this submission.

We thank you for the opportunity to prepare a submission.

Yours faithfully
Mental Health Law Centre

SANDRA BOULTER
Principal Solicitor
General Manager

Enc. Mental Health Commission submissions, dated 6 May 2014
EOC submission 1 April 2014

MENTAL HEALTH LAW CENTRE (WA) Inc.
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Our Ref: SB NCW 731

8 May 2014

Commissioner Tim Marney
Mental Health Commission
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Dear Commissioner Marney

TOWARDS A UNIFORMLY GOOD STANDARD OF CARE IN AUTHORISED PSYCHIATRIC HOSPITALS AND HOSTELS

COMPETING RIGHTS TO PRIVACY AND PROTECTION FROM HARM:
CCTV - with audio and no screens/monitors - in authorised hospitals and hostels

Upholding the rights of involuntary mental health patients or a breach of privacy?

What does Mental Health Bill 2013 need?

1. Background

You will note our previous submissions on CCTV surveillance. That submission has now been reviewed pro bono by an external law firm which specialises in privacy and confidentiality and this submission adopts that advice.

As you will note from the Stokes Report[1], the recent Coroner's Reports[2], the Annual Reports of the Council of Official Visitors and the MHLC's many submissions[3] on the

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[1] Professor Bryant Stokes, AM, 'Review of the admission or referral to and the discharge and transfer practices of public mental health facilities/services in Western Australia'(Review, Government of Western Australia Mental Health Commission and Department of Health, July 2012) 108

[2] Kevin Maxwell COLLINS
http://www.coronerscourt.wa.gov.au/_files/Collins_Kevin_finding_2014.pdf

Luke Isaac FORKIN
http://www.coronerscourt.wa.gov.au/_files/Forkin_finding_2014.pdf

Tom FOSKI
http://www.coronerscourt.wa.gov.au/_files/Foski_finding_2014.pdf

Amanda Alison GILBERT
http://www.coronerscourt.wa.gov.au/_files/Gilbert_Amanda_finding_2014.pdf

Ritchie GORDON
http://www.coronerscourt.wa.gov.au/_files/Gordon_Ritchie_finding_2014.pdf

Gregory Laurence HUNT
http://www.coronerscourt.wa.gov.au/_files/Hunt_finding_2014.pdf

Aaron Luke PRISGROVE
http://www.coronerscourt.wa.gov.au/_files/Prisgrove_finding_2014.pdf

Sarah Jane RUTHERFORD
http://www.coronerscourt.wa.gov.au/_files/Rutherford_Sarah_finding_2014.pdf

Robert Kenneth SCOTT
http://www.coronerscourt.wa.gov.au/_files/Scott_Robert_2014.pdf

Antoinette WILLIAMS
http://www.coronerscourt.wa.gov.au/_files/Williams_Antoinette_2014.pdf

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various iterations of the WA Mental Health Bill, one of the core issues facing the mental health services and involuntary patients is the variable standard of care delivered to involuntary patients, the absence of clearly defined uniform expected standards of care and service delivery, and where there is such a standard, the lack of independent uniform enforcement of such standards[4].

The other issue impeding a uniformly high standard of care is a cultural one – resistance to change - within some of the services[5], and as one very frustrated treating psychiatrist said to me in the past of one authorised hospital, it is a "basket case". Our experience with many of our clients places the standard of care delivered to them in a similar category.

It is unlikely that the new Mental Health Act can resolve the cultural and systemic issues around the variable service delivered by the mental health service to involuntary patients, without more.

One policy decision that could, and in our opinion is likely to, lead to far reaching improvements in the standard of the delivery of service in involuntary hospitals is the introduction of wide ranging closed circuit television (CCTV) with audio recording. This should be implemented in all places in all wards of all authorised hospitals and hostels, and in all places where patients are detained on referrals, but WITHOUT any monitors or screens associated with the recording.

Amend the MH Bill 2013 at clause 543 to include in the duties of the Chief Psychiatrist to develop standards for the CCTV surveillance in all authorised hospitals and hostels to which patients have access.

The submission below outlines the relevant applicable privacy and confidentiality laws.

In the alternative, while the MHC may not yet be in a position to decide whether or not uniform CCTV surveillance will achieve what this submission proposes and enforce it by statutory means in the MH Bill 2013, it is nonetheless important that it be ensured that it is lawful. Accordingly, we propose the following amendment to the powers of the Chief Psychiatrist (CP) to include the power to install CCTV surveillance, as the CP decides necessary and to ensure that any existing CCTV surveillance is lawful and not in breach of patient and staff privacy.

Amend the MH Bill 2013 to include at page 360 a new section 546 A.

The Chief Psychiatrist may require installation of Closed Circuit Television Surveillance Recording Devices in any place and any room where patients are detained under the Mental Health Act or to which detained patients have access, notwithstanding the provisions of any other law.

2. Submission Overview

In this submission, the Mental Health Law Centre (the Centre) explores the use of closed circuit television cameras (CCTV) in authorised hospitals to reduce the incidence of poor standards of care and even worse, abuse. The Centre proposes that CCTV surveillance recording be independent of the mental health service private and secured off-site to minimise loss of footage or misuse of information.

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[3]Based on our legal advocacy experiences, see www.mhlcwa.org.au
[4] See footnote 1above
[5] See footnote 1 above

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CCTV is used in the public areas of hospitals such as entries, waiting rooms and thoroughfares. The level of coverage may depend on each hospital's resources.

It might be argued, in our opinion, that the use of CCTV as we propose is an invasion of an individual's right to privacy.

This submission:

- addresses some of the reasons for and against the use of CCTV in authorised hospitals;
- outlines applicable statutory provisions in Western Australia protecting involuntary patients;
- outlines the law relating to privacy and confidential information in Australia;
- briefly discusses evidentiary issues; and
- recommends how CCTV could be used in authorised hospitals to balance the patients' competing rights of privacy and protection against harm, in an attempt to address the very real power imbalance between the patient and the service, especially behind locked doors.

3. Reasons for and against the use of CCTV in authorised hospitals

(a) Reasons Against

(i) More intense scrutiny could lead to defensive practice and a fettering of discretion.

Response

CCTV is a means for employers and proprietors to discharge and be seen to discharge their duty of care to provide safe workplaces for employees, and to safeguard their patients and other users of mental health services. While there may sometimes be a fine line between restraint and assault[6] there are adequate protections both in civil law[7] and criminal law[8] to discriminate fairly between the two. It is a matter of evidence.

(ii) The use of CCTV is a breach of patients' privacy.

Response

Whether or not there might be a breach of privacy committed by the use of CCTV in authorised hospitals will depend on the specific circumstances in question and on future developments in the law of privacy in Australia. The collecting party may be subject to obligations as to how personal information is collected, used and disclosed, if it is subject to privacy legislation.

In addition, the *Mental Health Act 1996* (MH Act) makes the disclosure of personal information unlawful except in certain specified circumstances. Processes can be introduced to address these obligations by requiring all

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[6] "Assault" includes striking, touching or otherwise applying force of any kind, directly or indirectly, with or without the other person's consent under such circumstances that the person attempting or threatening assault has actually or apparently a present ability to effect his/her purpose: WA *Criminal Code*, s 222

[7] In negligence, the test includes whether or not the defendant reached the requisite standard of care for that particular act or omission, and so takes into consideration the circumstances of the case.

[8] For example, s 259 *Criminal Code* provides that one is not criminally responsible for administering medical treatment in good faith and with reasonable care and skill for the other person's benefit.

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CCTV surveillance footage be delivered off-site to a secure location to prevent its misuse or improper application as a patient management tool.

Furthermore, if CCTV is adopted as a matter of policy, this could provide a defence under the section 206 defence to the *Mental Health Act 1996* (WA)[9] confidentiality obligations under section 206(2)(a).

(iii) It is argued that surveillance of patients through features such as CCTV cameras is a means through which patients are supervised and/or managed, thereby resulting in impeding building 'therapeutic relationships' with nurses and doctors.[10]

Response

However, this risk will not eventuate in our proposed application of CCTV cameras. The CCTV cameras are not a substitute for supervision and contact by nurses or doctors because monitors/screens would not be used.

(b) Reasons For

(i) The installation of CCTV in public and private areas of hospitals could protect patients against criminal neglect, and physical and sexual abuse.

The Council of Official Visitors is authorised under the MH Act to ensure, among other things, that involuntary patients are aware of their rights, that places in which they are detained are safe and suitable, and to inquire into and resolve complaints. In 2010-11, there were 2,690 people detained in WA under the MH Act.[11] The Council of Official Visitors received the following number of complaints in that one year:

- 24 for rough treatment ;
- 36 for incompetent treatment (but not negligent treatment);
- 25 for negligent treatment;
- 3 for discrimination;
- 3 for sexual impropriety;
- 3 for sexual violation;
- 9 for physical assault;
- 3 for unprofessional conduct;
- 15 for inadequate response to a complaint;
- 5 for reprisal following a complaint; and
- 21 for fraud.[12]

In 2012-13, there were 2,627 people detained in WA under the MH Act.[13] The Council of Official Visitors received the following number of complaints in that one year:

- 37 for rough treatment;

[9] And the equivalent provisions in the MH Bill 2013
[10] Clemence Due, Kathleen Connellan, Damien Riggs, 'Surveillance, Security and Violence in a Mental Health Ward: an ethnographic case-study of an Australian purpose-built unit' (2012)
[11] Annual Report 2010-11, Council of Official Visitors, Western Australia, p 58
[12] Annual Report 2010-11, Council of Official Visitors, Western Australia, pp 84-89
[13] Annual Report 2012-13, Council of Official Visitors, Western Australia, p 50

- 16 for Seclusion and Restraints;
- 102 Complaints about dignity, privacy and staff attitude; and
- 20 for serious issues.[14]

Below are some examples of abuse in mental health wards:

- In 2010, 27 year old mentally ill, Mr Lyji Vaggs, went to Townsville Hospital on the advice of a mental assessment team who first saw him at his home. After being told there was no room for him, Mr Vaggs became agitated. Security staff and police were called to restrain him. Witnesses saw him being sat on and laid upon by up to six security officers or orderlies, injected 3 times with anti-psychotic drugs and handcuffed. Mr Vaggs lapsed into respiratory failure and died. The consultant said it was "probably because of the restraints." The hospital had no CCTV records even though the incident occurred in a reception area. An inquest found that the combination of the sedation and restraint directly led to Mr Vaggs death.[15]

- In 2010 in Quebec City Canada, a patient sued a mental hospital for keeping him in isolation for almost 1,200 hours (over 3 months) with no bathroom or light.[16]

- On 1 October 2012, a 46 year old man was charged with raping a 60 year old grandmother in her hospital bed at the West London Mental Health Trust. The Police said the investigation was hampered because CCTV was not in operation at the time of the incident.[17]

(ii) The use of CCTV could lead to successful prosecutions for ill-treatment or neglect of patients.

We conducted an electronic search to ascertain how many prosecutions there had been pursuant to section 162 of the MH Act (offence of ill treatment), and we found none. In light of the limited resources in the context of the mental health system, particularly relating to the shortage of staff[18], the deterrent effect provided by CCTV surveillance could help the supervision of patients needed for the purpose of preventing abuse if only as a deterrent.

(iii) There may be a culture of secrecy or defensive practices amongst the mental health services staff. The use of functioning CCTV could develop a culture of transparency and accountability. In the Coroner's investigation into the death of Amanda Gilbert (a patient who was subject to sexual assaults at Graylands Hospital), it was found that following the funding for one-to one nursing care in 1997, there was an improvement in the deceased's care because the number of assaults were curtailed.[19] Evidently, an increase in the level of supervision leads to a reduction in the

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[14] Annual Report 2010-11, Council of Official Visitors, Western Australia, pp 84-89

[15] Information from "No CCTV of scuffle with mentally ill patient in Townsville Hospital", J Walker & T Koch, *The Australian*, 19 April 2010; "Family to sue hospital", B Baskin, *Townsville Bulletin*, 22 May 2010; "No one to blame in Vaggs death", R Johnson, *Townsville Bulletin*, 22 February 2012

[16] "Patient sues mental hospital for abusive isolation", M White, *Record*, 05 November 2010

[17] Information from "man arrested in hunt for hospital rapist", P Nettleton, *Evening Standard*, 1 October 2012 retrieved at www.dailymail.co.uk on 1 October 2012

[18] See footnote 1 above

[19]Coroner's Inquest into death of Gilbert, Amanda (Ref 50/12, 11 April 2014) 17 retrieved from http://www.coronerscourt.wa.gov.au/_files/Gilbert_Amanda_finding_2014.pdf on 28 April 2014.

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number of assaults committed. Although use of CCTV surveillance would not be a substitute for supervision (due to the absence of monitors), knowledge of the existence of CCTV cameras may act as deterrence to assaults.

A survey of mental health nurses, doctors and psychiatrists conducted in New Zealand found that 48% acted defensively in questioning patients about their safety.[20]

Below are some examples of systemic abuse facilitated by secrecy:

- The Maroondah Psychiatric Hospital in Melbourne covered-up allegations of sexual assaults over the course of a decade – it failed to report the rape of a 21 year old woman to Police, it failed to notify parents of a 15 year old in their care that she had been sexually assaulted and told a 20 year old patient who alleged that a male nurse had kissed and fondled her, and tried to force her to have sex that she should keep it quiet otherwise it might become "office gossip."[21]

- In 2004 in Victoria, one staff member was sacked and three were stood aside as the government investigated allegations of patient abuse and corruption in a mental hospital.[22]

- In 1996 in Massachusetts, Jason Davis alleged that he was physically assaulted by a mental health officer whom the Department of Mental Health knew had a criminal record for assault and battery. The officer applied a "head twisting technique with deadly force" and punched him 5 or 6 times with "extremely hard blows". The officer said to Davies, "you better shut up or you're going to get it."[23]

- In 1985 in the United States, the Justice Department investigated 14 psychiatric hospitals and ordered 3 to cease violations in relation to intimidation, violence and secrecy.[24]

- Importantly note must be taken of the recent Coronial Inquest into the death of Antoinette Williams[25]. Ms Williams was 19 years old when she died of an overdose of haloperidol administered by the treating team. The relevance of this case is that her nurse, who was left in charge of observing her, neglected his duties and as a result of this neglect Ms Williams died. If CCTV had been installed, it may have added some pressure on the nurse to actively check on Ms Williams, and this could have ultimately have saved her life. Unfortunately CCTV cameras were not there, and Ms Williams lost her life due to a nurse simply "peeking" at her through a window and fraudulently making up her vital signs so that the required observation appeared on her record to have been completed.

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[20] "Defensive practice in mental health", R Mullen, A Admiral, J Trevena, *The New Zealand Medical Journal,* Vol, 121, Issue 1286, 28 November 2008
[21] "Patient 'silenced' after sex abuse", R Baker & M McKenzie, *The Age*, 21 November 2011
[22] "Iemma reveals mental hospital abuse", *Illawarra Mercury*, 22 September 2004
[23] "Former hospital patient alleges abuse", *Telegram & Gazette Corporation*, 9 August 1986
[24] "Abuse Cited at States' Mental Facilities", *Los Angeles Times*, 2 April 1985
[25] Inquest into the death of Antoinette WILLIAMS, 25 February 2014

(iv) CCTV surveillance could also protect staff and patients. Nearly half of all workplace assaults occur in the health and community services industry.[26] CCTV recorded surveillance could assist in the prosecution of charges and equally in the defence against charges relating to assaults by patients against staff or other patients. A criminology study in the UK has found that knowledge of the operation of CCTV cameras had the effect of changing behaviours, and this included the desistance of an offender from offending.[27] It is possible that the same result could be achieved in the context of mental health patients' security procedures.

4. West Australian legislation and involuntary patients

In addition to the legislation protecting people such as the *Criminal Code*, the MH Act applies to voluntary and involuntary patients in public psychiatric hospitals and private hostels. Involuntary patients are those patients subject to MH Act orders detaining them in an authorised hospital or compelling them to accept treatment while living in the community.[28] Persons subject to such orders are those with a mental illness who require treatment to be provided to protect their health and safety, or that of another person; or to prevent the person from causing serious damage to property; and that person has refused or is unable to consent to treatment.[29]

The objects of the MH Act include that persons with a mental illness receive the best care and treatment, with the least restriction of their freedom and the least interference with their rights and dignity.[30] The Chief Psychiatrist (CP) currently has the responsibility for the medical care and welfare of all involuntary patients[31], although the CP delegates this responsible to clinical directors of services (who may or may not also be a patient's treating psychiatrist, and thus are in charge of their own oversight).

The specific provisions protecting involuntary patients from harm include prohibitions against:

- unauthorised psychosurgery, electroconvulsive therapy, deep sleep therapy, breach of which attracts up to 5 years' imprisonment;[32]
- unauthorised use of mechanical restraint, breach of which attracts $1,000 penalty;[33]
- ill-treatment or wilful neglect, breach of which attracts $4,000 fine or 1 year imprisonment.[34]

The complaints' procedure under the MH Act includes:

- requirement that patients or their carers be told of their rights;[35]
- provision for an "official visitor" to inspect, hear, resolve or refer complaints;[36] and

[26] Information from WorkSafe retrieved from www.commerce.wa.gov.au on 9 October 2012
[27] Jerry Warr, Mathew Page, Holly Crossen-White, 'The Appropriate Use of Closed Circuit Television (CCTV) Observation in a Secure Unit' (July 2005) 11 retrieved from http://eprints.bournemouth.ac.uk/11684/1/CCTV_report_6Jul05.pdf on 28 April 2014
[28] Section 3
[29] Section 26
[30] Section 5
[31] Section 9(1)
[32] Sections 99, 101 & 104
[33] Section 122
[34] Section 162
[35] Section 157

- that the Chief Psychiatrist report to the Mental Health Review Board on matters concerning the medical care or welfare of involuntary patients.[37]

The *Health and Disability Services (Complaints) Act 1985* (WA) (HDSC Act) provides that complaints relating to the unreasonable provision of a health service may be made by users and carers to the Health and Disability Services Complaints Office.[38]

The guiding principles of the HDSC Act include respect for the privacy and dignity of all persons receiving health care.[39] The Director of HaDSCO can refer the matter to negotiation,[40] conciliation,[41] obtain information, investigate premises[42] or issue a notice to remedy.[43] If the provider does not comply with the notice and the Director considers that the provider ought to have, the Director must compile a report, which is tabled before both Houses of Parliament.[44]

CCTV surveillance evidence would go a long way towards reducing the power imbalance that exists between patients and staff, which imbalance often goes to acceptability and credibility of patients' evidence.

5. Is there a general right to privacy?

(i) Overview

In Australia, it is not clear whether there is a "right" to privacy at common law. There is a separate equitable action to protect misuse of confidential information which has, in certain limited circumstances, been applied to address a breach of privacy.

Commonwealth and State legislation sets out provisions as to when personal information be obtained, how it must be stored, when it may be released and when persons can be subject to surveillance devices.

CCTV surveillance is currently used in public places in WA with little restriction simply because there is no legislation prohibiting it. However, for those entities operating CCTV, which are subject to Federal or State privacy legislation, a recent decision has highlighted the position there are a number of difficulties in operating CCTV in public spaces in compliance with privacy legislation.[45]

A central issue in determining whether or not personal information may be collected through CCTV surveillance is in relation to determining whether or not the individuals have consented to the collection, or the collecting party is otherwise authorised to collect the information; and whether or not they are permitted to use and to disclose the information for the contemplated purpose.

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[36] Section 188
[37] Section 10(d)
[38] Section 6, 19 & 25
[39] Section 4(d)
[40] Division 3A
[41] Division 3
[42] Part 4
[43] Section 50
[44] Section 52A
[45] SF v Shoalhaven City Council [2013] NSWADT 94

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(ii) Common law

At common law, there are two causes of actions enabling personal information or confidential information to be protected:

a. the tort of invasion of privacy and equitable breach of confidence; and/or

b. equitable breach of confidence.

While an equitable action for breach of confidence is well recognised, the existence of a tort of privacy as a cause of action in Australia is uncertain and may not be recognised.

a. Tort of Privacy

In the decision of *Australian Broadcasting Corporation v Lenah Game Meats Pty Ltd* (2002) 208 CLR 199, the High Court indicated that a general right of privacy could exist in particular circumstances. However, the High Court did not go so far as to declare the elements of such a tort.

Subsequent various divergent decisions in the other state courts have left uncertain whether there exists a tort of privacy.[46]

While the Western Australian Supreme Court is not bound by the decisions of other state courts, the recent decision *Sands v State of South Australia* [2013] SASC 44 by the Supreme Court of South Australia indicated that further developments are required before a tort of privacy is recognised. Further, there is no tort of privacy which has yet been recognised by the Supreme Court of Western Australia. A High Court decision is required before such a tort is confirmed.

Adding to the uncertainty as to the existence of a tort of privacy at common law, on 12 June 2013, the Attorney General Mark Dreyfus QC announced an inquiry into the protection of privacy in the digital era.[47] The Australian Law Reform Commission is directed by the terms of reference to inquire into, and report on, the prevention of serious invasions of privacy in the digital era. Within the scope of the terms of reference is the design of a statutory cause of action for serious invasions of privacy, including: legal thresholds; fault elements; damages; defences; exemptions; limitation periods; standing; and court ordered and other legal remedies.[48] The ALRC will complete its final report by June 2014.[49] This may be relevant for future considerations as to the issues raised in this submission.

b. Breach of confidence

In Australia, the equitable action for breach of confidence has been used to restrain breaches of privacy.

[46] See *Grosse v Purvis* [2003] QDC 151; *Grosse v Purvis* [2003] QDC 151; *Jane Doe v Australian Broadcasting Corporation* [2007] VCC 281

[47] Attorney-General's Department (Cth), 'Protecting Privacy in the Digital Era' (Media Release, 12 June 2013) <http://www.attorneygeneral.gov.au/Mediareleases/Pages/2013/Second%20quarter/12June2013-Protectingprivacyinthedigitalera.aspx>

[48] Commonwealth Attorney-General's Department, *Terms of Reference – Serious Invasions of Privacy in the Digital Era* (2013) <http://www.attorneygeneral.gov.au/Mediareleases/Documents/Termsofreference120613.pdf>

[49] Ibid

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Whether or not information is confidential is a question of fact in each case.[50]

For information to be subject to an obligation of confidence, the information must be:

- of a confidential nature and not a matter of common knowledge;[51] and
- not in the public domain.[52]

A breach of confidence occurs when a person uses, discloses or copies any confidential information for any purpose, other than that purpose the confidential information was reasonably intended by the information or impliedly or expressly authorised, and such use is to the detriment of the person who originally communicated the confidential information ("the Confider").[53] In such an event, equity will restrain any threatened abuse[54] and publication of confidential information improperly or surreptitiously obtained, or of information imparted in confidence, which should not be divulged.[55]

Relief has been given to the Confider where the use of information has caused only nominal damage to the confider.[56] Damage has been taken to include embarrassment,[57] loss of privacy[58] and fear of physical harm.[59]

It is arguable that the proposed CCTV footage will capture information of a personal nature pertaining to involuntary patients, such as symptoms of their mental and/or physical condition, which could be considered to be confidential information.

c. Commonwealth legislation

The *Privacy Act 1988* (Cth) (Privacy Act) regulates "personal information" of individuals. The Privacy Act has recently undergone amendments, which became effective on 14 March 2014.

The Privacy Act applies to the collection of personal information (including sensitive information) by an organisation only if the information is collected for inclusion in a record or a generally available publication.

"Personal information" is defined as information or an opinion, whether true or not, and whether recorded in a material form or not, about an identified individual, or an individual who is reasonably identifiable.

"Sensitive information" is a sub-category of personal information, and is defined to include information about an individual's racial or ethnic origin,

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[50] *Wright v Gasweld Pty Ltd* (1991) 22 NSWLR 317 at 334
[51] eg *Castrol Australia Pty Ltd v EmTech Associates Pty Ltd* (1980) 33 ALR 31; *Flamingo Park Pty Ltd v Dolly Dolly creation Pty Ltd* (1986) 65 ALR 500
[52] *Schindler Lifts Australia Pty Ltd v Debelak* (1989) 89 ALR 275
[53] *Corrs Pavey Whiting & Byrne v Collector of Customs (Vic)* (1987) 14 FCR 434, at 443
[54] eg *Castrol Australia Pty Ltd v EmTech Associates Pty Ltd* (1980) 33 ALR 31; *Flamingo Park Pty Ltd v Dolly Dolly Creation Pty Ltd* (1986) 65 ALR 500
[55] *Commonwealth v John Fairfax & Sons Ltd* (1980) 147 CLR 39, at 50
[56] *Interfirm Comparison (Aust) Pty Ltd Law Society of New South Wales* [1975] 2 NSWLR 104
[57] *Pollard v Photographic Co (1888)* 40 Ch D 345
[58] *Foster v Mountford* (176) 14 ALR 71
[59] *G v Day* [1982] 1 NSWLR 24

health information or biometric information. Health information is defined broadly to include information about the health or a disability of an individual.

A "record" is defined as including a document or an electronic or other device.

A "document" is defined broadly to include any record of information, whether it is in writing, images, or photograph.

Surveillance footage of involuntary patients or any individual in the hospital wards will be personal information, and is likely to constitute sensitive information, when it reveals health information about an individual.

The Privacy Act applies to Commonwealth and Australian Capital Territory government agencies, which are subject to the IPPs under the current Act.[60] The Privacy Act does not apply to State or Northern Territory government agencies. Thus it does not apply to authorised psychiatric hospitals but it does apply to psychiatric hostels.

The Australian Privacy Principles (APPs) apply to private sector organisations defined as including individuals, body corporates, partnerships, trusts or unincorporated associations but not a State or Territory Authority or prescribed State or Territory instrumentality or small business.[61] State or Territory Authority includes a State Department, a body established under State law or by State governor, person performing duties for an office established under State law.[62]

While the majority of mental health hospitals in Western Australia are public hospitals, and therefore are not be subject to the Privacy Act, the Privacy Act is relevant for any private hospitals and Commonwealth funded psychiatric hostels in Western Australia.

When the Privacy Act is applicable, the collecting party must comply with the obligations as to how it handles CCTV surveillance recording of an individual under the applicable APPs. APPs applicable to the proposed CCTV surveillance recoding activity include:

(a) collection of personal information[63]

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[61] *Privacy Act 1988* (Cth) s. 6C; Small business defined at s 6D including those whose turnover is less than $3M and expressly excludes health services: s 6D(4)b

[62] *Privacy Act 1988* (Cth)s. 6C

[63] *Privacy Act 1988* (WA) – Schedule 3: Australian Privacy Principles

1. <u>Collection</u>

1.1 An organisation must not collect personal information unless the information is necessary for one or more of its functions or activities.

1.2 An organisation must collect personal information only by lawful and fair means and not in an unreasonably intrusive way.

1.3 At or before the time (or, if that is not practicable, as soon as practicable after) an organisation collects personal information about an individual from the individual, the organisation must take reasonable steps to ensure that the individual is aware of:

a. the identity of the organisation and how to contact it; and

b. the fact that he or she is able to gain access to the information; and

c. the purposes for which the information is collected; and

d. the organisations (or the types of organisations) to which the organisation usually discloses information of that kind; and

e. any law that requires the particular information to be collected; and

f. the main consequences (if any) for the individual if all or part of the information is not provided.

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The CCTV surveillance recording of patients in mental health facilities may reveal sensitive information, including evidence of any health conditions. Therefore, the collecting party would be subject to the restrictions relevant to the collection of sensitive information, the most relevant of which is to only collect such information with the consent of the individual except in limited circumstances. One of the relevant circumstances where collection without consent is permitted is where collection is required by law.

It is unclear as to who has authority to provide consent on behalf of an involuntary patient who does not have capacity to consent/refuse. The Chief Psychiatrist has responsibility for the medical care and welfare of all involuntary patients. Even on the assumption that the Chief Psychiatrist has the authority to provide consent on behalf of the involuntary patients to surveillance, any surveillance of the nature proposed would require consent on behalf of all the involuntary patients, which would only be effective for as long as it was maintained. In addition, consent would be required of all voluntary patients, and there is some doubt whether consent is truly obtained in circumstances where the consent provided by a patient is required before the State will provide medical treatment and facilities to that person.

The collecting party must also ensure that the personal information is collected by a lawful and fair means, and not in unreasonably intrusive way, and take reasonable steps to notify individuals that it has collected their personal information. It is questionable whether surveillance could be undertaken in the manner proposed in this submission in a way, which is considered not to be unreasonably intrusive (no matter how justifiable).[64]

Another issue to consider is that personal information of employees of the relevant facility will also be collected. If the personal information is collected by the employer, the employer would be exempt from the obligations relating to collection, use and storage of the employee's personal information. [65]

(b) Use and disclosure [66]

1.4 If it is reasonable and practicable to do so, an organisation must collect personal information about an individual only from that individual.
1.5 If an organisation collects personal information about an individual from someone else, it must take reasonable steps to ensure that the individual is or has been made aware of the matters listed in subclause 1.3 except to the extent that making the individual aware of the matters would pose a serious threat to the life or health of any individual.

[64] Accordingly, to prepare the way for CCTV Surveillance in authorised hospitals and psychiatric hostels the MH Act and the MH Bill should provide for this should it be considered desirable in the future

[65] Relevant employment contracts should provide for and note this.

[66] Australian Privacy Principles: *Privacy Act 1988* (Cth), Schedule 3

2.1 An organisation must not use or disclose personal information about an individual for a purpose (the secondary purpose) other than the primary purpose of collection unless:

a. both of the following apply:

i. the secondary purpose is related to the primary purpose of collection and, if the personal information is sensitive information, directly related to the primary purpose of collection;

The collecting party is permitted under the Privacy Act to use and disclose the CCTV surveillance recording for the primary purpose of collection, namely, monitoring the patients, preventing any unlawful activity against the hospital patients, and identifying any parties subject to that unlawful activity. In addition, the collecting party is entitled to use and disclose the CCTV surveillance footage if it has reason to suspect that unlawful activity has been, is being or may be engaged in, and uses or discloses the personal information as a necessary part of its investigation of the matter or in reporting its concerns to relevant persons or authorities.

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ii. *the individual would reasonably expect the organisation to use or disclose the information for the secondary purpose; or*

b. *the individual has consented to the use or disclosure; or*

c. *if the information is not sensitive information and the use of the information is for the secondary purpose of direct marketing:*
   i. *it is impracticable for the organisation to seek the individual's consent before that particular use; and*
   ii. *the organisation will not charge the individual for giving effect to a request by the individual to the organisation not to receive direct marketing communications; and*
   iii. *the individual has not made a request to the organisation not to receive direct marketing communications; and*
   iv. *in each direct marketing communication with the individual, the organisation draws to the individual's attention, or prominently displays a notice, that he or she may express a wish not to receive any further direct marketing communications; and*
   v. *each written direct marketing communication by the organisation with the individual (up to and including the communication that involves the use) sets out the organisation's business address and telephone number and, if the communication with the individual is made by fax, telex or other electronic means, a number or address at which the organisation can be directly contacted electronically; or*

d. *if the information is health information and the use or disclosure is necessary for research, or the compilation or analysis of statistics, relevant to public health or public safety:*
   i. *it is impracticable for the organisation to seek the individual's consent before the use or disclosure; and*
   ii. *the use or disclosure is conducted in accordance with guidelines approved by the Commissioner under section 95A for the purposes of this subparagraph; and*
   iii. *in the case of disclosure the organisation reasonably believes that the recipient of the health information will not disclose the health information, or personal information derived from the health information; or*

e. *the organisation reasonably believes that the use or disclosure is necessary to lessen or prevent:*
   i. *a serious and imminent threat to an individual's life, health or safety; or*
   ii. *a serious threat to public health or public safety; or*

e. *ea. if the information is genetic information and the organisation has obtained the genetic information in the course of providing a health service to the individual:*
   i. *the organisation reasonably believes that the use or disclosure is necessary to lessen or prevent a serious threat to the life, health or safety (whether or not the threat is imminent) of an individual who is a genetic relative of the individual to whom the genetic information relates; and*
   ii. *the use or disclosure is conducted in accordance with guidelines approved by the Commissioner under section 95AA for the purposes of this subparagraph; and*
   iii. *in the case of disclosure the recipient of the genetic information is a genetic relative of the individual; or*

f. *the organisation has reason to suspect that unlawful activity has been, is being or may be engaged in, and uses or discloses the personal information as a necessary part of its investigation of the matter or in reporting its concerns to relevant persons or authorities; or*

g. *the use or disclosure is required or authorised by or under law; or*

h. *the organisation reasonably believes that the use or disclosure is reasonably necessary for one or more of the following by or on behalf of an enforcement body:*
   i. *the prevention, detection, investigation, prosecution or punishment of criminal offences, breaches of a law imposing a penalty or sanction or breaches of a prescribed law;*
   ii. *the enforcement of laws relating to the confiscation of the proceeds of crime;*
   iii. *the protection of the public revenue;*
   iv. *the prevention, detection, investigation or remedying of seriously improper conduct or prescribed conduct;*
   v. *the preparation for, or conduct of, proceedings before any court or tribunal, or implementation of the orders of a court or tribunal.*

Breaches[67] of the Privacy Act are investigated by the Information Privacy Commissioner who can investigate breaches and facilitate conciliation and settlement.[68] The Commissioner can make a determination with which an organisation must comply[69] and if the organisation does not, the determination may be enforced in the Federal Court or Federal Magistrate's Court.[70] Relevantly, such a breach may include a serious or repeated interference with the privacy of an individual. An interference with the privacy of an individual includes an act or practice which breaches an APP. Under the Privacy Act, the civil penalty is 2,000 penalty units, which is $1.7 million for bodies corporate and $340,000 for individuals, for each breach.

The NSW decision of *SF v Shoalhaven City Council*[71] (Shoalhaven), which was considered by the NSW Administrative Decisions Tribunal (ADT), highlights the potential privacy issues in using CCTV surveillance recording in public places for the purposes of "crime prevention", which maybe analogous to the scenario contemplated by this submission. While Shoalhaven is concerned with the *Privacy and Personal Information Act 1998* (NSW) (PPI Act), and is not binding on a decision under the Privacy Act, it could provide some guidance for how particular provisions in the Privacy Act are interpreted.

In particular, the ADT's interpretation of the PPI Act, section 11, which addresses an entity's obligation to collect personal information in a manner, which is, "*fit for purpose, is not excessive, and is accurate, up to date and complete*" should be considered in the context of the equivalent APP provisions. In particular, the requirement under the APPs to collect personal information in a manner, which is "*reasonably necessary for, or directly related to one or more of the entity's functions or activities*" may be interpreted similarly to the requirement to collect information in a manner which is not "*excessive*".

In *Shoalhaven,* the ADT held that the collection of the Applicant's personal information by way of a 24 hour video recording by the Shoalhaven City Council was "excessive", where such collection was for the purpose of "crime prevention". Relevantly in relation to this submission, the ADT held that the vast majority information collected was "collateral information" and so the Applicant's personal collected information was considered not to be necessary and was held to be "excessive" for this purpose. In making the decision, the ADT accepted evidence that CCTV surveillance did not assist the Shoalhaven City Council in crime prevention and that in that case, the CCTV was of such quality that it was not possible to identify any persons of interest for the purposes of crime prevention.

The ADT held that the Applicant's information collected by the Shoalhaven City Council was "not relevant" for the purpose of crime prevention.

Thus it is uncertain as to whether or not, had the ADT accepted the evidence that the collection of personal information would assist in crime prevention, the ADT would have decided that collecting the Applicant's personal information would be collateral or necessary in fulfilling the overall purpose (though it appears difficult to understand how the use of CCTV

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[67] *Privacy Act 1988* (Cth)s. 6A – 6BA
[68] *Privacy Act 1988* (Cth) s. 23A
[69] *Privacy Act 1988* (Cth) s. 52
[70] *Privacy Act 1988* s. 55A
[71] *SF v Shoalhaven City Council* [2013] NSWADT 94

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surveillance for crime prevention could otherwise practically operate, without constant surveillance). If this reasoning is followed in a decision under the Privacy Act, it may be held that constant surveillance is in breach of the relevant APP. [72]

Part VI of the Privacy Act gives the Privacy Commissioner the power to make a Public Interest Determination that an act or practice of an Australian or ACT Government agency, or a private sector organisation, which might constitute a breach of an APP or an approved privacy code, shall be not be a breach of the principle or approved code for the purposes of the Act.

(iv) WA State legislation

Western Australia does not have specific state-based privacy legislation, unlike other states in Australia. [73]

The *Surveillance Devices Act 1998* (WA) (the SD Act) prohibits the installation, use or maintenance of listening, tracking and optical surveillance devices by a person to record or observe a "private activity" or "private conversation".[74] Individuals in breach of these provisions are liable for a $5,000 fine or 12 months imprisonment, or both; and corporations are liable for a $50,000 fine.[75]

The SD Act prohibition does not apply to installation, use or maintenance of surveillance devices in areas, which are reasonably expected to be an area where there is a "private activity" or a "private conversation" if it is:

(i) In accordance with a warrant or emergency authorisation;[76]

(ii) authorised under Commonwealth law;[77] or

(iii) in the "public interest".[78] "Public interest" is broadly defined. The definition includes, "the protection of public health and the protection of rights and freedoms of citizens."[79]

There is an exception to the SD Act prohibition if the use of the optical surveillance device was recorded or observed unintentionally. The scope of the reasonable expectation for privacy as a prohibition on surveillance is accordingly uncertain but clearly does not apply if there is no expectation of privacy.

A "*person who has under his or her care, supervision or authority*" a child or protected person who is a principal person to a private activity may, on behalf of the child or protected person, use an optical surveillance device to record visually or observe the private activity if there are reasonable grounds for believing that the use of the listening or optical device will contribute towards the protection of the best interests of the child or protected person; and is in the public interest. [80] A hospital/hostel patient is

[72] See footnote 65 above
[73] Although there are a number of statutory privacy and confidentiality provisions in a number of State Acts.
[74] Surveillance Devices Act 1998 (WA), section 3
[75] Surveillance Devices Act 1998 (WA), Section 5-7
[76] Surveillance Devices Act 1998 (WA) ss 6(2)(a) and s6(2)(b)
[77] Surveillance Devices Act 1998 (WA) ss5(2)(c) and 6(2)(c)
[78] Surveillance Devices Act 1998 (WA) ss 5(2)(d) and 6(2)(d)
[79] Surveillance Devices Act 1998 (WA) Section 24
[80] Surveillance Devices Act 1998 (WA) Sections 26 & 27

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a protected person if they are, by reason of mental impairment, unable to consent to the use of a surveillance device.[81]

The phrase "*a person who has under his or her care, supervision or authority*" could arguably apply to the Chief Psychiatrist who could authorise optical and/or listening surveillance devices to be used in authorised hospitals and psychiatric hostels, providing that such use is in the public interest.

Accordingly, subject to any other applicable laws, and if the Chief Psychiatrist has such authority to consent on behalf of involuntary patients or otherwise obtain the consent of patients, then under the SD Act, surveillance devices could be used to monitor the patients in the authorised hospitals to contribute towards the protection of the best interests of patients and is in the public interest by:

- raising the standard of care of outpatients;
- reducing the influence of the power imbalance when credibility of evidence is at issue, for example following assaults and/or rude behavior;
- reducing harm against staff;
- reducing harm against patients;
- preventing/inhibiting the occurrence of a "Serious Incident"[82];
- promoting a more efficient resolution of complaints against staff or patients; and therefore
- better using court/Tribunal time; and
- better using public monies.

However, the ability to rely on the protected person exemption is dependent on the use of the surveillance device being lawful. Accordingly, if the surveillance is a tort (of invasion of privacy), breaches the Privacy Act or constitutes a breach of an equitable duty of confidence, then the SD Act exemption cannot be relied upon.

Furthermore, the CCTV surveillance recording of patients (or staff) taken in authorised hospitals would be classified as confidential information under the MH Act. The MH Act prohibits a person from divulging any personal information obtained by reason of any function that person has in the administration of that Act. The prohibition has exceptions including disclosure in the course of duty (which may include reporting on a matter concerning the medical care or welfare of involuntary patients)[83], for lawful purposes[84] or for investigating a suspected offence.[85]

6. Evidentiary issues facing CCTV use

General

The admissibility of the evidence of visual images as evidence also needs to be considered. Clearly, it would be futile if surveillance footage from authorised

[81] *Surveillance Devices Act 1998* (WA) section 27(4)
[82]See also "**Serious Incidents and Unexpected Deaths**" at http://www.chiefpsychiatrist.health.wa.gov.au/reporting/incidents.cfm.
[83] *Mental Health Act 1996* (WA) s.10(d)
[84] *Mental Health Act 1996* (WA) s.206(2)(b)
[85] *Mental Health Act 1996* (WA) s.206

hospitals and hostels could not be used in criminal prosecutions arising from offences of neglect, physical or sexual harm; in civil actions for damages or to help investigate a complaint.

The first test in determining admissibility is relevance. Irrelevant evidence is excluded.[86] The classification of evidence will determine which evidentiary rules apply to it. Visual recordings or digital images could be classified as real evidence or documentary evidence.[87]

Real evidence

A surveillance recording could be admitted as real evidence because it assists the testimony given by witnesses[88] or be probative evidence in its own right.[89]

Documentary evidence

A surveillance recording could also be admitted as documentary evidence including any disk, tape, recorded track or film or negative.[90]

Documentary evidence is an exception to the hearsay rule.[91] The weight and effect of evidence admitted as an exception to the hearsay rule is determined by s 79D[92]. Considerations include the reliability of the device from which the information was obtained and the reliability of the means by which it was produced.[93]

Other

Additionally, the court has discretion to exclude evidence that is relevant and otherwise admissible if:

- in criminal cases, its prejudicial effect would outweigh its probative value[94] in the sense that the accused's rights to proper procedure is protected;[95]
- in civil cases, it is only remotely relevant;[96] and

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[86] *Hollington v F Hewthorn & Co Ltd* [1943] KB 587 at 594; *Papakosmas v R* (1999) 196 CLR 297
[87] *Evidence Act 1906* (WA) s.79B
[88] *Ex parte Sampson; Re Governor of Her Majesty's Penitentiary at Malabar* [1966] 1 NSWR 305
[89] *R v Sitek* [1988] 2 Qd R 284
[90] *Evidence Act 1906* (WA), s.79B
[91] *Evidence Act 1906* (WA), s.79C(3)(a)
[92] *Evidence Act 1906* (WA): S 79D

79D .Evidence admitted under s. 79C, weight and effect of

(1) In estimating the weight, if any, to be attached to a statement rendered admissible as evidence by section 79C regard shall be had to all the circumstances from which any inference can reasonably be drawn as to the accuracy or otherwise of the statement, and, in particular —

(a) to the question of whether or not the statement was made contemporaneously with the occurrence or existence of the facts stated; and

(b) to the question of whether or not the qualified person or any person concerned with making or keeping the document containing the statement, had any incentive to conceal or misrepresent the facts; and

(c) to the question of whether or not the information in the statement was of a kind which was collected systematically; and

(d) to the question of whether or not the information in the statement was collected pursuant to a duty to do so; and

(e) where the statement wholly or in part reproduces or is derived from information from one or more devices, to the reliability of the device or devices; and

(f) where the statement reproduces or is derived from any information, to the reliability of the means of reproduction or derivation.

(2) For the purpose of any rule of law or practice requiring evidence to be corroborated or regulating the manner in which uncorroborated evidence is to be treated, a statement rendered admissible as evidence by virtue of section 79C shall not be treated as corroboration of the evidence given by the qualified person.

[93] *Evidence Act 1906* (WA), s 79D(1)(e)(f)
[94] *Evidence Act 1995* (Cth) s 137; *Evidence Act 1906* (WA) s.112
[95] *R v Swaffield* (1998) 192 CLR 159

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- in criminal and civil cases, it would result in an unfair trial as its reliability has been affected by the means in which it was procured[97].

In criminal prosecutions, illegally or improperly obtained evidence is not *prima facie* inadmissible but confers discretion on a judge to reject it.[98] The exercise of discretion involves balancing public policy considerations – the desire to convict and protect individuals from unlawful or unfair treatment,[99] and society's right to insist that those who enforce the law themselves respect it[100].

7. RECOMMENDATIONS

That the Mental Health Bill 2013 be amended as proposed above.

That the required standards within the Mental Health Bill 2013 Bill include the use of CCTV surveillance:

1. of patients in authorised hospitals, and the subsequent collection, use and storage of personal information from such surveillance; and

2. to collect, hold and use the personal information of patients in authorised hospitals to inhibit the risk and occurrence of harm to patients.

And that the Mental Health Commission (MHC):

1. obtains State Solicitor's advice about the legal position taken in this submission;

2. discusses with or seeks submissions from the Public Advocate on CCTV surveillance recording on the basis that she is the legal guardian of some involuntary patients;

3. discusses with and/or seeks submissions from the Inspector of Custodial Services as a similar need for CCTV may be warranted in prisons hospitals (if it is not already installed);

4. discusses with and/or require the Director of Health and Disability Services Complaints Office to prepare a report for the MHC about the proposal for the use of CCTV in authorised hospitals and hostels; and

5. obtains the evidence, which shows that CCTV surveillance prevents/inhibits the occurrence of harm to patients in authorised hospitals and hostels, and thus raises the standard of care of the patients

And once satisfied as to the above, that the MHC:

6. requires the Chief Psychiatrist to draft an appropriate CCTV standard that, at the very least, addresses all the issues in this submission, including restrictions regarding the extent to which CCTV cameras are installed, how the personal information collected may be collected, held and used, and the minimum quality requirements for the use of any such CCTV surveillance;

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[96] *Kennedy v Wallace* (2004) 208 ALR 424
[97] *McDermott v R* (1948) 76 CLR 501, at 513
[98] *R v Ireland* (1970) 126 CLR 321, at 335
[99] *R v Ireland* (1970) 126 CLR 54, at 75
[100] *Bunning v Cross* (1978) 141 CLR 321, at 335

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7. Obtains the required consents are provided to the Chief Psychiatrist or the collecting party so as to obtain consent from the legal guardians of patients in authorised hospitals, to allow the collecting party to collect, hold and use the personal information in the manner proposed in this submission, for the purposes of preventing the occurrence of harm to patients in authorised hospitals, where that is necessary;

8. Pursuant to the SD Act, requires the installation of CCTV (with sound and no monitors) in all authorised hospitals and psychiatric hostels, including in all places where patients in authorised hospitals interact or could interact with other patients or staff;

9. Enacting State legislation similar to NSW *Privacy and Personal Information 1988*, which among other things:

- applies to public sector agencies;
- applies to "personal information", which includes finger prints, body samples and genetic information[101] and "health information", which includes other personal information collected to provide a health service;[102]
- creates duty and offence provisions relating to misuse of personal information;[103]
- creates the position of an independent Privacy Commissioner who has the power to investigate breaches of that Act; and
- allows for the Administrative Decisions Tribunal to review investigations by the Privacy Commissioner;

10. Further considers:

- the extent to which CCTV should be used, that is, should it extend to bathrooms and toilets (perhaps at low level only or at the entrance to these places); and
- whether or not a submission should be made to the Office of the Australian Information Commissioner requesting that a Public Interest Determination be made for the use of CCTV cameras in all places authorised to detain persons under the MH Act to which the *Privacy Act* applies.

Please do not hesitate to contact me for any further comment or supplementary submissions that would be helpful.

Yours faithfully
Mental Health Law Centre

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[101] *Privacy and Personal Information Act 1998* (NSW) s.4
[102] *Health Records and Information Privacy Act 2002* (NSW) s.6(b)
[103] For example, a public sector agency must not disclose any personal information unless for the purpose of the register: s.57; corrupt disclosure and use: s,62; offering supply unlawfully obtained personal information: s.63

SANDRA BOULTER
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General Manager

MENTAL HEALTH LAW CENTRE (WA) Inc.
ABN 40 306 626 287

Our Ref: SB/AM NCW 944

1 April 2014

Public Sector Commission
Locked Bag 3002
WEST PERTH WA 6872

Via email: EOCReview@psc.wa.gov.au

***EQUAL OPPORTUNITY ACT 1984* (EO ACT)**
MENTAL HEALTH LAW CENTRE (WA) Inc. SUBMISSION

The Mental Health Law Centre is a community legal centre, which specialises in providing free legal advice and representation to people with a mental illness, when their legal problem is causally related to their legal issue. The main focus of our work is assisting patients who are involuntary under the provisions of the *Mental Health Act 1996*(WA) and mentally impaired accused persons who are subject to criminal charges, particularly those who are subject to the *Criminal Law (Mentally Impaired Accused) Act 1996* (WA).

BACKGROUND

Stigma

It has been widely reported that at least 20% of West Australians have a mental illness, and many are in need of treatment.

Stigma associated with mental illness is also widely recognised as creating an impediment to seeking treatment, as increasing the likelihood of a much higher incidence of physical illness and creating a general unwillingness to disclose the issue at work and with family.

"Stigma is severe social disapproval of personal characteristics or beliefs that are perceived to be against cultural norms"[1]

"One of the key effects of stigma is the development and reinforcement of myths and stereotypes" see health.nt.gov.au

Stigma against people with mental illness leads to misrepresentations of them as "violent, comical or incompetent": see sane.org/stigmawatch

Stigma around mental illness in Australia is widespread and systematic in a broad of reach of areas such as:

1. Political – Mental health services receive little political attention and are not a priority area

[1] Goffman, Erving. *Stigma: Notes on the management of spoiled identity*. Simon and Schuster, 2009.

2. Funding allocation – Australia spends 8% of the health budget on mental health comparable to OECD countries 12% or more in terms of proportion.

3. Planning and Service delivery – National decision making on mental health services is poorly coordinated while other health areas are given higher priorities.

4. Professional – mental health professionals are focused on treating people when acutely ill. Some services treat patients with a mental illness and their families in a disrespectful manner.

5. Legislative/justice – *Disability Discrimination Act 1992* does not protect people with a mental illness or other disability from vilification, as it protects other groups in society such as on religious and racial grounds: see sane.org/stigmawatch/stigmawatch

Three out of four people with a mental illness report that they have experienced stigma.

Stigma is a mark of disgrace that sets a person apart. When a person is labelled by their illness they are seen as part of a stereotyped group. Negative attitudes create prejudice, which leads to negative actions and discrimination.

Stigma brings experiences and feelings of:

- shame
- blame
- hopelessness
- distress
- misrepresentation in the media
- reluctance to seek and/or accept necessary help.

Families are also affected by stigma, leading to a lack of support. For mental health professionals, stigma means that they themselves are seen as abnormal, corrupt or evil, and psychiatric treatments are often viewed with suspicion and horror: (www.mentalhealth.wa.gov.au)

Statistical Studies

A 2006 Australian study found that,

- nearly 1 in 4 of people felt depression was a sign of personal weakness and would not employ a person with depression
- around a third would not vote for a politician with depression
- 42% thought people with depression were unpredictable
- one in 5 said that if they had depression they would not tell anyone
- nearly 2 in 3 people surveyed thought people with schizophrenia were unpredictable and a quarter felt that they were dangerous

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- Some groups are subjected to multiple types of stigma and discrimination at the same time, such as people with an intellectual disability or those from a cultural or ethnic minority. (mentalhealth.wa.gov.au)

Research conducted by the WHO found:[2]

- around one in five adult Australians has some form of mental health issue; and
- 27% of people between 16 and 24 years have a mental health issue.

Statistics given by Professor Ian Hickie from Mental Health Council of Australia:[3]

- Only 38% of people with a mental health problem get any treatment in a 12 month period;
- For other health disorders the figure is estimated to be between 70-80% in a 12 month period; and
- Only 1 in 6 people with depression receive effective treatment.

Statistics taken from survey undertaken by the Centre of Mental Health Research (published on 6th February 2005) from a nationally representative survey of stigma:

- 21% of people said they would be unwilling to work closely with someone who has depression;
- 34% of people said they would not be willing to work with someone who has schizophrenia;
- 30% of people said they would be unwilling to vote for a politician with depression;
- 46% of people said they would be unwilling to vote for a politician with schizophrenia; and
- 70% of people thought that other people would not be willing to work with someone with depression.

(biomedcentral.com/content/pdf/1471-244x-5-9.pdf)

Mental Health WA: 2006 Study

- 66% of people thought people with schizophrenia were unpredictable; and
- 42% of people thought that people with depression were unpredictable.

National Survey of Mental Health and Well Being Study 2002:

- People with a psychotic illness are often victims of violence;
- 15.3% of people with a psychotic disorder did not feel safe in their present neighbourhood; and

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[2] World Health Organisation (2008). The global burden of disease: 2004 update.

[3] Commonwealth, *Parliamentary Debates*, Senate - Select Committee On Mental Health, 19 May 2005 (Professor Ian Hickie, Mental Health Council of Australia)

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- 17.6% of people with a psychotic disorder reported having been physically assaulted, beaten, molested, or otherwise a victim of violence in the previous 12 months.

The Government of Western Australia Mental Health Commission reports:

- Three out of four people with a mental illness report that they have experience stigma;
- Nearly 1 in 4 people felt depression was a sign of personal weakness and would not employ a person with depression;
- Around a third would not vote for a politician with depression;
- 42% thought people with depression were unpredictable;
- One in 5 said that if they had depression they would not tell anyone; and
- Nearly 2 in 3 people surveyed thought people with schizophrenia were unpredictable and a quarter felt that they were dangerous.

(mentalhealth.wa.gov.au/about_mental/mh_stigma.aspx as at August 5, 2010)

SUBMISSIONS

Application of the EO Act to mental illness

Part IVA of the EO Act makes it unlawful to discriminate on the basis of impairment, subject to limited exceptions.

Section 4 of the EO Act defines "impairment" as one or more of the following conditions —

> ***impairment*** in relation to a person, means one or more of the following conditions —
>
> (a) any defect or disturbance in the normal structure or functioning of a person's body; or
>
> (b) any defect or disturbance in the normal structure or functioning of a person's brain; or
>
> (c) any illness or condition which impairs a person's thought processes, perception of reality, emotions or judgment or which results in disturbed behaviour,
>
> whether arising from a condition subsisting at birth or from an illness or injury and includes an impairment —
>
> (d) which presently exists or existed in the past but has now ceased to exist; or
>
> (e) which is imputed to the person;

The EO Act definition of impairment is broad enough to cover any mental illness. Mental illness can impair thought processes, perception of reality, emotions or judgment, or result in disturbed behaviour.

It must be noted that, due to the EO Act s4, subsection (d), persons who have experienced and recovered from a non-chronic mental illness would also properly fall under the definition of a person with an "impairment".

Implications of the Application of the current Act to mental illness

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It is important to note that the term "mental illness" is an umbrella term as wide as "physical illness". It is not necessarily impairing or disabling. It is stigmatising to infer or provide for this.

Some mental illnesses such as depression are treatable and often temporary (if treated successfully) and which result in no chronic impairment/disability. Other mental illness such as schizophrenia and bi-polar disorder tend to be chronic but these illnesses can still be well-managed with good treatment. Many people suffering from these illnesses live successful and independent lives.

Mental illness must be distinguished from other, in some cases more, permanent intellectual impairments and disabilities, which may or may not be successfully managed: for example a permanent Intellectual Disability.

Stigma surrounding mental illness is a continuing issue.

People who have experienced a mental illness continue to be labelled insultingly as "psycho", "mad", "crazy" and/or "weak" with associated hand gestures and body language sadly familiar to us all.

This is true also of people who have experienced a mental illness in the past with no ongoing impairment. Stigma produces lack of understanding of and empathy with people with a mental illness.

Sadly, even people who have not experienced a mental illness can experience insults that they have a mental illness, because the labeller knows how much the stigma makes the insult.

The objects of the EO Act are listed in s 3 and include:

> (a) to eliminate, so far as is possible, discrimination against persons on the ground of sex, marital status or pregnancy, family responsibility or family status, sexual orientation, race, religious or political conviction, impairment, age, publication of relevant details on the Fines Enforcement Registrar's website or, in certain cases, gender history in the areas of work, accommodation, education, the provision of goods, facilities and services and the activities of clubs; and
>
> ...
>
> (d) *to promote recognition and acceptance within the community of the equality of persons ... regardless of their ... impairments...*

The *Oxford Concise Medical Dictionary* defines the word "impairment" as a cause of a "handicap" or "disablement". The *Macquarie Dictionary* (5th Edition) defines "impaired" as "denoting that the human function specified or implied is damaged or reduced in capacity".

Generally, the word "impairment" is understood to relate to a disability. A definition of "impairment", which includes all mental illnesses suggests that if someone has experienced, or is experiencing the signs and symptoms of a mental illness, they are impaired or disabled, or that they have some kind of reduction in their capacity to make decisions, which may or may not be true.

We submit that, by effectively prescribing in the EO Act all mental illnesses as "impairments", the EO Act tends to foster discrimination against people with a

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mental illness instead of helping eliminate discrimination and stigma of mental illness.

Elimination of discrimination and stigma on the basis of mental illness will be achieved in our society when mental illnesses are approached with the same understanding and attitudes to the attitudes to physical illness. We would not classify chronic physical illnesses, which do not result in impairment/disability as impairments. We should not classify mental illness, which are not currently disabling as impairments but as a mental illness, the discrimination against which should be prohibited by the Act.

Suggesting that if someone has experienced, or is experiencing, a mental illness, they are impaired/disabled or that they have some kind of reduction in mental capacity is counter-productive in the area of anti-discrimination law as it fosters the inaccurate opinion and stigma of, and the myths and stereotypes around mental illness.

It is important that employers and service providers, who are bound by the EO Act are not encouraged by its terms to view mental illness as necessarily involving an impairment/disability, in the broad terms that the classification "impairment" engages.

SPECIFIC SUBMISSIONS

1. Separate Mental Illness from Mental Impairment

In light of the foregoing discussion, we submit that the definition of "impairment" contained in s 4 of the Act should be amended.

Defining whether or not a person has an "impairment" should and must depend on the circumstances of the individual, and not the cause or diagnosis. This is because, even if a person suffers from a chronic, serious mental illness such as Bipolar Disorder or Schizophrenia (illnesses which are impairing/disabling for many people), the illness may not be a cause of impairment in every person suffering from the illness (for example, if it is treated successfully).

We submit that the definition of "impairment" should expressly exclude mental illness and s4 be amended to include mental illness as defined in the Mental Health Bill 2013[4] currently being debated in parliament.

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[4] Mental Illness is defined in the:
Mental Health Act 1996 (WA) as:

4. Mental illness, defined

(1) For the purposes of this Act a person has a mental illness if the person suffers from a disturbance of thought, mood, volition, perception, orientation or memory that impairs judgment or behaviour to a significant extent.

(2) However a person does not have a mental illness by reason only of one or more of the following, that is, that the person —

(a) holds, or refuses to hold, a particular religious, philosophical, or political belief or opinion;

(b) is sexually promiscuous, or has a particular sexual preference;

(c) engages in immoral or indecent conduct;

(d) has an intellectual disability;

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Further, we submit that the Act should be amended to contain a separate Part titled "Discrimination on the Basis of Mental Illness". The content of this Part should be substantially similar to the content of Part IVA Impairment of the current Act but different where outlined in this submission.

Creating a separate part of the Act, which applies to mental illness eliminates the issue of labelling mental illnesses as "impairments". It also makes it clear to people applying the Act that if a person suffers from a mental illness, he or she is not necessarily impaired or disabled, but is still in need of anti-discrimination law.

2. Part 1VA Division 3

Division 3 should include another part "Community" under the new part, "Discrimination on the Basis of Mental Illness".

Many of our clients are victimised by neighbours and members of the community in which they live, calling them names relating to their mental illness

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(e) takes drugs or alcohol;
(f) demonstrates anti-social behaviour.

Mental Health Bill 2013 currently being debated in parliament and provides the following expanded definition of mental illness:

6. When a person has a mental illness

(1) A person has a mental illness if the person has a condition that —
  (a) is characterised by a disturbance of thought, mood, volition, perception, orientation or memory; and
  (b) significantly impairs (temporarily or permanently) the person's judgment or behaviour.
(2) A person does not have a mental illness merely because one or more of these things apply —
  (a) the person holds, or refuses or fails to hold, a particular religious, cultural, political or philosophical belief or opinion;
  (b) the person engages in, or refuses or fails to engage in, a particular religious, cultural or political activity;
  (c) the person is, or is not, a member of a particular religious, cultural or racial group;
  (d) the person has, or does not have, a particular political, economic or social status;
  (e) the person has a particular sexual preference or orientation;
  (f) the person is sexually promiscuous;
  (g) the person engages in indecent, immoral or illegal conduct;
  (h) the person has an intellectual disability;
  (i) the person uses alcohol or other drugs;
  (j) the person is involved in, or has been involved in, personal or professional conflict;
  (k) the person engages in anti-social behaviour;
  (l) the person has at any time been —
    (i) provided with treatment; or
    (ii) admitted by or detained at a hospital for the purpose of providing the person with treatment.
(3) Subsection (2)(i) does not prevent the serious or permanent physiological, biochemical or psychological effects of the use of alcohol or other drugs from being regarded as an indication that a person has a mental illness.
(4) A decision whether or not a person has a mental illness must be made in accordance with internationally accepted standards prescribed by the regulations for this subsection.

or their involuntary detention arising from their mental illness. This denigration and victimisation is particularly harmful to their stability, recovery and getting along with people in the community in which they live. This can arise simply because many people are ignorant about and/or scared of mental illness. The nature of some of the signs and symptoms of, or side effects of the treatment for their illness exacerbates the fact of and the impact of name calling and victimisation, and this is even known to some of the name callers.

Many involuntary patients or ex involuntary patients subject themselves to self-stigma as a result of the community stigma about treatment that is needed in the acute phase of their illness. Reducing the stigma in others will tend to reduce the tendency to self-stigma.

The vast numbers of people experiencing the debilitating impacts of mental illness need protection from the EO Act as one of the important elements of their recovery from this illness.

Conclusion

The EO Act has an opportunity to play a role in reducing the stigma and discrimination surrounding the diagnosis of and experience of mental illness.

The EO Act can be improved by clearly distinguishing permanent mental impairment from mental illness especially in the Long Title, s3(a) objects, s4 "impairment" definition, s4(4); and adding a new part after Part IVA called "Discrimination on the Basis of Mental Illness"; and introducing laws to prohibit harassment of someone with mental illness.

We endorse the submissions made by the Employment Law Centre and note we have not had the opportunity to review any other submissions.

Thank you for the opportunity to make this late submission.

Yours faithfully
Mental Health Law Centre

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