

A Case of Two Acts – the Rights of the Severely Mentally Ill and Forced Feeding

An Introduction

The case of *Re: Langham & Ors* [2005] QSC 127 reads like a case of simple statutory construction. However, its implications run very deep. The decision has far reaching impacts on the way the *Mental Health Act 2000* (Qld) (“the MH Act”) will operate in cases involving forced feeding, or, as it is technically known, artificial hydration and nutrition (ANH). It will also have the effect that the safe-guards contained in the *Guardianship and Administration Act 2000* (Qld) (“the GA act”) will not operate to protect the rights of the severely mentally ill in situations involving consent to health care.

Factual Background

The case concerned, Geoffrey Alan Langham (“Geoffrey”), currently aged 57 years, has been the subject of a forensic order under section 288 of the *MH Act 2000* since 25 August 1997, following a finding of unsoundness of mind in relation to criminal charges. Geoffrey has been detained as an inpatient of the high security unit of The Park Centre for Mental Health (the Park). Geoffrey has had treatment-resistant schizophrenia since the mid-1980s. This illness is characterised by grandiose and persecutory delusions featuring a persistent belief in a vast conspiracy against him which involves all psychiatrists who have treated him. Involuntary treatment has been enforced upon Geoffrey who has responded with extensive and at times life-threatening protests, predominantly, a refusal to eat and drink. His refusal to accept food is driven by a psychotic, psychiatric condition.

The Adult Guardian first provided health care consent on behalf of Geoffrey, as Statutory Health Attorney of last resort, on 20 June 2003. Geoffrey has refused all meals since April 2004, surviving on a “milky coffee” until July 2004. Between Easter and July 2004, his weight dropped from 94 kgs to 73 kgs.

On 22 July 2004, the Adult Guardian consented to the insertion of a nasogastric tube (NGT) for the purposes of giving artificial hydration and nutrition. This consent was pursuant to section 63(2) of the *Powers of Attorney Act 1998* (Qld) as statutory health attorney of last resort (in accordance with the statutory substituted decision maker regime). On 26 July 2004, Geoffrey was admitted to the Ipswich Hospital as his physical state deteriorated before the consent was acted upon. The NGT was inserted there and after five days he returned to the Park. From July 2004 to April 2005, Geoffrey has required ANH via various methods. Some methods required further hospitalisation and surgery at Ipswich hospital.

In February 2005, two applications were made to the Guardianship and Administration Tribunal (“the Tribunal”): an application for the appointment of the Adult Guardian as guardian and an application by the Adult Guardian for directions as to whether the artificial nutrition and hydration (“ANH”) being given against Geoffrey's will should be consented to under the *GA Act* or the *MH Act*.

On 6 April 2005, Geoffrey resumed normal feeding and drinking. This was as a result of a negotiated agreement that Geoffrey would not receive psychotropic

medication; would be given a television; and would be moved to another less restrictive ward.

The Framing of the Question

The Tribunal referred a number of legal questions to the Supreme Court of Queensland for consideration and answer. The chief issue was the question whether the provision of ANH to Geoffrey is properly to be considered as “treatment” under the *Mental Health Act 2000* such that a decision to give ANH is one which can be made pursuant to that Act. The alternative view of the matter was that the ANH constituted “Health care” under the *Guardianship and Administration Act 2000* such that a decision to give ANH is one which must be consented to by an appropriate person under that Act.

The question was considered important because of the different focus of the respective Acts: one directed, albeit with safeguards to treating the mentally ill. The other focussed, also with safeguards, on providing substituted decision making mechanisms for any person without intellectual capacity for those decisions.

Justice Chesterman’s Answer

The Court focused upon the construction question whether forcibly feeding Geoffrey was properly understood as “treatment” as that word, in for the purposes of the *MH Act*. An affirmative answer to that question meant that the question of forced feeding was dealt with and authorised by s.517 MH Act which provides as follows:

“517 Treatment of particular patients without consent and with use of reasonable force

- (1) This section applies to a patient under an involuntary treatment or forensic order.
- (2) Subject to chapter 4, part 3, division 2,¹ the patient may be treated for the person’s mental illness without the consent of the person or anyone else.
- (3) A person lawfully providing, or lawfully helping in providing, the treatment may use reasonable force to provide or help provide the treatment.”

In those circumstances, the consent of a guardian was not necessary and forced feeding was just another treatment option along with the question of what medication might be prescribed. If such feeding does not constitute treatment, then the consent of the Adult Guardian as default health attorney for Geoffrey would be necessary.

The schedule 2 Dictionary to the MH Act defines “treatment” as follows”

“‘treatment’, of a person who has a mental illness, means anything done, or to be done, with the intention of having a therapeutic effect on the person’s illness.”

In this context, Justice Chesterman treated the issue as a narrow question of construction. Is forced feeding properly thought of as intended to have a

¹ These sections provide certain restricted regimes for treatments such as seclusion, restraint, Electroconvulsive therapy and psychosurgery.

therapeutic effect on Geoffrey's illness. His reasoning appears from the following passage:

“Treatment must, I think, encompass more than those measures which are purely curative. To state the obvious, measures taken to address the symptoms of a disease are part of its treatment though their function is to reduce the patient's suffering and distress rather than to cure the disease. Measures taken to lower a fever or dull pain will not cure the underlying causes of those symptoms but are on any sensible view of what constitutes treatment, part of it. Palliative care given to a dying patient is treatment for the terminal stages of the disease, although the care will not arrest the course of the disease. If one must accommodate the position within the statutory definition of treatment it can be done. Treatment is anything done with the intention that it have a therapeutic effect. An effect will be therapeutic if it relates to, is connected with, measures taken to cure the disease. The alleviation of suffering is so connected.

Schizophrenia is the product of a malfunction of part of the brain, probably chemical in origin. The symptoms of the malfunction are, in this case, deluded thoughts. The existence and content of those thoughts can only be ascertained by the first respondent's behaviour which is shaped by the delusions, and by his explanation for his conduct. It is impossible to distinguish between the deluded thought and the action it generates. Both are symptoms of the schizophrenia.

The conduct in question, the fruit of the delusion, is the rejection of food and drink. To supply the first respondent with sustenance, even against his will, is to treat a symptom of his disease. It is therefore treatment as defined by the *MH Act*: it is done with the intention of alleviating his suffering, which is therapeutic”.

The respondents' argument leads to the conclusion that keeping a disturbed man alive is not treatment for his condition though it is the cause of the risk to his life. This is not only 'atomistic', it is gruesome.

His honour went on to find that ANH was “treatment” under the *MH Act* and, therefore, the substituted decision maker regimes for consent for people with impaired capacity in the *GA Act* do not apply.

Consideration and Comment

His honour's reasoning is plausible in the context to which he addressed himself. However, it is submitted that the decision fails to give proper weight to aspects of the statutory context which are not evident from the reasons. This has some disturbing implications for the way in which the mental health regime established by the *MH Act* will be administered in future. It is also suggested that the solution to the construction question fails to give sufficient weight to the common law presumptions against the taking away of common law rights, in this case, the right to refuse treatment.

We would suggest that the following provisions of the *MH Act* provide a context which might have led to a different solution to the construction question. First, section 4 sets out the purpose of the legislation as follows:

“4 Purpose of Act

The purpose of this Act is to provide for the involuntary assessment and treatment, and the protection, of persons (whether adults or minors) who have mental illnesses while at the same time safeguarding their rights.” (Emphasis added.)

Sections 8 and 9 set out a number of principles to apply to the way the Act is administered and its purpose achieved. They provide in part as follows:

“8 General principles for administration of Act

The following principles apply to the administration of this Act in relation to a person who has a mental illness—

(a) Same human rights

- the right of all persons to the same basic human rights must be recognised and taken into account
- a person’s right to respect for his or her human worth and dignity as an individual must be recognised and taken into account

(b) Matters to be considered in making decisions

- to the greatest extent practicable, a person is to be encouraged to take part in making decisions affecting the person’s life, especially decisions about treatment
- to the greatest extent practicable, in making a decision about a person, the person’s views and the effect on his or her family or carers are to be taken into account
- a person is presumed to have capacity to make decisions about the person’s assessment, treatment and choosing of an allied person

...

(f) Maintenance of supportive relationships and community participation

- the importance of a person’s continued participation in community life and maintaining existing supportive relationships are to be taken into account to the greatest extent practicable, including, for example, by treatment in the community in which the person lives

...

(h) Provision of treatment

- treatment provided under this Act must be administered to a person who has a mental illness only if it is appropriate to promote and maintain the person’s mental health and wellbeing

...

9 Principles for exercising powers and performing functions

A power or function under this Act relating to a person who has a mental illness must be exercised or performed so that—

- (a) the person’s liberty and rights are adversely affected only if there is no less restrictive way to protect the person’s health and safety or to protect others; and
- (b) any adverse effect on the person’s liberty and rights is the minimum necessary in the circumstances.” (Emphasis added)

It is suggested that the decision fails to give proper weight to the principles set out above. The decision to administer ANH is to be taken by the service (and its personnel) who has already enforced mental health treatment for the patient (by overriding their consent). These decisions are to be made without any external review or input of the kind that applies to other persons with impaired decision-making capacity under the legislative regime provided by the GA Act. This approach fails to respect the rights of the patient and separates the involuntary patient further from normality and community life than the statutory principles encourage or support.

Another issue arises as to the consonance of the construction of Justice Chesterman with the treatment criteria laid down by s.14 MH Act. Significantly, all treatment criteria must apply before involuntary treatment may be administered.²

14 What are the treatment criteria

- (1) The *treatment criteria* for a person, are all of the following—
 - (a) the person has a mental illness;

² For example, see ss.108 – 111 (involuntary treatment orders).

- (b) the person's illness requires immediate treatment;
- (c) the proposed treatment is available at an authorized mental health service;
- (d) because of the person's illness—
 - (i) there is an imminent risk that the person may cause harm to himself or herself or someone else; or
 - (ii) the person is likely to suffer serious mental or physical deterioration;
- (e) there is no less restrictive way of ensuring the person receives appropriate treatment for the illness;
- (f) the person—
 - (i) lacks the capacity to consent to be treated for the illness; or
 - (ii) has unreasonably refused proposed treatment for the illness. (Emphasis added)

An involuntary treatment order (pursuant to s.108 is to be revoked if the treatment criteria cease to apply (s.112(5)). They are then to be reviewed by an external body, the Mental Health Review Tribunal, at six weeks after being placed on the order, and then regularly at six monthly intervals, s.187.

In the present case, the unusual nature of ANH considered as a treatment for mental illness is highlighted by the fact that it could not be provided at the relevant mental health service as required by s.14 (c) MH Act in that Geoffrey had to be admitted to Ipswich Hospital in order to receive the application of the ANH. It is submitted that this is not a trivial point. The importance of meeting the treatment criteria was specifically referred to in the second reading speech of the Mental Health Bill, as it was “clearly inappropriate” to provide psychiatric treatment to conditions that are not mental illnesses, and conversely, therefore to authorise provision of non-psychiatric treatment within Mental Health services to people suffering from a mental illness.

Concluding Remarks

The decision involves the serious implication that the powers granted to impose involuntary treatment by the Act now extends to treatment that is not traditionally considered to be mental health treatment of which forced feeding is a particularly cogent example. To a very significant extent, this seems to derogate from the philosophy espoused in sections 4, 8 and 9 of the MH Act which purport to promote minimal interference with the rights of involuntary patients and a desire to respect those rights as much as possible. The absence of involvement of outside agencies which would occur through application of the GA Act means that involuntary patients will have a single agency having almost total control over their lives including in the administering of non-mental health involuntary treatment. The undesirability of this has been spelled out on many occasions including in the terms of the *Disability Services Act 1992* which provides in s.18 as follows:

“No single organization to exercise control over life of person with disability. Programs and services should be designed and implemented to ensure that no single organisation that is a service provider exercises control over all or most aspects of the life of a person with a disability.”

Another indicator of the unexpected nature of the decision and the undesirable nature of its impact is that it is in conflict with the MHA Statement of Patients Rights which states that involuntary treatment provisions do not apply to other health care or personal decisions. The person placed on in involuntary treatment order was considered to still retain the right to consent or refuse treatment.

The decision of *Langham* deserves to be thoroughly discussed by stakeholders in this area of service provision. Its implications need to be thoroughly understood so that appropriate policy input can be provided to those who advise governments. After a thorough discussion has occurred, thought may need to be given to legislative intervention which may be needed to restore what many thought to be the legal position.

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