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***Submission in response to the Mental Health and Wellbeing Act Engagement Paper***

1. Liberty Victoria welcomes the opportunity to provide comments on the proposed *Mental Health and Wellbeing Act* (**MHWA**). Liberty Victoria would also like to acknowledge the work engaged in by the Victorian Government to date in response to the final report of the Royal Commission into the Victorian Mental Health System (**RCVMHS**).

2. Liberty Victoria has worked to defend and extend human rights and freedoms in Victoria for more than eighty years. Since 1936 we have sought to influence public debate and government policy on a range of human rights issues. Liberty Victoria is a peak civil liberties organisation in Australia and advocates for human rights and civil liberties. As such, Liberty Victoria is actively involved in the development and revision of Australia's laws and systems of government.

3. The members and office holders of Liberty Victoria include people from all walks of life, such as legal practitioners, policy and advocacy experts, businesspeople, and students. More information on our organisation and activities can be found at: https://libertyvictoria.org.au.

4. As an organisation that seeks to advance civil liberties and human rights, Liberty Victoria's response to this Engagement Paper will focused on the civil liberties and human rights implications of the MHWA.

5. This submission should be read as extending to consumers who receive mental health services voluntarily, those who receive services compulsorily within hospital settings or the community, and those who receive mental health services in forensic settings (including prisons).

**Question 1: Do you think the proposals meet the Royal Commission's recommendations about the objectives and principles of the new Act?**

**Question 2: How do you think the proposals about objectives and principles could be improved?**

6. The provision of quality mental health treatment has the capacity to positively impact upon people experiencing mental illness. However, there are circumstances in which the provision of such treatment — and the provision of compulsory treatment in particular — has the capacity to significantly curtail the rights and freedoms of consumers. Accordingly, it is vital that promoting and protecting human rights should be a central focus of and underpin the framework of a reformed mental health system in Victoria.

7. The *Charter of Human Rights and Responsibilities Act 2005* (Vic) (the **Charter**) provides for several human rights that are engaged when a person traverses the mental health system. These rights include:

    a. the right to equality and non-discrimination (s8 of the Charter);

    b. the protection from torture and cruel, inhumane and degrading treatment (s10(a) and (b) of the Charter);

    c. the right against being subject to medical treatment with full, free and informed consent (s 10(c) of the Charter);

d. the right to privacy, which includes the right to personal autonomy, individual identity and personal development, personal and mental integrity and stability, and the inherent dignity of the person (s 13(a) of the Charter);[1]

e. the freedom of movement (s 12 of the Charter); and

f. the right to liberty and security (s 21(1) of the Charter).

8. The practical protection of human rights under the Charter is mainly ensured by s 38 of the Charter, which requires a 'public authority' to:

a. act in a way that is compatible with human rights (known as the 'substantive limb'); and

b. in making a decision, give proper consideration to a relevant human right (known as the 'procedural limb').

9. When a person exercises functions under the *Mental Health Act 2014* (the **MHA**), that person likely falls within the meaning of 'public authority'. For example, when an authorised psychiatrist is deciding whether to make a Temporary Treatment Order under the MHA, or when a clinician administers treatment compulsorily, both people are subject to s 38 of the Charter.

10. The human rights of mental health consumers are also protected under a range of international human rights instruments to which Australia is a signatory including, most significantly, the *Convention on the Rights of Persons with Disability* (**CRPD**). Relevantly, the CRPD provides, inter alia:

a. the right of persons with disability to equal protection and benefit of the law, without discrimination (art 5 of the CRPD);

b. the right of people with disability to enjoy their legal capacity on an equal basis with others, and to supportive measures to exercise that legal capacity (art 12 of the CRPD);

c. the right to liberty and security of person (art 14 of the CRPD);

d. the freedom from torture and inhuman treatment, exploitation, violence and abuse (arts 15 and 16 of the CRPD);

e. the right to respect for a person's physical and mental integrity on an equal basis with others (art 17 of the CRPD); and

[1] *Kracke v Mental Health Review Board* (2009) 29 VAR 1; [2009] VCAT 646, [619]–[620]

f. the right to enjoy the highest attainable standard of health without discrimination on the basis of disability (art 25 of the CRPD).

11. Other relevant instruments include the *Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, the *International Covenant on Civil and Political Rights*, the *International Covenant on Economic, Social and Cultural Rights* and the *Convention on the Rights of the Child*.

12. One of the stated aims of the proposed objectives is to ensure service providers, decision makers and the community are aware of and respect these rights and that a person is empowered to exercise these rights.

13. In Liberty Victoria's view, the proposed principles under the MHWA go some way to achieving this objective. However, the objective could be better achieved if the MHWA expressly requires decision-makers under the MHWA to consider and act compatibly with Charter rights. While this may seem duplicative or repetitive of what is already provided for in s 38 of the Charter, the inclusion of an express principle would state in the clearest of terms — and in a readily accessible way — that Charter-compliance is fundamental to decision-making and action-taking under the MHWA. This is important given that the most frequent users of the MHWA are not legally trained and may not understand the related operation of the Charter.

14. As the final report of the RCVMHS points out, one of the aspirations of the MHA was to modernise the provision of mental health services by imbedding supported decision-making and a recovery-oriented practice; effectively a more human rights compatible framework.[2] However, this aspiration to modernise remains largely unrealised. Despite the MHA having operated for six years, the RCVMHS found that:

a. the treatment criteria for compulsory treatment are not well understood or correctly applied by decision makers;

b. safeguards set out in the legislation, for example, advance statements and nominated persons, are not well known or commonly used by consumers, families, carers or supporters;

c. mental health practitioners are not complying with requirements under the MHA to seek informed consent of consumers before administering treatment and to presume that consumers have capacity to give informed consent; and

[2] State of Victoria, Royal Commission into Victoria's Mental Health System, Final Report, Volume 4: The fundamentals for enduring reform, Parl Paper No 202, Session 2018–21 (document 5 of 6), 23–26.

d. the mental health principles, which are meant to represent the fundamental beliefs and values underpinning treatment, care and support under the legislation, are yet to be embedded in clinical practice.[3]

15. Expressly embedding a principle that requires Charter-compliance within the MHWA would better ensure that human rights are understood, respected and promoted.

16. Liberty Victoria is also concerned that the requirement for service providers and decision-makers "make all reasonable efforts" to comply with the principles of the Act is an insufficient measure to ensure the objectives of the MHWA are achieved.

17. Presently, the MHA requires a person performing a duty or function or exercising a power under the MHA to "have regard to" the principles articulated under the Act. Merely 'having regard to' the principles has not translated into meaningful protection of consumer's rights.

18. Requiring decision-makers and action-takers to 'make all reasonable efforts' is unlikely to be a sufficiently robust standard and will similarly fail to achieve the systemic change required to reform the Victorian Mental Health System.

19. The substantive and procedural limbs of the Charter provide useful comparators to the test which ought to be applied. Under the substantive limb, actions may only be taken if they are substantively compatible with Charter rights subject to justifiable limitations under s 7 of the Charter. The procedural limb requires not just that 'regard to' Charter rights be given — those rights must be *properly* considered. This is a stronger test than the common law requirement of administrative decision-makers to 'take into account' relevant considerations. In effect, it requires decision makers "to do more than merely invoke the Charter like a mantra"; decision-makers must "seriously [turn] his or her mind to the possible impact of the decision on a person's human rights and the implications thereof for the affected person, and that the countervailing interests or obligations were identified."[4]

20. Liberty Victoria recommends that similarly robust tests are introduced so that human rights principles — including to act or to make decisions in a Charter-compatible way — are given proper effect.

[3] State of Victoria, Royal Commission into Victoria's Mental Health System, Final Report, Volume 4: The fundamentals for enduring reform, Parl Paper No 202, Session 2018–21 (document 5 of 6), 28.
[4] *Castles v Secretary to the Department of Justice* [2010] VSC 310; 28 VR 141, [186].

**Question 3: Do you think the proposals meet the Royal Commission's recommendations about non-legal advocacy?**

**Question 4: How do you think the proposals about non-legal advocacy could be improved?**

21. Liberty Victoria strongly supports the recommendation of an opt-out model of access to non-legal advocacy to consumers who are subject to or at risk of compulsory treatment.

22. Consumers who are treated compulsorily face the very real prospect of having their human rights limited. It is vital that they are able to access advocacy services to ensure that they are treated in a way that is consistent with the preservation of their human rights wherever possible.

23. While any person may theoretically access services such as the Independent Mental Health Advocacy service, various barriers may inhibit a person's ability to meaningfully access those services. Support in the form of non-legal advocacy is important. Non-legal advocates act on a consumer's instructions, and not their perceived 'best interest', which enables a person who requires support to express their views and more effectively participate in decision-making which affects their rights. The provision of this support is an important check on a system that overwhelmingly exists behind closed doors.

24. To improve the access to non-legal advocacy, the MHWA should ensure that non-legal advocates have similar rights and powers to legal advocates. This should include access to services and records, and the right of consumers to contact a non-legal advocate unimpeded.

25. It is our view that access to non-legal advocates should be a baseline requirement. There are also cases in which access to legal advocates are essential to a person's ability to meaningfully enforce their rights.[5] In such cases, it is vital that consumers have access to lawyers.

[5] State of Victoria, Royal Commission into Victoria's Mental Health System, Final Report, Volume 4: The fundamentals for enduring reform, Parl Paper No 202, Session 2018–21 (document 5 of 6), 397–399, Figure 32.7.

**Question 5: Do you think the proposals meet the Royal Commission's recommendations about supported decision making?**

**Question 6: How do you think the proposals about supported decision making could be improved?**

*Improving the use of statements of rights*

26. Self-advocacy is important to uphold consumer autonomy and ensure that consumers can exercise their rights. However, self-advocacy is meaningless if a consumer is unfamiliar with their rights or mechanisms about how to enforce their rights. The mere provision of a written statement of rights and an oral explanation about it is an insufficient minimum standard.

27. It is Liberty Victoria's view that the authorised psychiatrist should, in all instances, explain a statement of rights to consumers in a comprehensible way so that consumers can meaningfully understand their rights and, if desired, exercise them. In discharging this obligation, the authorised psychiatrist should be satisfied that the consumer has understood their rights or, if not so satisfied, that all reasonable steps have been made to assist a person to understand their rights.

*Supporting consumers to make treatment decisions*

28. Supported decision-making is (at least in theory) embedded into Divs 1 and 2 of Pt 5 of the MHA. For example, even where a person is subject to a valid treatment order, s 71(3) of the MHA establishes that compulsory treatment may only be provided if:

    a. the person does not give informed consent to the proposed treatment; and

    b. a psychiatrist is satisfied that there is no less restrictive way for a person to be treated other that the treatment proposed by the authorised psychiatrist.[6]

29. The starting point in such a decision is that a person is presumed to have capacity to give informed consent.[7] The test for determining if a capacity to give informed consent is outlined under s 68 of the MHA. Principles which are relevant include:

    a. a person's capacity to give informed consent is specific to the decision that the person is to make; and

    b. the person's capacity may change over time; and

[6] *Mental Health Act 2014*, s 71(1)–(3).
[7] *Mental Health Act 2014*, s 70.

c. a person should not be assumed to lack capacity only because oof their age, appearance, condition or behaviour; and

d. a person should not be assumed to lack capacity only because they make a decision which is considered to be unwise; and

e. capacity should be assessed at a time and in ana environment which allows the person's capacity to be assessed most accurately.

30. Further, to give informed consent, the person must be given adequate information about the decision to be made and be given a reasonable opportunity to make the decision.[8] In providing adequate information, the person must be able to ask questions and be provided with answers or other relevant information. Moreover, a reasonable opportunity to make the decision includes the opportunity to discuss the matters with a medical or other health professional, to obtain advice or assistance from another source, and to other supports.

31. Complying with these principles is more consistent with a supported decision-making model as it empowers the consumer to make (or not make) the decision. Compliance also best promotes a person's right to self-determination, personal autonomy and the dignity of recognition as recognised in *PBU & NJE v Mental Health Tribunal*.[9]

32. However, as reported in the RCVMHS final report, it is unclear to what extent authorised psychiatrists consider these provisions before administering treatment under s 71(3), because records of such decisions are not consistently made.[10] Other than the exposition of these principles, the MHA provides no guidance as to how informed consent is to be obtained in practice. Further, there is no independent oversight or monitoring as to the exercise of powers under s 71(3). Indeed, it is not within the purview of the Mental Health Tribunal to make decisions about treatment.

33. Liberty Victoria recommends that:

a. A clear framework be established for recording and monitoring of treatment decisions. This framework should be an obligation for treatment decisions to be recorded and reported where they are made without the informed consent of a consumer;

b. There should be greater guidance as to what is expected of authorised psychiatrists when treatment decisions need to be made including that all

[8] *Mental Health Act 2014*, s 69(1)(b) and (c).
[9] [2018] VSC 564
[10] State of Victoria, Royal Commission into Victoria's Mental Health System, Final Report, Volume 4: the fundamentals for enduring reform, Parl Paper No 202, Session 2018–21 (document 5 of 6), 406.

practicable steps be taken to enable consumers to make a treatment decision themselves;

c. It should be made clear that consumers are entitled to be afforded the dignity of having their views and beliefs respected, even if the authorised psychiatrist might consider them unwise. This includes treatment decisions which may involve a degree of risk, more time and/or involve non-pharmacological treatments (for example, counselling or psychology); and

d. It should be expressly stated that a perceived lack of insight into one's diagnosis or need for treatment is not be a proxy for deciding that a person cannot give informed consent to treatment.

*Enforcing advance statements and nominated person's directions*

34. Advance statements under the MHA enable a person to express their views and preferences about treatment. These statements, however, are not binding. The authorised psychiatrist is permitted to overrule the competent refusal of consent. The scope of the obligation under the MHA is to "consider" any advance statement before making a treatment decision.[11] However, as noted above, there is little evidence that this in fact occurs.[12] Again, this practice is not consistent with a person's right to self-determination, personal autonomy and the dignity of recognition.

35. The ability of an authorised psychiatrist to act contrary to the views expressed in an advance statement sits at odds with other laws such as the *Medical Treatment Planning and Decisions Act 2016* and the *Guardianship and Administration Act 2019*. Substituted decisions can only be made in respect of a person who is found to not have decision-making capacity for the relevant decision.[13] Advance care statements with instructional directives or instructions from a medical treatment decision-maker are binding and enforceable, and may only be overridden in very limited circumstances.[14] The difference between these laws and the MHA arguably shows a structural form of discrimination. That is, consumers who make advanced statement can be discriminated against on the basis of a mental illness contrary to the right to equality and non-discrimination under s 8 of the Charter.

[11] *Mental Health Act 2014*, s 71(4).
[12] State of Victoria, Royal Commission into Victoria's Mental Health hSystem, Final Report, Volume 4: The fundamentals for enduring reform, Parl Paper No 202, Session 2018–21 (document 5 of 6), 406.
[13] *Guardianship and Administration Act 2019*, s 30; *Medical Treatment Planning Decisions Act 2016*, ss 50, 58 and 63.
[14] See, eg, *Medical Treatment Planning Decisions Act 2016*, s 60.

36. Liberty Victoria recommends that advance statements made under the MHWA and the directions of nominated persons (made consistently with a consumer's instructions) should be binding. This will encourage the use of these modes of substituted decision-making, the uptake of which to date has been low. Only in limited circumstances should an authorised psychiatrist be able to overrule the competent refusal of consent.

*Second opinions*

37. An important safeguard of a consumer's rights is the ability to seek a second psychiatric opinion. However, a second opinion is not binding over an authorised psychiatrist.

38. If a second opinion is provided which is not consistent with the opinion of the authorised psychiatrist (either in respect of the treatment order or treatment decisions), the authorised psychiatrist is required to review the person subject to the treatment order and decide whether to adopt any of the recommendations contained in the second opinion. If the authorised psychiatrist disagrees with the second opinion, the psychiatrist must tell the consumer about their rights to apply to the Metal Health Tribunal for revocation of the treatment order or to the Chief Psychiatrist a review of the treatment (as the case requires). In the meantime, the treatment order continues and the consumer must continue to receive any compulsory treatment.

39. The existing framework unfairly places the onus on the consumer to apply for revocation of the treatment order or change to treatment decisions despite the existence of a second opinion to the contrary. Given a treatment order and compulsory treatment interfere with a person's human rights, the onus should shift to the authorised psychiatrist to prove that the treatment order should continue and/or that the proposed treatment should continue to be given.

40. Where a second opinion has been provided that recommends that the treatment criteria are not satisfied and/or the treatment should be revised (including because the consumer has capacity to give informed consent to treatment and is refusing such treatment), Liberty Victoria recommends that:

    a. the authorised psychiatrist must comply with the recommendations of the second opinion; and

    b. if the authorised psychiatrist does not agree with the second opinion, they should be required to apply to the Mental Health Tribunal to continue the treatment order or the Chief Psychiatrist to review the treatment decision.

**Question 7: Do you think the proposals meet the Royal Commission's recommendations about information collection, use and sharing?**

**Question 8: How do you think the proposals about information collection, use and sharing could be improved?**

41. In principle, Liberty Victoria supports the proposals concerning information collection, use and sharing insofar as it assists consumers and their advocates (both legal and non-legal) access their health information.

42. Given that the Engagement Paper does not set out what the information sharing system would look like, Liberty Victoria cannot offer any comment as to how the system could be improved. However, we wish to emphasis that all consumers should have the right to privacy and for their private and health information to be protected. Any system design should ensure that there are appropriate safeguards in place so that information is not disclosed without the informed consent of the consumer.

**Question 9: Do you think the proposals meet the Royal Commission's recommendations about reducing the use and negative impacts of compulsory assessment and treatment?**

**Question 10: How do you think the proposals about compulsory treatment and assessment could be improved?**

43. Compulsory treatment involves an interference with a person's human rights including the right to equality, the right to privacy, the right to liberty and security and, potentially in some cases, the protection from torture and cruel, inhuman, or degrading treatment. The right to the highest attainable standard of health is also engaged. Given the engagement with these rights, it is important that compulsory treatment be properly regulated and avoided as far as possible.

44. The RCVMHS final report, however, revealed some worrying statistics about the rate of treatment orders in Victoria, demonstrating the ineffectiveness of the MHA to reduce the use of compulsory treatment. In recent years, there has been an increase in the number of treatment orders made in Victoria. Many people remained on consecutive treatment orders for periods lasting longer than 12 months. The rate of acute separations that were involuntary was higher than the national average. Further, the used of Community Treatment Orders in Victoria was significantly higher compared to

most other states and territories.[15] These statistics reveal that reform is needed to reverse this trend of increased use of compulsory treatment in Victoria.

45. Human rights under the Charter can be limited if the limitation is reasonable and demonstrably justifiable taking into account:

    a. the nature of the right; and

    b. the importance of the purpose of the limitation; and

    c. the nature and extent of the limitation; and

    d. the relationship between the limitation and its purpose; and

    e. any less restrictive means reasonably available to achieve the purpose that the limitation seeks to achieve.

46. Accordingly, Victorian law permits the limitation of a person's human rights if the purpose of providing compulsory treatment is reasonable and demonstrable justifiable.

47. Liberty Victoria notes that there is an unresolved tension between the ongoing use of compulsory treatment and compliance with international human rights instruments, namely the CRPD. On some interpretations of the CRPD, compulsory mental health treatment in all its forms is not consistent with the right to legal capacity and must be prohibited in all its forms.[16] On other views, compulsory treatment may be consistent with human rights instruments if considerations about mental illness are removed and the focus shifted to general risk prevention, thereby resolving the discriminatory element of substitute decision-making laws relation to mental health treatment.[17] Such an approach, however, is likely to still be discriminatory, albeit in an indirect way.

48. Liberty Victoria recommends that, if compulsory treatment for mental illness is to remain in place, the preferrable approach is to use compulsory treatment as a last resort only, and only after all practicable steps to support a consumer to make a treatment decision and other less restrictive treatment options — especially non-pharmacological treatments — have been exhausted.

[15] State of Victoria, Royal Commission into Victoria's Mental Health System, Final Report, Volume 4: The fundamentals for enduring reform, Parl Paper No 202, Session 2018–21 (document 5 of 6), 384.
[16] Committee on the Rights of Persons with Disabilities, General Comment No 1, Article 12: Equal Recognition before the Law, 11th sess, UN Doc CRPD/C/ GC/1 (19 May 2014) (General Comment No 1).
[17] See, eg, John Dawson & George Szmukler, 'Fusion of mental health and incapacity legislation' (2006) 188(6) *The British Journal of Psychiatry* 504.

49. For this reason, Liberty Victoria mostly endorses the proposed changes to the criteria for compulsory treatment outlined in the Engagement Paper. However, Liberty Victoria makes two suggestions:

    a. "Serious distress" should be determined by reference to the consumer's subjective view; and

    b. "Serious harm" to the consumer should not be interpreted to mean 'serious deterioration of a person's mental health' as it is presently construed under the MHA. To do so would likely result in no change to the rate of compulsory treatment.

50. Liberty Victoria also recommends that special treatments, including electroconvulsive treatment, should remain regulated by separate provisions. Principles relating to supported decision-making and the rights of self-determination, personal autonomy and dignity of risk should inform the decision-making process for such treatments.

51. Finally, Liberty Victoria considers that the best way to avoid the use of compulsory treatment is to increase investment in early intervention, prevention and postvention services so that such services are accessible and provided in a timely manner. If done so successfully, the need for compulsory treatment would ideally be eliminated altogether.

**Question 11: Do you think the proposals meet the Royal Commission's recommendations about reducing the use and negative impacts of seclusion and restraint, and regulation of chemical restraint?**

**Question 12: How do you think the proposals about seclusion and restraint could be improved?**

52. Restrictive, or non-therapeutic, interventions — whether in the form of seclusion, physical or mechanical restraints, psychological or emotional restraint, and chemical restraints — represent a significant interference of a consumer's human rights. They restrict a person's freedom of movement and, in some cases, may constitute cruel inhuman or degrading treatment in breach of the Charter and various international human rights instruments.

53. Liberty Victoria is particularly concerned with the complete lack of definition of 'chemical restraint' under the MHA and any regulation and monitoring of its use on consumers of mental health services in Victoria. This can be contrasted with aged care and disability sectors which require the use of psychotropic medication to be recorded

and reported, and the mental health systems in some other jurisdictions including Tasmania, Queensland, South Australia and New South Wales.[18]

54. The evidence to the RCVMHS from consumers was that the medication they received was "over-sedating and unnecessary or part of a coercive approach to treatment". A significant number of complaints to the Mental Health Complaints Commission concerned the use of chemical restraints. The impact of chemical restraint can be significant. The effects may be psychological, traumatic and result in or exacerbate feelings of hopelessness.[19]

55. There is no reason in principle why the use of chemical restraint, like any other form of restraint, should be left undefined and unregulated. Effective regulation will ensure that the use of these interventions is only provided if they can be demonstrably justified, are reasonable, and represent the least restrictive option available in the circumstances.

56. Liberty Victoria supports the recommendation to define 'chemical restraint' and regulate its use. Chemical restraint should only be used as a last resort after exhausting all other less restrictive options. Supplementing this regulatory framework should be a requirement for service providers to record, monitor and report the use of chemical restraint to reduce — and ideally eliminate – this practice.

57. Liberty Victoria agrees that seclusion and all forms of restraint should be used only as a last resort with the aim of eliminating this practice. While a deadline for the elimination of the practice is helpful, a more ambitious target than 10 years to achieve this goal should be set.

**Question 13: Do you think the proposals meet the Royal Commission's recommendations about governance and oversight?**

**Question 14: How do you think the proposals about governance and oversight could be improved?**

58. Liberty Victoria does not propose to respond to the proposed governance and oversight structured as suggested in the Engagement Paper except to say that, consistent with what has been outlined above, compliance with a consumer's human rights and civil liberties should be an key component of any governance and oversight structure that is established.

[18] See State of Victoria, Royal Commission into Victoria's Mental Health System, Final Report, Volume 4: The fundamentals for enduring reform, Parl Paper No 202, Session 2018–21 (document 5 of 6), 334.
[19] State of Victoria, Royal Commission into Victoria's Mental Health System, Final Report, Volume 4: The fundamentals for enduring reform, Parl Paper No 202, Session 2018–21 (document 5 of 6), 332.