

# Submission to the Exposure Draft Mental Health Bill 2010

by the

**Mental Health Legal Centre Inc.**

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## Background:

The Mental Health Legal Centre Inc (**MHLC**) is a Victorian state-wide specialist community legal centre. It is a non-profit organisation run by an independent Committee of Management and receives the majority of its funding from the Victorian Department of Health and Victoria Legal Aid. In addition project funding has been secured from philanthropic and other funding sources for a range of projects.

The MHLC provides telephone legal advice and referral to callers from around Victoria, direct legal advocacy and community education about mental health and the law for people in Victoria with, or labelled as having, a mental illness. The MHLC also undertakes substantial research, law reform and policy work in relation to mental health and the law, the aim of which is to further the rights of people with mental illness in Victoria.

As one of only two specialist community legal centres in Australia for mental health law, the MHLC has developed significant expertise through its casework, research and law reform work, which has informed our submission.

Legal representation before the Mental Health Review Board for people subject to Community Treatment Orders constitutes the majority of casework undertaken by the Centre and a significant amount of all legal services, including advice (24%). Such representation is provided by employee lawyers as well as lawyers in private practice who volunteer as lawyers for the MHLC, supervised by the MHLC through the Pro Bono Justice Project. Approximately 15% of our overall legal services work (advice and casework) involves other issues relating specifically to Community Treatment Orders. Involuntary detention comprises 14% and complaints against health services constitutes 13%. Other common legal areas in which we assist clients are Guardianship and Administration matters, privacy and confidentiality of and access to health records and other information under Freedom of Information, and other complaints.<sup>1</sup>

The MHLC produces a substantial number of resources and publications which provide information to mental health consumers on their rights and the law in various areas, most notably, the *Patients' Rights* booklet, developed in collaboration with Victoria Legal Aid (VLA) – the most comprehensive information booklet for involuntary patients in Victoria. This publication is highly sought-after by people with a mental illness and others and copies stocked by mental health services.

We refer to our submission to the Review of the Mental Health Act (**MHA**) Consultation Paper (Consultation Paper), made in February 2009. This submission should be read in light of the recommendations we made at that time and, while we do not propose to repeat our submissions, we have highlighted our comments where relevant.

Other recent submissions and law reform and policy projects undertaken by the MHLC which are of particular relevance to this review include:

- Submission to the Department of Health Consultation Paper, *Because Mental health Matters*, May 2008
- *Lacking Insight* – report on the experiences of involuntary patients before the MHRB, Ingvarson, M, Topp, V and Thomas, M, October 2008

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<sup>1</sup> MHLC Annual Report 2008-09 financial year, p 57. Available at: [http://www.communitylaw.org.au/mentalhealth/cb\\_pages/images/Annual%20Report0809.pdf](http://www.communitylaw.org.au/mentalhealth/cb_pages/images/Annual%20Report0809.pdf)

- A multi-staged research project on advance directives for mental health involving consultation with consumers/users of mental health services and clinicians and other stakeholders to gauge their views on advance directives. The findings from the research are currently being written up with a view to making recommendations for reform in law and practice to ensure appropriate recognition and respect for advance directives for mental health.
- Submission to the Victorian Parliamentary Law Reform Committee (**VPLRC**) – Review of Powers of Attorney, September 2009
- Submission to the Victorian Law Reform Commission (**VLRC**) Information Paper on the Guardianship Reference, May 2010.

The information gleaned through these research projects, their findings and recommendations have informed the MHLC's submission to the bill.

We acknowledge the expertise, views and experiences of the mental health consumers who attended the MHLC's consumer forum on the Draft Bill in February 2011. The report from that discussion forum, *What consumers want from mental health laws* is appended to this submission at Appendix 1 and we have drawn on it as relevant.

We also acknowledge Allens Arthur Robinson lawyers for providing pro bono advice on the human rights implications of aspects of the draft bill.

With this background and expertise, we welcome the opportunity to make a submission to the Exposure Draft Mental Health Bill 2010 (**Draft Bill**).

## **Introduction:**

The MHLC's submission to the Consultation Paper highlighted the fact that people with a mental illness are often not afforded the same opportunities to exercise their human rights, nor the same protections against breaches of their human rights as other members of the community. We expressed our concern that the current Mental Health Act reinforces this discrimination and prejudice and stressed the need for the law to be consistent with the promotion and protection of the human rights of people with, or labelled as having a mental illness, on an equal basis with others.

We called for a holistic approach to capacity-based legislation and stressed the need for a paradigm shift in the way that mental health laws are conceived – moving away from legislation which focuses on a paternalistic approach of healthcare and decision-making based on a coercive and punitive model. Instead we called on the government to develop laws which empower people with a mental illness and protect and promote their rights to autonomy, dignity and bodily integrity through:

- enforceable advance directives, including respect for the appointment of a person authorised to make decisions (akin to an enduring power of guardianship) or be involved in decision-making;
- stronger regulation and accountability of restrictive practices, including ECT and restraint;

- abolition of anachronistic and punitive practices such as forced treatment for people who have the capacity to consent to or refuse treatment and who are refusing treatment, and involuntary seclusion;
- tightening the criteria for involuntary treatment; and
- requiring supported decision-making options to be explored and trialled to ensure that involuntary treatment is only used as a measure of last support;
- articulation and promotion of the rights of voluntary patients, including provision of a treatment plan if the person desires it;
- establishment of transparent, independent robust complaints and audit mechanisms with appropriate responsibility and accountability through appeal and penalty provisions;

It is imperative that the law fulfils these aims through its structure, form and substance.

Involuntary psychiatric treatment by definition engages a range of human rights enshrined in Victoria's Charter of Human Rights (**the Charter**) and the UN Convention on the Rights of Persons with Disabilities (**CRPD**), including:

- the right to autonomy on an equal basis with others (Art 12 CRPD) including the right to be free from medical treatment without consent (s10(c) Charter)
- Recognition and equality before the law (s8 Charter, Art 12 CRPD)
- the right to be free from torture and cruel, inhuman and degrading treatment (s10(a) and (b) Charter and Art 15 CRPD)
- the right to a fair trial, including the right to be heard without undue delay (s24 Charter)
- the right to liberty and security of person (s21 Charter and Art 14 CRPD)
- the right to humane treatment when deprived of liberty (s22 Charter)
- the right to privacy and bodily integrity (s 13 Charter and Art 17 CRPD)
- freedom of movement (s12 Charter)

Given the significant impact the legislation will have on a range of fundamental human rights, we echo the disappointment expressed in the Law Institute of Victoria's (**LIV**) submission, that the Government's Statement of Compatibility will only be made publicly available at the time the Bill is introduced to parliament.

## General comments

1. We welcome the introduction of a staged compulsory order scheme, but have significant doubts as to whether the scheme as it is structured will deliver greater rights protections for people with a mental illness. Despite changes to the names and maximum length of various orders and other minor changes to the process, we are of the view that the involuntary or compulsory treatment order regime remains largely the same and does not reflect a significantly greater promotion of rights than current practice.
2. These concerns are shared by many consumers, as evidenced by the findings of the report *What consumers want from new mental health laws*, based on a consumer forum

on the Draft Bill conducted by the MHLC in February 2011.<sup>2</sup> Our concerns are further magnified by what we believe to be an overall weaker system of independent review through the Mental Health Tribunal (**MHT**) both in terms of the frequency and procedure for automatic reviews, and appeal rights (renamed as applications for revocation).

3. Despite the resounding criticism in the community of the length of Victoria's initial "8-week" statutory review period - the longest period of any jurisdiction in Australia, it is deeply concerning that the Draft Bill contains, at best, no substantial improvement in review periods (7 weeks initially for inpatients) and, at worst, an alarmingly longer review (4 months or more for involuntary patients in the community, thereafter every 18 months). We reiterate our long-held position that it is no answer for the Draft Bill to rely on a person's right to appeal (renamed application for revocation) as sufficient accountability.
4. The introduction of the new role of Review Officers cannot redress this deficiency in the review safeguards. In our view Review Officers are problematic due to their lack of independence and the confusion in their qualifications and role. Such a scheme cannot be a substitute for judicial oversight and timely review of the compulsory order regime. Nor can they be a substitute for adequately funded legal advice and representation for people subject to compulsory psychiatric treatment.
5. The MHLC has long advocated for people with a mental illness to have greater control over decision-making in relation to psychiatric treatment and support, particularly in advance of a mental health crisis through an advance directive. To this end, we welcome the Draft Bill's recognition of a person's formal documentation of their wishes and preferences in a so-called 'advance statement'. We also welcome the acknowledgement of the person's right to nominate a person or persons to be involved in decision-making. We are disappointed however, that the Draft Bill gives only limited scope and scant weight to these issues, which are at the cornerstone of what many consumers see supported decision-making. In our view, without progressive robust legislative force for such mechanisms, the goal of supported decision-making cannot be realised.
6. We welcome the shift in the way that guardians carers and family members and others are consulted and their views and wishes taken into account. We are pleased to see the Draft Bill now consistently places the onus now on the treating staff to obtain the consent of the person themselves **before** this occurs.
7. We strongly support the introduction of a system of prior Tribunal authorisation before electro-convulsive therapy can take be performed. Victoria had lagged behind other jurisdictions in this respect. Although we recommend ECT only be performed where the person has given their full free and informed consent, it is important that a transparent, accountable system be developed to govern this invasive treatment.
8. We are also pleased to see the establishment of a separate Mental Health Commissioner with the power to investigate complaints including issuing of compliance

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<sup>2</sup> *What consumers want from new mental health laws*, MHLC, February 2011, Appendix 1, at p4-5.

notices. We are disappointed however that the independence of such a body, and hence the accountability of mental health services will be compromised by its position within the Victorian Department of Health. Critical to the success of any such body, we stress the need for adequate resourcing to enable it to fulfil its role with the necessary rigour and transparency.

9. The Draft Bill contains much aspirational content, yet the detail is complex and in some cases inconsistent – for example the various capacity tests articulated throughout. The risk is that, rather than clinicians and others being more robust in ensuring restrictions on rights are kept to the minimum necessary, are proportionate and reasonable, the status quo will remain. Overall, we share consumers’ scepticism about the ability of the Draft Bill to engender the paradigm shift in mental health service provision which the system desperately needs – from a focus on coercive treatment to a voluntary empowering and participatory system of holistic care and treatment.<sup>3</sup>
10. Our considered view is that the Draft Bill, while it makes some progress in discrete areas, by and large maintains the compulsory treatment regime as it currently stands. We are disappointed in particular that changes to the process and criteria for involuntary treatment and independent statutory review provisions have not resulted in meaningful reform to promote the right of people with mental illness to make their own decisions about their health and wellbeing, with the type and level of support they desire.

As Tina Minkowitz, psychiatric survivor and lawyer notes:

if reform cannot deliver any real improvement, it does not serve the purpose of social justice and instead functions as a junk substitute that deflects the energy of a movement and limits people’s imaginations.<sup>4</sup>

## Specific comments:

## Purpose, objectives and principles of the Bill

11. The purpose and objectives of legislation are critical in determining the way in which all other provisions should be interpreted. In particular, they outline the parameters for Charter compliant statutory interpretation by virtue of section 32 of the Charter which states:

(1) So far as it is possible to do so consistently with their purpose, all statutory provisions must be interpreted in a way that is compatible with human rights. (emphasis added)

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<sup>3</sup> See *What consumers want from new mental health laws*, (MHLC), February 2011, Appendix 1, p 3

<sup>4</sup> Tina Minkowitz (2010) ‘The Unfinished Business of liberation’ *New Paradigm*, Summer 2009-2010, 11-12, p 11.

They also determine the scope of permissible limitations on human rights pursuant to section 7 of the Charter.

12. As we outlined in our introduction, the Draft Bill necessarily impacts significantly on a person's human rights and, in our submission, it is imperative therefore that the principles, objects and purposes are drafted in language consistent with the CRPD and in particular reflect the General Principles at Article 3:

- (a) Respect for inherent dignity, individual autonomy including the freedom to make one's own choices, and independence of persons;
- (b) Non-discrimination;
- (c) Full and effective participation and inclusion in society;
- (d) Respect for difference and acceptance of persons with disabilities as part of human diversity and humanity;
- (e) Equality of opportunity;
- (f) Accessibility;
- (g) Equality between men and women;
- (h) Respect for the evolving capacities of children with disabilities and respect for the right of children with disabilities to preserve their identities.

13. In our view the Draft Bill is not consistent with Art 3 above and does not reflect the positive and empowering spirit and language of the CRPD which has widely been regarded as reflecting and driving a paradigm shift in recognition of the rights, autonomy and dignity of people with mental illness equally with other members of society.

## ***Purpose***

14. The purpose outlined at clause 1 (b) is troubling since, at the very outset it focuses on qualifying and limiting rights. That paragraph provides that:

...persons receiving treatment for a mental illness retain their rights, dignity and self-respect to the extent that is consistent with their protection, the protection of members of the public and the proper delivery of mental health services.

15. These references to a person "retaining" rights only to a limited extent, and providing for the person's "protection" and the "protection" of others is disappointing. Such language only reinforces discriminatory and outdated paternalistic attitudes – that people with mental illness are deserving of lesser rights than other members of the community, and that mental illness is synonymous with violence and dangerousness. Furthermore the purpose does not encourage supported decision-making. In contrast, there are no qualifications articulated in the principles of dignity, autonomy and participation at Article 3 of the CRPD.

16. We question why, at cl 1(b) the protection of members of the public is a legitimate

overarching purpose for mental health legislation in a free and democratic society. Furthermore, we are particularly concerned that so-called “proper delivery of mental health services” can ever be used as a justification for restricting a person’s rights, dignity and self-respect. Not only is the language of this clause vague and open to abuse, but it fundamentally misconstrues what it means to exercise one’s rights and for the law to protect and promote such rights. In our view, consistent with Article 12(4) of the CRPD, it is the rights and dignity of the person with the mental illness which should qualify or limit *mental health service delivery*, not the other way around.

17. In our view the specific purpose directed towards the provision of mental health services this should be a distinct sub-clause or paragraph. We also recommend removing references to “protection” of people and “retaining” rights to a limited extent, and phrasing the purpose in the language of “promotion of rights, rather than their curtailment. For example (b) could be rewritten as follows:

...

- (b) “promotes the rights, dignity and autonomy of the person” and  
(c) “provides for the proper delivery of mental health services consistent with the promotion of the rights, dignity and autonomy of the person”.

## ***Objectives***

18. The objectives at cl 6(1) should be amended to promote the rights of persons who are most acutely affected by mental health laws – people with a mental illness. An express objective should be compliance with international human rights law, including the CRPD and the Mental Illness Principles to the extent they are relevant. This is particularly important also, given that authorised psychiatrists appointed under cl 287 of the Draft Bill, as staff of approved mental health services which perform the public function of providing involuntary psychiatric treatment, will be public authorities pursuant to s4(1) of the Charter. They will have additional obligations to act consistently with the human rights pursuant to s38. Likewise, the MHT will most likely be considered a public authority when acting in an administrative capacity, including in its determination of review proceedings.
19. We are troubled by the provision at para (a) which explicitly balances the rights of consumers with “the rights of other people”. We urge this be removed as it inappropriately conflates the objective of providing care and treatment to people with a mental illness, with the object of ensuring public safety. The overall objective should be to provide for the care and treatment of people with a mental illness consistent with the promotion and protection of their human rights.
20. We recommend also that para (c) be amended to include promotion of a person’s independence and autonomy, in line with Art 3 CRPD.

## ***General principles***

21. We welcome the introduction at cl 7(4) of general of principles of:

- (a) consultation with the person in the making of decisions,
- (b) supporting the person to make their own decisions,
- (c) providing them with the necessary support and information to enable them to exercise their rights in the Draft Bill, and
- (d) considering the persons preferences and wishes in decision-making.

22. We are pleased to see that these principles adopt the language of supported decision-making, including the provision of information and that they apply regardless of whether the person is a voluntary or an involuntary patient. Unfortunately however, the experience of consumers with similar 'aspirational' provisions in the current Treatment Planning provisions (at s 19A MHA) demonstrates that more substance is required if these principles really are to be given effect. As the *Lacking Insight* report noted:

Treatment Plans are *not* the result of a discussion held between two (or more) equal parties. There is a decided power imbalance in the relationship between a psychiatrist and a person who is subject to treatment by law.<sup>5</sup>

23. In the MHA this power imbalance is then reinforced by the lack of any obligation on the psychiatrist to follow a person's wishes in developing the treatment plan, as well as the MHRB's inability to vary the treatment plan.<sup>6</sup> In the Draft Bill therefore it is our view that the principles in clause 7 can only be enlivened by strengthening the advance directives provisions, nominated person scheme as well as safeguards of treatment planning requirements and review by the MHT (discussed throughout our submission).

24. As for the provision of treatment in cl 7(5), we are pleased to see an acknowledgement of a person's right to take risks (para f) and that treatment only be provided for the therapeutic benefit of a person, not for convenience or as punishment (para a). We also welcome the express consideration of any specific needs including cultural, gender and sexuality (cl 8). We urge amendment to para (e) to include respect for a person's autonomy, alongside their privacy and dignity.

25. In our view, the aim of providing treatment services on a voluntary basis, with involuntary treatment being an option of last resort (at cl 7(5)(b), (c) and (d)) will only succeed if the service system itself undergoes fundamental change to provide access to a range of services on a voluntary basis – something which consumers are sceptical about, given people do not currently have a choice of services, are bound to attend only the service in their region, and where care and treatment is not necessarily provided to a person seeking assistance before they are in acute distress. As consumers commented in a forum into mental health law reform:

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<sup>5</sup> Topp, Thomas & Ingvarson, *Lacking Insight: Involuntary patient experience of the Victorian Mental Health Review Board*, MHLC, October 2008, at 34. Available at:

[www.communitylaw.org.au/mentalhealth](http://www.communitylaw.org.au/mentalhealth)

<sup>6</sup> Ibid.

Is there anything in this Act that's going to change what happens now 'cos you can... get attended to at a clinic if you are made 'involuntary'. Everyone talks about voluntary patients but [try] showing up saying, 'I'm in distress' and you won't get in if they don't see you're serious enough... [as a voluntary patient] you'll be the first one kicked out.

Consumers were sceptical that the draft laws would improve this situation. As one person explained:

[the distinction between] voluntary versus involuntary is a farce unless the system's funded properly; pretending that there's a difference is just ridiculous.<sup>7</sup>

### ***Capacity and supported decision-making***

26. We recommend that the numerous tests of capacity– or more specifically ‘incapacity’<sup>8</sup> – regardless of what they are named (eg. “(in)capacity to make a decision”, “not able to consent”, “significantly impaired” capacity) be streamlined consistent with the criteria outlined in cl 70(c) and 71(c).
27. We support an enunciation of the presumption of capacity as a general principle in the Draft Bill (see cl 7(2)). The Draft Bill must articulate that the presumption can only be rebutted with cogent evidence to the contrary. People with mental illness frequently complain that in fact it is precisely the *opposite* attitude that prevails in clinical practice and elsewhere – it is presumed that a person *lacks* capacity to make decisions for themselves, simply because of their diagnosis of mental illness.
28. A person should not have to prove their capacity to make decisions or be treated voluntarily. Rather, the authorised psychiatrist should bear the onus of proof to provide sufficiently cogent evidence of incapacity – or “significant impairment” - in the person’s decision-making that would justify taking away their right to make their own decision to consent or refuse treatment. For consistency with this principle therefore, cl 7(2) should be defined in the negative – namely “... **unless** the person does **not** have the requisite decision-making capacity” or “**unless** their decision-making ability is significant impaired”.
29. We are concerned that the presumption of capacity is not promoted consistently throughout the Draft Bill as required by Art 12 of the CRPD. We are gravely concerned that the right of all adults to make their own decision to consent to or refuse treatment - such a fundamental tenet of healthcare decision-making – is rendered tokenistic or meaningless by clauses in the Draft Bill authorising involuntary treatment because a person is refusing treatment (cl 125(1)(a)) together with the lack of enforceability of advance statements and advance refusals of treatment (see cl 154).

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<sup>7</sup> See Appendix 1 at p 3.

<sup>8</sup> (See cl 3(2), 70, 71, 120, 121, 125)

30. In addition, we would like to see the following principles relating to the right to autonomy and capacity articulated in the bill. We note the VPLRC has recommended these principles be included in power of attorney legislation as statements of principle to guide the assessment of capacity:

- capacity is specific to each decision to be made
- impaired decision-making capacity may be temporary or permanent
- a person must not be presumed to have impaired decision-making capacity merely because he or she makes a decision that is, in the opinion of others, unwise
- a person should not be treated as unable to make a decision if it is possible for him or her to make that decision with appropriate support.

31. In our view, the Draft Bill as it stands does not comply with the Government's human rights obligations nor with community expectations around autonomy and supported decision-making for people with mental illness.

## Compulsory treatment orders

### *General comments*

32. We welcome the concept of a staged order scheme, which ensures that a person can only be made subject to an ITO or CTO once it has been determined that they *have* rather than merely *appear to have* a mental illness. But, despite some minor amendments to tighten the wording of the criteria for compulsory orders, the substitute decision-making process of a person being made an involuntary patient, remains essentially the same. This is a concern shared overwhelmingly by consumers at the MHLC's forum on the Draft Bill.<sup>9</sup> Said one group, commenting on the compulsory treatment and treatment planning provisions:

We're not sure that the changes are that vast that they would have really any significant change in what happens .... the going for review [at the Mental Health Tribunal before extending certain orders]... is actually a different change that will happen but we're not sure that any of the other changes are significant enough to create a change on the ground

Another group noted that:

... the only benefit we could see really was being able to nominate somebody. We're a bit cynical [but]... that's about the only thing we could say is a benefit. Otherwise it looks much the same, just in different wording.

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<sup>9</sup> See Appendix 1, pp. 4-5.

## ***Assessment Orders:***

33. We note that some consumers see a benefit in an assessment period limited to 72 hours, if it achieves the aim of promoting recovery.<sup>10</sup> In the MHLC's view, it is unclear whether the scheme as it stands in the draft bill will result in greater protection of a person's rights. The assessment order, although not formally defined as such under the Draft Bill, is an involuntary order which authorizes involuntary detention and treatment (albeit limited).
34. We oppose the use of involuntary treatment during an assessment period except where such treatment would be permissible consistent with the common law principle of "emergency medical treatment". The Draft Bill now expressly limits treatment which can be given involuntarily on such an interim order, both in terms of the type of treatment which can be given, and the circumstances in which such treatment can be given (Clause 68) to that which the authorised psychiatrist or registered medical practitioner "believes on reasonable grounds [to be] the minimum treatment necessary as a matter of urgency (a) to save the person's life; or (b) to prevent suffering or relieve pain or distress". We strongly object to the above criterion at (b) referring to undefined and subjective terms of "suffering" and "distress". Widening involuntary treatment beyond that which is a "medical emergency" risks violating a person's rights in the Charter to protection from cruel inhuman and degrading treatment (s19(b)), recognition and equality before the law (s 8) and privacy and reputation (s13).
35. We are concerned however that under cl 67(2) and (3) the authorized psychiatrist has the power to extend an order by a total of 72 hours, effectively rendering an assessment order up to 6 days duration. In our view, this is not a proportionate limitation on a person's human rights, in particular the right to freedom from treatment without consent in s10(c) of the Charter. In effect, these provisions extend what was previously limited to a 24-hour period for examination by the authorised psychiatrist (at s 12AC, MHA) and we therefore recommend the extension power be removed.
36. We are particularly concerned that the MHT appears to have no jurisdiction to determine the validity of an assessment order or any other matter arising from the involuntary treatment under such an order. Such an oversight is arguably in breach of the right to a fair hearing, which includes a right to access a court or tribunal.<sup>11</sup> As it involves a deprivation of liberty, without the safeguard of mandatory review – or indeed any right of appeal to the MHT, the assessment order provisions themselves are also an unjustifiable limitation on a person's right to liberty and security of person under s 21 of the Charter. The MHT must be empowered to review a person's assessment order and treatment subject to an assessment order, and to hear and determine appeals/applications for revocation.
37. In our view a person's advance directive or advance statement would be illuminating in assessing whether a person met the criteria for an assessment order. We support a

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<sup>10</sup> See Appendix 1, p 4.

<sup>11</sup> See eg. *Kijewska v Poland* [2007] ECHR Application no 73002/01 (6 September 2007) and *Materials Fabrication Pty Ltd v Boulderstone Pty Ltd* [2009] VSC 405 (8 September 2009).

person's advance directive being followed given that the very purpose of an advance directive is to minimise distress for that person in the event of a mental health crisis.<sup>12</sup> We also recommend that to the extent that it is relevant to a person's admission to hospital and/or a period of assessment and/or an initial treatment period, a person's advance directive should therefore be followed, unless there are clear and cogent reasons why to do so would be inconsistent with the Draft Bill.

## Process and criteria for compulsory treatment

### *Length of Orders & Statutory Review by the Mental Health Tribunal*

38. In general, we welcome the fact that an initial ITO or CTO expires after a prescribed period of 28 days and 3 months respectively. We support the additional safeguard of prior Tribunal authorisation before continued, extended treatment orders can be made beyond that time (cl 79 and cl 80). Consumers we spoke to also saw as an improvement the fact that an ITO has a prescribed duration (now 28 days) and that the authorised psychiatrist can no longer simply extend a CTO.<sup>13</sup>
39. Overall however, we have grave concerns about the length of time during which a person may be subjected to forced treatment before a full, independent review takes place by the Mental Health Tribunal (MHT). Our concerns are shared by consumers also.<sup>14</sup>
40. Under the Draft Bill, the length of time for which a person may be is, in the case of an inpatient in hospital, on an ITO, only marginally reduced – from 8 weeks to around 7 weeks (being a total of an assessment order of up to 72 hours + extension of total of 72 hours before assessment by an authorized psychiatrist + a 28-day ITO + a further extension of the order by the Mental Health Tribunal (MHT) for up to 10 business days or two weeks).
41. In the case of a person living in the community on a CTO, the review period would appear to have lengthened considerably - from 8 weeks to up to around 4 months or more, depending upon their pathway (a total of a 6-day assessment order + 3-month CTO + extension of further 10 business days by the MHT = almost 3 months, 3 weeks). If a person has been treated as an involuntary inpatient hospital for some period (up to 28 days) we would assume that a CTO may be able to be made by the authorised psychiatrist without the need to have a hearing at the MHT, thereby extending the statutory review period even further to anything up to nearly 4 months 3 weeks). As for periodic reviews thereafter, in the case of an extended CTO, their duration has increased from 12 months to 18 months. These lengthened review periods are deeply concerning – a feeling shared by consumers also.<sup>15</sup>

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<sup>12</sup> See Topp and Martin, Advance directives for mental health, New Paradigm, 2008.

<sup>13</sup> See Appendix, p 5.

<sup>14</sup> See Appendix 1 at p8.

<sup>15</sup> See Appendix 1 at p5.

42. We reiterate consumers' disappointment with the now 18-month review period for a person on an extended CTO. This should be reduced to 6 months consistent with our previous submission.
43. We note that the average inpatient stay is around 2 weeks and therefore, despite the 28-day restriction on an ITO, this 'safeguard' is illusory as many people are likely to be discharged from hospital without having had a statutory review mandated under legislation. In the case of an Extended Inpatient Treatment Order, the bill effectively affords a person a review within 6 months – shortening the review time by half, which, again is a stronger safeguard but only of benefit to people who remain detained and treated involuntarily in hospital for longer than 6 months. We are unsure of the statistics, but guess the numbers of people in such a position is minimal.
44. Furthermore, adequate resourcing and provision of legal representation is central to ensuring that people's rights are respected, promoted and enforced. We note that Review Officers have no explicit responsibility to advise a person about or assist them in contacting a lawyer for legal representation. The Draft Bill should be amended accordingly.

### ***Compulsory treatment in the community***

45. The Draft Bill does not make clear the process for a person being discharged from hospital (on an ITO), into the community for continued compulsory treatment, which we know happens on many occasions currently. It would appear that under the Draft Bill the authorised psychiatrist may be able to simply make a CTO after a period of involuntary detention and treatment in hospital on an ITO and, provided this occurred before the ITO expired (namely within 28 days) there is no requirement that a review be conducted by the MHT. Equally, a person may be made subject to an assessment order, directly followed by a CTO. Either way, as outlined below, the implications on a person's rights is alarming.
46. The Draft Bill no longer mandates an initial review of a CTO within a designated time frame.<sup>16</sup> Under the Draft Bill however, the only statutory review requirement for an involuntary patient in the community refers to the making or extending of an Extended CTO (ECTO) by the MHT. Clause 80(2) makes it clear that an ECTO can only be made for a person who is already on a CTO, which may be up to 3 months duration. If a person is discharged into the community and a CTO made before the ITO expires, they may be subjected to involuntary treatment for a period of more than 4 months or more without statutory review, as follows:

6 days assessment order + 28 day ITO + 3months CTO = 4 months 6 days

If the authorised psychiatrist decided the person no longer needed to be an involuntary patient at the end of the CTO (above), it would expire and no hearing at all need have been conducted. Only if the authorised psychiatrist made application to the MHT for an

<sup>16</sup> Under the MHA this 'initial 8-week review' at s 30(1) effectively applies to people on **both** ITOs and CTOs, since the CTO effectively sits on top of an underlying ITO.

Extended CTO to be made (cl 80) would the MHT be required by law to conduct a hearing. Even then, the MHT has the power to extend the CTO a further 10 business days beyond the 3 month period, if the MHT “determines that it cannot hear and determine the application before the expiry of the Order” (cl 80(4) and (5)). In such circumstances a person may not have a hearing despite nearly 5 months of involuntary treatment, as follows:

6 days assessment order + 28 day ITO + 3months CTO + 10 bus days (2 weeks)  
extension by MHT = nearly 4 months 3 weeks

47. In our view, given that the average length of inpatient stay is no more than around 2 weeks and in our experience many clients on CTOs have been placed on such an order immediately after having been discharged from hospital on an ITO, it is likely that involuntary patients on CTOs will experience the compulsory order scheme under the Draft Bill as described above.
48. Four months or more without any mandatory statutory review by an independent body is in our view a gross breach of a person’s right not to have their privacy unlawfully or arbitrarily interfered with (s 13 of the Charter). The right to privacy has been accepted in Victoria as broad enough to encapsulate the right to bodily integrity and the right to choose what should happen to oneself as regards medical treatment.<sup>17</sup> We reiterate our view that, given the restrictions on a person’s human rights in the making of compulsory orders, timely statutory review periods are a crucial safeguard which must be incorporated into legislation. A right to appeal or apply for revocation of an order is insufficient safeguard to ensure that a person’s privacy, liberty dignity and autonomy rights are only restricted where proportionate and where they can be demonstrably justified in a free and democratic society.<sup>18</sup>
49. We reiterate the submission of the LIV and our previous submission which maintains that prolonged treatment without review constitutes a serious infringement of a person’s human rights, including right to privacy, liberty and security of person and the protection from medical treatment without full free and informed consent. Furthermore, the irregular and infrequent mandatory statutory reviews now under the Draft Bill violate Art 12 (4) of the CRPD which provides that restrictions on a person’s autonomy, for example through involuntary treatment, must be subject to safeguards that:
- ...respect the rights, will and preferences of the person, ... are proportional and tailored to the person’s circumstances, apply for the shortest time possible and are subject to regular review by a competent, independent and impartial authority or judicial body. The safeguards shall be proportional to the degree to which such measures affect the person’s rights and interests.
50. Similarly the requirement to notify the nominated person and other certain people on the making or variation of various orders (eg. Cl 83(6), cl 82, cl 80(3)(b)(iii)) are merely that – a requirement to notify the MHT that an order such as a CTO has been made. There is

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<sup>17</sup> See *Kracke v MHRB* [2009] VCAT 646 at [569]

<sup>18</sup> See s 7 Charter.

no corresponding obligation for the MHT to conduct a hearing in the event a CTO is made for example, and we stress that the **discretion** at cl 89 and cl 25(c) to conduct a review of its own motion is in no way a sufficient safeguard of a person's rights.

51. We recommend the Draft Bill be amended to mandate initial and regular statutory review by the MHT for a person on a compulsory order, whether on an Assessment Order, ITO CTO or extended orders. Consistent with our previous submission to the Consultation Paper, an initial review must take place within 3 days of being made an involuntary patient and automatically thereafter every 6 months.<sup>19</sup> We support a review being conducted within 3 month after a person has been placed on a CTO, provided that, together with any immediate prior involuntary inpatient admission, they have not been an involuntary patient in total for any longer than 6 months without a statutory review hearing.
52. We welcome the tightening of the provisions for what was formally revocation of a CTO requiring transport back to hospital in the case of non-compliance with a CTO or ECTO generally (cl 86) or through failure to attend (cl 85). Specifically we support the 6-hour limit on the power to detain in hospital for failure to attend the clinic (cl85(5) and (6)). Likewise the requirement that the authorised psychiatrist examine the person within 24 hours of being received pursuant to cl 86(5) is an improvement on the MHA which had no such requirement. We would however support further limiting the threshold criteria for involuntary treatment, but urge consistency with what we propose below – the criteria in cl70(d) and 71(d) – namely “imminent and **serious** risk of **serious** harm” and “**serious** risk of **serious** physical or mental deterioration”. We also applaud the added notice provisions at sub-clause (4).

### ***Criteria for compulsory treatment***

53. We support in general the attempts to codify in the Draft Bill the MHRB's jurisprudence in relation to the “5 criteria” for involuntary (now compulsory) treatment at cl 70 and 71. We make the following recommendations of amendments to the criteria to ensure involuntary treatment is a measure of last resort once all less restrictive options have been properly explored:
- sub-clause (b) should explicitly include to requirement to balance the positive effects of the treatment with the adverse effects of the treatment. This codification of the MHRB's jurisprudence is important;
  - sub-clause (c) – we welcome the removal of “refusing treatment” as part of the criteria for involuntary treatment, however its inclusion in cl 125(1)(a) is concerning (see below). We support the use of the generally accepted common-law definition of a test of capacity, or more specifically incapacity, and therefore recommend the following amendments:

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<sup>19</sup> See MHLC submission p 76

- removal of reference to “**appreciate**” in para (iii) as such term is unnecessary, subjective and implies a value judgement on the manner in which a person should weigh the information in arriving at a decision. We note the UK’s Mental Capacity Act 2005 does not refer to “appreciate” as a factor in its definition of “incapacity”.
- Sub-clause (d) – we welcome the tightening of this criterion regarding risk, however we are of the view that the bill should go further to ensure that **only serious and imminent risk** which is attributable to the person’s diagnosed **mental illness** will meet the threshold.
  - Para (i) should be amended to read “an imminent and **serious** risk of harm to the person or to another person”. We recommend removal of the reference to the person “causing” the harm as this unfairly focuses responsibility or blame on the person rather than linking the risk to the person’s mental illness
  - para (ii) should be amended to “a **serious** risk that the person will suffer serious physical or mental deterioration”
- In relation to the para (e) for CTOs, we are concerned to ensure that a person is not made subject to more restrictive measures – such as continued detention as an inpatient on an ITO - where it is deemed that “appropriate treatment” is not “available” on a CTO. We recommend this criterion make explicit the balance required to ensure that the restriction on a person’s rights is reasonable, justified, proportionate and necessary.

54. We note that in the 2009/2010 financial year, the MHRB discharged 351 people – an overall rate of only around 3-4%. Interestingly, in more than half those cases, the MHRB found the criteria relating to a person’s capacity to consent, and/or to less restrictive treatment alternatives to an involuntary order were **not** met, in 180 and 206 cases respectively.<sup>20</sup> Although the overall rate of discharge is extremely low, the breakdown of these statistics underline the importance of clearly expressed criteria and the fact that the treating team’s assessment of the person’s capacity to consent cannot simply be accepted at face value without scrutiny. A rigorous hearing and testing of the evidence by an independent Tribunal is fundamental. As we recommended in *Lacking Insight* report, the Tribunal must:

- Acknowledge that the rationale for involuntary detention and treatment must, on the day of the hearing, be justified;
- actively test and question the evidence of the treating team; and
- ensure that the evidence of the treating team is examined, without prejudice, by careful questioning.<sup>21</sup>

<sup>20</sup> MHRB Annual Report 2009-2010, p13, [http://www.mhrb.vic.gov.au/publications/documents/AR2010/2010%20Annual%20Report%20FINAL.p](http://www.mhrb.vic.gov.au/publications/documents/AR2010/2010%20Annual%20Report%20FINAL.pdf)

<sup>21</sup> *Lacking Insight*, p 10.

# The Mental Health Tribunal

## *General comments*

55. The Draft Bill must do more to articulate and strengthen the role and obligations of the MHT as we recommended in *Lacking Insight* regarding:

- the importance of MHT's inquisitorial role;
- access to information and documents,
- independent legal advice and/or representation,
- ensuring a person's understanding of the process,
- 'rituals' and processes of a hearing,
- Statements of reasons (now called reasons for determination)
- the unique experiences of Koori people and people from rural areas and from culturally and linguistically diverse backgrounds,
- the importance of consumers members.

## *Tribunal members*

56. We are pleased that reviews of orders and the making of Extended treatment orders must be conducted by 3-members of the Tribunal, and that where a single member sits, that member must be a legal member (Sch2, cl34(2)).

57. We note that 'community members' have now been replaced by "expert" members who must have "a special interest or expertise in mental illness". We are encouraged by the fact that a person with the lived experience of mental illness would meet these qualifications however there is no guarantee this would be the case – arguably a mental health professional may equally qualify. In our view, consumers themselves should be prioritised as members of the MHT. Said consumers at the MHLC's forum:

The possibility of a consumer member [on the Tribunal]... would take us in leaps and bounds... it really would.<sup>22</sup>

## *Young people*

58. We endorse the submission of Youthlaw which calls for automatic review by the MHT of all psychiatric treatment of people under 18 years of age, regardless of whether they are subject to involuntary treatment or not. We note that the MHLC does not currently receive many requests for representation before the MHRB for young people. We are aware that the parents or guardians of a young person may at present consent to treatment on the person's behalf, even if the person themselves may object. In such circumstances the person is denied the opportunity to have their situation reviewed by an independent Tribunal. In this respect we welcome the opportunity for a person under 18

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<sup>22</sup> See Appendix, p 8

to appoint a nominated person to be consulted by and to receive information from the service.

### ***Power to make orders ‘on the papers’ or ‘informally’***

59. We have grave concerns about the potential for Extended CTOs and Extended ITOs to be made and extended by the MHT “on the papers” or “by holding a private and informal meeting” – implying no formal hearing even be conducted (cl 80(11) and 79(10)). This also applies to extending a CTO or ITO for 10 business days if the hearing cannot be conducted before expiration of the order (cl 79(5)(b) and cl 80(5)(b)).
60. Such provisions are arguably in breach of the right to a fair hearing (s 24 Charter) which necessarily includes the right to equal access to and equality before the courts. In our view a determination affecting a person’s involuntary treatment, such as the making, confirming, varying or revocation of an order, must be made only after a full hearing takes place. Although this can only occur if a person consents to this process, there is no process to ensure they are giving full, free and informed consent. Given that in 2009-2010 only 4.3% of hearings involving legal representation<sup>23</sup>, we are sceptical about how consent will be obtained and whether people will be given sufficient information to make an informed decision. Consumers likewise are adamant that a decision about a person’s involuntary order can never and should never occur on the papers.<sup>24</sup>
61. With only 50% of people attending their MHRB hearings in 2009-2010, these provisions only serve to undermine the already low confidence that some people have in the transparency and independence of the review process. A person’s right to choose not to attend the hearing should not be confused with an apparent “waiver” of their right to have their involuntary status determined robustly and transparently. As we recommended in *Lacking Insight* report, the MHT should:
- Acknowledge that the rationale for involuntary detention and/or treatment, on the day of the hearing, must be justified by the treating team and
  - Actively test and question the evidence of the treating team.
62. We question whether MHT members could be satisfied to the same extent that the procedure had correctly been applied and that there was sufficient cogent evidence of the ECTO and EITO criteria being met if the evidence cannot be scrutinized or clinicians directly questioned on the evidence. We are concerned this could lead to a two-tiered review system – a retrograde step particularly in light of the fact that the MHT is in our view a public authority under the s4(1) of the Charter, at least in its administrative capacity. Given the fact that involuntary treatment engages fundamental rights to liberty, autonomy and privacy, with the obvious imbalance of power between the person subject to involuntary treatment and the treating clinician, the legislation must ensure the review procedures promote rather than diminish a person’s rights. The inquisitorial nature of the

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<sup>23</sup> MHRB Annual Report 2009-2010, p 5, available at: <http://www.mhrb.vic.gov.au/publications/documents/AR2010/2010%20Annual%20Report%20FINAL.pdf>

<sup>24</sup> See Appendix 1, p9.

MHT is an important means of ensuring that independent review takes place and that people are only subject to orders as a means of last resort.

63. Furthermore, in our view, the provisions constitute a breach of the State's obligations under Art 13 of the CRPD (Access to Justice) since, when a decision is made "on the papers" a person is not a direct participant in the process. We recommend therefore the MHT have no such power and these provisions be removed.
64. It is unclear how any appeal of a determination made in such a way would proceed and likewise the obligation to produce written reasons for the determination upon request.

### ***Power to extend orders to conduct a hearing***

65. We are gravely concerned about the powers of the Tribunal to determine to extend a compulsory order by 10 business days if it cannot hear and determine an application for an Extended CTO (ECTO) (cl 80(4) and (5)) or Extended ITO (EITO) before its expiry. We strongly oppose the MHT being invested with the power to prolong a person's detention and/or involuntary treatment by 2 weeks without the need for a hearing or considering submissions. This is inconsistent with the obligation to limit restrictions on a person's rights to that which is reasonable, justified, proportionate and necessary pursuant to section 7 of the Charter. Restricting a person's rights to liberty, autonomy, privacy and freedom of movement by making a compulsory order in such a way, albeit for an interim period, cannot be justified on the grounds of the administrative convenience or resource implications of the review body or mental health service, particularly when the Draft Bill prescribes additional obligations for examination by the authorised psychiatrist at least 15 days for the expiration date of the order (cl 77) in express contemplation of the application process to the MHT.
66. We urge the provisions in cl 79(4) and (5), and again at cl 80(4) and (5) be removed and any application for an extension of involuntary treatment by way of a ECTO or EITO should only be determined after a full hearing of the MHT, upon application in accordance with the (remaining) provisions in cl 79 or cl 80 as appropriate.
67. Reliance on the Charter of Human Rights to enforce a person's rights, as we found in the *Kracke* decision, is in effect, for the person themselves, a paper tiger if the only remedy a person is entitled, where their rights are breached, is a declaration of the fact. The legislation must give effect to the rights in the Charter, by prescribing consequence for non-compliance, not excuses or exceptions to compliance with prescribed time limits.

### ***Powers regarding treatment plans***

68. We are seriously concerned that the MHT appears to have even fewer powers when it comes to review of treatment plans under the Draft Bill than under the MHA. Indeed it is concerning that the MHT only appears to be required to formally review a treatment plan in the making or extending of an ECTO (see cl 25 and cl 80(6)). Upon an

application for revocation, the MHT has a **discretion** to make an order that the authorised psychiatrist review the treatment plan (cl87(6)(a)(iii)). A similar discretion applies to reviews of the MHT's own accord pursuant to cl 89 (itself a discretionary power). However there is no obligation to review the treatment plan, nor is there any power, it would seem for the MHT to formally review the treatment plan as a matter of course for the making of a EITO for example. This is a severe diminution in the safeguards for people on compulsory orders. It is critical that a process be mandated to ensure that any treatment does not fall foul of the rights under the Charter, in particular the right to be free from cruel, inhuman and degrading treatment (s10(b)).

69. In our experience, the responsibility to review a treatment plan (under s35A MHA) whenever an order is being reviewed – whether automatically or by appeal - is an important part of the accountability process to ensure that less restrictive options are indeed considered and trialled. Even when a person has not been discharged from their order, an order that the treatment plan be reviewed, for example so the service can explore transfer of treatment to a private psychiatrist, or the trial of oral medication, is an important outcome. We are alarmed by the retrograde step of removing even the most basic review requirements for orders in the Draft Bill. We reiterate our recommendation for further powers of the MHT to vary a person's treatment plan.
70. We reiterate our call for the Draft Bill to include an **obligation** on the MHT to review a person's treatment plan whenever reviewing a compulsory order or assessment order, and be empowered with a range of options to order not only a a review by the authorised psychiatrist, but the MHT be empowered itself to vary the plan, or make other directions as it sees fit. For example some consumers have felt strongly that the Tribunal should have the power to direct the mental health service to trial alternative medications – in other words, not be limited to merely ordering the authorised psychiatrist “take another look at” the treatment plan.<sup>25</sup>

### ***Tribunal's obligations in the hearing***

71. We welcome the adoption of some of the recommendation made in *Lacking Insight* for explicit responsibilities of the MHT in Sch 2, cl 23(1) to give written notice about their rights to statements of reasons (now 'reasons for determination') and their right to appeal to VCAT and how to do so. Similarly we welcome the express obligations at Sch 2, cl 5(1), in particular to ensure the person understands the determination it makes and the reasons for a determination or any other decision, order or direction. We hope this will avoid the inconsistency we have experienced between various divisions of the MHRB under the current MHA.
72. We note the MHT's power to refer a question of law to the Supreme Court pursuant to cl 36. We are concerned however that sub-clause (3) and (4) be amended to provide the MHT with discretion to stay the operation of a compulsory order or any other treatment pending the outcome of the Supreme Court's proceeding or opinion. We note that this power exists in s149 of the VCAT Act.

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<sup>25</sup> See Appendix 1, at p 9

## ***Appearance at a hearing, representation and proceedings closed to public***

73. We are gravely concerned that the MHT will now have the power to order a person subject to the order be excluded from their own hearing (Sch 2, cl 18(6)) if determines that it “would be significantly detrimental to [their health.]” We are not aware of any such provision in other jurisdictions. Preventing a person from attending in person their own hearing is a clear breach of the right to natural justice. This should be clearly distinguished from a person’s right, if they so choose and having been appropriately advised about their rights and the MHT process, to decide voluntarily not to attend themselves.
74. It is our strong view that the MHT, its divisions and individual members must do everything possible to encourage and enable the person to participate as fully as possible in the hearing, consistent with the principles of therapeutic jurisprudence. In any event, we doubt how the MHT could ever be in a position to make such a determination above, before the hearing. We therefore strongly urge this paragraph be removed and para (1) amended accordingly.

## ***Access to documents & non-disclosure applications***

75. People must be given every opportunity to prepare for and participate in the hearing, which includes access to documents given to the MHT. As consumers at a forum on the Draft Bill identified, the Draft Bill must provide that,
- The treating team has an obligation to give a person timely information about their right to see their file prior to their hearing.
  - The person must also be given adequate time to see their file to allow them to prepare their case.
  - Access to files before a hearing should be provided free of charge
  - The treating team should have specific obligations to facilitate file access; and
  - A person’s exercise of their rights should not be dependent on whether they have a lawyer assisting them or not <sup>26</sup>
76. We are strongly of the view that the 24hour time frame within which a person must be given access to documents prior to their hearing (s 26(7)), be reinstated. We understand that, particularly for inpatient hearings, it is not unusual for information and documents, including the psychiatrist’s ‘report on involuntary status’ to be given to the client or their lawyer less than 24 hours prior to the hearing. This is of grave concern.
77. The legislation must expressly articulate the MHT’s obligations to determine an application for non-disclosure consistent with the right to a fair hearing and the rules of natural justice and procedural fairness. It should also expressly state that these

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<sup>26</sup> Appendix 1, p9

principles, coupled with the rights to autonomy, liberty and privacy, also apply to the MHT's determination of whether the MHT itself should look at material which the person themselves would be prevented from seeing. We recommend therefore that Sch 2 cl 17 and cl 16(6) be amended accordingly.

78. Furthermore, all these key provisions regarding natural justice, file access and non-disclosure are crucial aspects of MHT's role & should be given appropriate weight in the body of the bill, not relegated to the schedules, particularly since cl 29 makes it clear that provisions of the Bill will "trump" any requirement specified in Schedule 2.

### ***Legal representation before the Tribunal***

79. Independent legal representation, where the lawyer is acting on the person's instructions to put forward the client's views and experiences, can enable the person to more fully participate in the hearing process. Furthermore, consumers at a forum on the Draft Bill stated clearly that in their view, if person decides they cannot attend their hearing in person, they should have the opportunity to send a representative of their choice to attend on their behalf.<sup>27</sup>

80. As the report *Lacking Insight* found, advocacy before the MHRB is a vital way of ensuring that the person's rights are upheld, that the person's voice is heard by the Board as well as being an important way of empowering the person themselves.<sup>28</sup> One person explained that having a lawyer with her at a Board hearing would mean she "wouldn't feel so powerless". For another person, having legal representation meant that before the hearing the involuntary treatment criteria were explained. He said that being given detailed information about what was going to happen in the hearing was very helpful.<sup>29</sup> The MHRB itself in its annual report 09/10 notes that "The presence of an advocate provides support and ensures that the patient's rights are appropriately protected."<sup>30</sup>

81. We are concerned that in the only reference in the Draft Bill to legal representation – clearly a vital aspect of the process of appeal and review – is relegated to the Schedule (sch 2, cl 18(3)). Furthermore, there is no specific mention of the right to legal representation as distinct from other forms of advocacy or support. The Bill should clearly articulate in the main body of the Bill – not the schedule - that the person has a right to legal representation, as well as the right to any other advocacy or representation which the person authorises.

82. For people's ability to exercise the right to legal representation however, it is vitally important the government make a commitment to adequately fund independent legal

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<sup>27</sup> Appendix p 9

<sup>28</sup> *Lacking Insight* p 57.

<sup>29</sup> *Ibid* p 58.

<sup>30</sup> Page 9, available at:

<http://www.mhrb.vic.gov.au/publications/documents/AR2010/2010%20Annual%20Report%20FINAL.pdf>

representation before the MHT for everyone made subject to an order compelling involuntary treatment, including an assessment order.

83. Simply stating the right, while an important statutory measure, is not a sufficient safeguard for people's rights. The reality is that overall, in any given year, no more than 10% of people are legally represented before the Board. Where around 70% of hearings involve people on CTOs, the MHLC is the main provider of free legal advice and representation to people. Despite the increasing capacity of the MHLC to provide such representation through its employee lawyers and pro bono program, the MHLC is still not able to meet the current demand, to say nothing of the additional unmet need due to people being unaware of the availability of legal advocacy or otherwise. It is disappointing that the coordination and supervision of MHLC's pro bono program is still yet to receive recurrent government funding.
84. We anticipate that the MHT may be required to sit more frequently than the current general fortnightly roster. Whether this will result in an increased number of hearings is yet to be seen, but, in any event we are concerned that the government's allocated budget for implementation of the Bill will not be sufficient to fund legal representation and address the consistently deplorable rate of representation.

## Review Officers

85. Whilst we support a timeframe on the provision of information about rights within a specified timeframe, for people on both inpatient (ITO) and outpatient treatment orders (CTOs) we are concerned about what will happen in practice. In our view not only is information about rights important, but more critical is access to independent legal advice and representation for people who seek it.
86. Review Officers are clearly not independent (sitting as they do, within the Department of Health, alongside the MHT). It is unclear whether their role is to provide information or legal advice as indicated in the Explanatory Memorandum. There is no requirement that a review officer be legally trained such that they would be qualified to provide independent legal advice. We echo the concerns of the LIV that there is a risk that people may believe they have received independent advice or legal advice from a Review Officer when in fact they have not.
87. Some consumers feel Review Officers should be legally qualified, and for many, as our report from a consumer forum found:

...the lack of independence of Review Officers was a very real concern to many people. Many consumers expressed concern that the role of the Review Officer was confusing in particular because their lack of independence was not clear to people reading the Draft Bill – some people had had the impression that Review Officers *were* independent ...<sup>31</sup>

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<sup>31</sup> See Appendix 1, p 9

88. We are particularly concerned about the function of Review Officers to review compliance with the process for compulsory orders for two main reasons. First, arguably this requires assessing if the law has been complied – both in terms of the process and legal criteria as articulated in legislation. This necessarily requires legal skills for which Review Officers are not trained. In our view it is far more appropriate that a judicial body determine these issues. Review Officers have no determinative power, merely discretion to review and to refer the matter to the mental health service or, alternatively the MHT.

89. In this respect, we are gravely concerned that Review Officers have been introduced to effectively replace the ‘initial review’ currently undertaken by the MHRB within 8 weeks of a person being made involuntary, as evidenced by the following statement at p 5 of the Explanatory Memorandum. In relation to Review Officers it states:

This flexible, procedural check on orders is better suited to the needs of patients than a formal hearing process in the early stages of a compulsory treatment order, which can be stressful for the patient.

90. We are strongly opposed to such a statement. Instead of watering down the independence and robust review process, the Draft Bill should put the onus firmly on the MHT and others to ensure the hearing process is fair, open, accountable and empowering for a person, and the Members conduct themselves in such a way as to minimise stress for the person, consistent with the principles of therapeutic jurisprudence. The right to a fair hearing in s24 of the Charter also includes a right of equal access to a court or tribunal.<sup>32</sup> As stated in *Golder v UK*:

The fair, public and expeditious characteristics of judicial proceedings are of no value at all if there are no judicial proceedings.<sup>33</sup>

91. It is our view that the procedural check by Review Officers falls foul of s24 of the Charter – it cannot and should not be a substitute for a full, independent hearing by the Tribunal to determine the validity of orders. We note in this respect the discretion of both Review Officers to refer a matter to the MHT at cl 88(1), and indeed the discretion of the MHT to conduct a hearing where “it considers appropriate” at cl 89(1). In our view the absence of mandatory review provisions is a diminution of a person’s rights from the current MHA. Furthermore, if the process has not been complied with a Tribunal should use its inherent power to make a determination as to jurisdictional issues. It is inappropriate for a “mistake” such as the validity of an order to be “corrected” by the mental health service. Likewise, we doubt whether a Tribunal would have such a power to “correct” an error which would otherwise render it with no jurisdiction – eg. because the order was executed unlawfully or outside the parameters of the empowering legislation.

92. Second, it seems clear this review process is designed as a check and balance for the benefit of clinical services rather than as a safeguard to ensure a person is only being

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<sup>32</sup> *Materials Fabrication Pty Ltd v Baulderstone Pty Ltd* [2009] VSC 405 (8 September 2009)

<sup>33</sup> (1975) 1 EHRR 524.

treated in accordance with their rights under law and in the least restrictive manner possible. Consumers also shared the concern that a Review Officer did not act **for** the person in the way a lawyer does for example or in the way that another support person whom the person appoints as their representative would do. Nor do Review Officers have determinative power like the MHT. As one consumer explained:

...you wouldn't need a Review Officer if everyone's doing their job! Why's the person there in the first place?... Are they going to review the decision?<sup>34</sup>

- 93.** In our view the money spent employing Review Officers could be better spent funding lawyers such as those at the MHLC who are independent, can provide legal advice as opposed to mere information about such rights, are bound by lawyer-client confidentiality, have a duty to act on a person's instructions and can take action on the client's behalf to enforce or safeguard their rights.
- 94.** In addition, as we submitted to the Consultation Paper, we recommend the Draft Bill provide for a mandatory initial review by an independent Tribunal within three days of a person being made subject to a compulsory treatment order.

## Supported decision-making,

- 95.** Consumers feel strongly that advance directives or advance statements, provided they are strengthened and have greater weight in the Draft Bill, are the key to operationalising supported decision-making. Overall, consumers have expressed the view that the Draft Bill cannot be said to have "adopted a supported decision-making approach" in the absence of significant amendments to advance statements provisions.<sup>35</sup>

## Advance statements and advance directives

- 96.** The MHLC has long advocated for the introduction of legally recognized advance directives – documents which allow a person to determine what should happen in relation to their mental health treatment and other life management arrangements, in advance of their becoming unwell when their capacity may be impaired.<sup>36</sup> Appropriate recognition, enforceability and accountability of such documents are an important mechanism to ensure people with mental illness have the opportunity to maximize their autonomy in advance of a mental health crisis when decision-making might otherwise be taken away from the person themselves.

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<sup>34</sup> See Appendix 1, at p10.

<sup>35</sup> See Appendix 1 at p 12.

<sup>36</sup> See for example MHLC, 'Advance directives: Maximising consumers autonomy dignity and control' above n 76; Topp, V and Leslie, C (2009) 'Defending the right to autonomy and self determination: Advance directives for mental health' *Health Issues Journal* 101, 26-28. Topp, V, Leslie, C (2009) 'Who knows best: Advance directives in action' Presentation at 'Everyday people everyday rights' VEOHRC Human rights conference, 17 March 2009, available at [www.humanrightscommission.vic.gov.au/conference/Catherineleslie.ppt](http://www.humanrightscommission.vic.gov.au/conference/Catherineleslie.ppt)

## ***Advance statements***

97. To the extent that a mental health act recognize the importance of and refer to advance directives, we welcome the express recognition of formal documentation of a person's decisions, wishes and preferences in a so-called "advance statement" at cl 150 though we make further recommendations to strengthen their status in the Draft Bill (see below).
98. We are encouraged by a wider definition than purely 'treatment preferences' which encompasses both treatment for the person's diagnosed mental illness as well as any other personal preferences. However, the fact that such personal preferences must be limited to the person's treatment may not give consumers the opportunity to include matters which are most important to them in their life.<sup>37</sup> For example it would appear that other important life management arrangements, such as care of children, accommodation or employment may not be implemented but may nevertheless be critical issues for the well-being of a person and matters in which clinical staff could play a facilitative role. Consumers at the recent MHLC forum also took issue with the language used in the Draft Bill, in particular "wishes and preferences" which devalues the person's experience and views.<sup>38</sup>
99. As we submitted to the MHA's Consultation Paper, and echoed in the VLRC's Guardianship reference, advance directives, due to their broad scope and similarity with powers of attorney type documents, are best situated within the guardianship legislation, rather than solely under a mental health act. We recommend therefore that the Draft Bill be reviewed to ensure its consistency with the proposed reforms to guardianship laws, proposed by the VLRC when it reports to Government later in 2011.

## ***Requirements for making an advance statement***

100. We welcome the fact that the requirements at cl 152 to execute an advance statement are accessible and that a person need not necessarily be made subject to an intrusive capacity assessment. We also welcome the broad range of people who can sign a statement under s152(1)(d). Should advance statements or directives in relation to specific treatment refusals be enforceable as discussed below, we recommend consulting widely among consumers the precise requirements for valid execution of such documents, to ensure the appropriate balance between accessibility and certainty as to their legal validity.
101. We are concerned that clinicians and others need only check a person's medical file to discharge their obligations to ascertain whether a person has an advance statement (cl 154(2) and (3)). Some consumers may not be comfortable with their advance statement on file and may instead prefer it be kept with their nominated person for example. We recommend cl 154(3) include an alternative by way of asking a nominated person if they have the advance statement or know where it can be found.

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<sup>37</sup> See Appendix 1 at p11  
<sup>38</sup> Ibid.

## ***Weight and enforceability***

102. We note the purpose at cl 150 is to “support the capacity of a person... to make decisions about their treatment”. Sadly, in our view this purpose is not given effect to in the legislation which requires only scant weight to be given to the documents. Wishes and preferences need merely be “considered” or “have regard to” in the event that the person’s capacity to make decisions is significantly impaired.
103. Whilst we welcome the obligation to consider a person’s advance statement applies broadly to clinicians and the MHT as well as “any other body required to make a decision in relation to the treatment of a patient”, in the MHLC’s view the Draft Bill does not give the recognition and weight to a person’s wishes and decisions that people with mental illness are calling for,<sup>39</sup> or that their autonomy and dignity demand.
104. Similarly, consumers are overwhelmingly in favour of advance statements having far stronger weight than merely a requirement that clinicians and the MHT “have regard” to them (See cl 154(1)). Otherwise, the Draft Bill does little more than replicate the existing provisions for Treatment plans (s19A MHA). Consumers have argued:

We really dislike the language.... We want it to be stronger. We want it to say that ‘[the advance statement] must be followed unless there are compelling reason not to’, rather than they ‘must have regard to’ because that’s wishy washy and we want it to be more “person first”.<sup>40</sup>

105. The ineffectiveness of current treatment planning provisions in s19A MHA and their implementation in practice is one reason why people have called for advance directives to be legally recognised and with appropriate force. Even the *Guardianship & Administration Act 1986* for example, whilst currently under review by the VLRC, has much stronger language in relation to the weight to be given to a person’s wishes. It states at s4(2)(c) that powers under that Act are to be exercised such that “the wishes of a person with a disability are **wherever possible given effect to**”.
106. We therefore recommend the Draft Bill state that clinicians, the MHT and others empowered under the Draft Bill must give effect to the wishes of a person as articulated in their advance statement unless to do so would breach their obligations under the legislation.

## ***Advance treatment refusals***

107. The MHLC has long called for people with mental illness to have the same right to refuse treatment in advance, as any other member of the community. We note that numerous other organizations and individuals have reiterated their support for legally enforceable advance directives in their submissions to the Draft Bill, including the LIV

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<sup>39</sup> See Appendix 1 at p 10-12.

<sup>40</sup> Ibid.

and OPA. Consumers are clear that, at least when it comes to refusing certain treatments, advance statements or directives must be enforceable. At the recent MHLC consumer forum, one group explained that:

What do we want the law to do? Advance directives that override everything else, ie. If I say I don't want ECT or a certain medication in my advance directive when I'm capable, that should be respected even if I'm made involuntary. It shouldn't be able to be overridden.<sup>41</sup>

108. Since the MHLC's submission the Consultation Paper on the Review of the MHA, two key Supreme Court decisions have confirmed the applicability and scope of advance directives in Australia, at least in relation to advance refusals of general (non-psychiatric) treatment.<sup>42</sup> The following extract of our submission to the VLRC Review of Guardianship is equally relevant to advance treatment refusals in the Draft Bill:

The scope of enforceability of 'advance refusals' in Australia was clarified further by McDougall J in *Hunter* to assist clinicians faced with emergency decisions. McDougall J expressly limited the applicability of the principle of emergency medical treatment to circumstances in which, among other things 'the person has not signified that he or she does not wish the treatment, or treatment of that kind, to be carried out'.<sup>43</sup> In other words, medical practitioners cannot rely on the 'doctrine of necessity' to override a valid advance refusal of treatment.

We submit that the law in relation to advance refusals is unambiguous and reform is needed as a matter of urgency to ensure that people with mental illness are not discriminated against in this way.<sup>44</sup>

109. The Draft Bill should reflect the common law position as articulated in the above decisions. At a minimum, particular decisions a person makes and articulates in an advance directive or advance statement, must be given effect to, provided the person's capacity to make such a directive is not rebutted with cogent evidence of otherwise. In addition it should also expressly state that an advance refusal to undergo ECT, made when the person had capacity to make such a decision must be complied with.

110. As Tina Minkowitz notes in her Foreword to *Lacking Insight*, only if health care providers "are required to obey [advance directives] and not merely take them into consideration" can advance directives facilitate the cultural and practical shift from a system based on compulsion to a supported decision-making model, which the CRPD calls for.<sup>45</sup>

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<sup>41</sup> Appendix 1, p10.

<sup>42</sup> See for example, *Brightwater Care Group v Rossiter* [2009] WASC 229 (20 August 2009) and *Hunter and New England Area Health Service v A* [2009] NSWSC 761 (6 August 2009).

<sup>43</sup> *Hunter* above at [40].

<sup>44</sup> Submission, at p45.

<sup>45</sup> *Lacking Insight*, p 7.

111. We note that the VLRC will be reporting later in 2011 and will also be considering the applicability of advance directives and compliance with a person's wishes and we recommend therefore that the Draft Bill be reviewed to ensure consistency with the VLRC's recommendations.

### ***Accountability for overriding an advance statement***

112. We welcome the introduction of monitoring and accountability measures for clinicians and others in implementing a person's advance statement. Many consumers see such a process as the most important in ensuring that their voice is listened to and taken seriously, even if preference may not always be complied with. The MHLC's multi-stage research project in advance directives has highlighted the importance of robust accountability of clinicians' actions in following a person's stated directives. Anyone can ask for a letter or a document to be put on their file, but the key is getting it read and respected. For example, one consumer described the value of the document as ensuring that "the 'well' me gets a seat at the table". Others describe the document as akin to a "birthing plan".

113. We welcome the required process that, where the clinician proposes to override a person's advance statement, they must document the circumstances and reasons for doing so, and give written advice to the person and the MH Commissioner and others pursuant to cl 154(4). This requirement should also extend to the MHT – the clause does not make this sufficiently clear. Among consumers there is also considerable support for the Commissioner having the power and resources to investigate overrides and issue a compliance notice in relation to an advance statement.<sup>46</sup>

114. We recommend that a person have a right to appeal a decision about an advance statement to the MHT or, where the relevant decision is made by the MHT, appeal to VCAT. The MHT and VCAT should have the power to stay treatment or a decision to override the advance statement, pending the outcome of a hearing. As for overriding an advance refusal of treatment however, we reiterate that this aspect of a person's advance statement cannot be overridden. We note that the Office of the Public Advocate's submission calls for all overrides to be authorised in advance by the MHT. Whether the MHT or another Tribunal such as VCAT should have the power to authorise an override of a validly executed advance refusal of treatment requires further consultation.

115. Again, we note that the VLRC in its review of guardianship laws is considering what legal force advance directives should have, as well the interaction between guardianship and mental health laws. We recommend the government undertake further consultation as to the precise model for enforceability and accountability for mental health services' implementing a person's advance directive, whether through an advance statement or otherwise.

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<sup>46</sup> See Appendix 1, p 11.

## Nominated person scheme

116. We support the introduction of a nominated person scheme (Part 10, Div 2), whereby a person can nominate who they would like to receive information on their behalf and be consulted in decision-making. We support the fact that a person under 18 may also appoint a nominated person (cl 156(1)).
117. We are however concerned that the scope and role of the nominated person scheme is too restrictive. First, the role is effectively limited to provision of information about orders and treatment and being consulted about treatment.
118. Consistent with our submission to the VLRC's Information Paper in its review of Guardianship laws, the MHLC strongly supports people with mental illness having the equal right to appoint a decision-maker for psychiatric treatment in the same way as any other member of the community may appoint an "agent" or 'Medical power of attorney' under the *Medical Treatment Act 1988* for general (non-psychiatric) treatment. Such person in our view should have the same role as a medical power of attorney, in that they can consent to or refuse treatment on behalf of a person once they are deemed to lack the requisite decision-making capacity. The Agent must also be guided by the person's wishes as outlined in a person's advance statement, or compelled to act in accordance with an advance refusal. The person – the donor – should also have the right to prescribe limits on the donee's power – for example, to limit decisions of this NP to those regarding ECT treatment, or treatment as described in accordance with a person's advance directive or advance statement.
119. As far as the provision of information is concerned, the Draft Bill is premised on the assumption that a person would choose to have the *one* nominated person receiving information and being consulted about the range of incidents or circumstances prescribed. Consumers at the MHLC's forum on the Draft Bill saw this as a distinct disadvantage of the scheme and were in favour of having the power to appoint alternative nominated persons in the event the first could not fulfil the role, and multiple support people, for example in various roles.<sup>47</sup> A person may for example prefer to nominate one person to be advised of their admission to hospital at the outset, who may then be able to make the necessary arrangements for the person's personal affairs, but choose not to have this person consulted about ongoing decisions related to treatment. One consumer described:
- I actually think that limiting it to just one person... is really limiting. In my own life I think that doesn't quite work and I'd like the capacity to nominate a few people. Like have my 3 people who are my support network... kept in the loop...<sup>48</sup>
120. We note with interest OPA's suggestion at [2.3] of its submission, to include a form or schedule of tick boxes by which the person could indicate which information the

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<sup>47</sup> Appendix 1, p11

<sup>48</sup> Appendix 1, p11

nominated person would receive. In addition, we suggest if a person has provided details of the consent to provision of such information and/or a consultative role to particular support people in their advance directive, that this must be acted upon unless the person has withdrawn their consent.

121. We welcome the accessible requirements for appointment of a nominated person at cl 158. In our view however, the revocation provisions must be consistent with the provisions for revocation of an enduring guardian under guardianship laws (see s35D of the GAA) which is currently under review by the VLRC.

## **Treatment planning and participation in decision-making**

122. We support the additional requirement for a treatment plan (cl 132), and in particular that a person's treatment plan also include a statement of the person's wishes and preferences, such as their advance statement / advance directive. Consumers are still sceptical that these provisions would avoid inconsistencies in the extent to which a person is involved in the process, depending on whether they are perceived as "cooperative" or "refusing treatment" and their legal status.<sup>49</sup>

123. A treatment plan must be provided to all people on compulsory orders, not only to people in the community or at the point of discharge into the community. The exclusion of treatment plan requirements for inpatients under the Draft Bill is a distinct disadvantage for many consumers.<sup>50</sup> Some consumers have recommended:

[the treatment plan] should be looked at at least weekly and [the person] should have explanations given to them as to what decisions are being proposed and why they're being proposed so they are then in a position to give informed consent. It's very hard to give informed consent if you do not know and have not had it explained to you the reasons... why the decisions are being made.<sup>51</sup>

124. We welcome the requirement that the treatment plan be considered by the MHT in the making or extending of Extended ITOs and Extended CTOs. We recommend cl 80(6)(b) be removed and the MHT should be prevented from making or extending an Extended CTO without first approving the treatment plan. To do otherwise denies treatment plans the respect they should have and undermines the entire process of treatment planning, which the Draft Bill rightly identifies should be "collaborative".

125. We question whether the introduction of the very broad provisions such as cl 131 'Collaborative planning' adds anything meaningful to the requirements in relation to

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<sup>49</sup> Appendix 1, p6-7

<sup>50</sup> See Appendix 1 at p7.

<sup>51</sup> See Appendix 1, p6

treatment planning and the principles described above. This is the case particularly given our recommendation that Treatment Plans be provided to all users of public mental health services, including voluntary patients if they so desire. We see no reason not to extend the provision of treatment plans to voluntary patients. This is consistent with the requirements of the CRPD which, at para (k) of the preamble, notes that:

“despite these various instruments and undertakings, person with disabilities continue to face barriers in their participation as equal members of society and violations of their human rights...”

126. In our view, the success of these broad “treatment planning” provisions will depend upon their implementation by clinicians. In particular, whether people are given the opportunity to discuss with their treating team their wishes and preferences, whether people are given information and an explanation about the treatment proposed, and whether the person receives a copy of their treatment plan in sufficient time before their MHT hearing for example. Codes of Practice would be particularly valuable in this regard.
127. We are disappointed that the MHT has power to vary a person’s treatment plan when conducting a review of an order or hearing an application for revocation. The power to vary suspend or require review in cl 25(a)(xii) only applies if the MHT has referred a matter of law to the Supreme Court.

## **Involuntary treatment if refusing treatment**

128. We strongly reiterate our stated position that a person who has the capacity to consent to or refuse treatment cannot be treated involuntarily. This flows from the established common law right to autonomy which the law will enforce, unless there is cogent evidence to prove otherwise that the person’s decision-making capacity is sufficiently impaired regarding that particular decision. This is consistent with the presumption of capacity and the scope of autonomy in medical decision-making whereby a person has the right to make decisions about their own bodies and treatment, regardless of whether others perceive such a decision to be unwise or even irrational. To give effect to these core human rights principles – and indeed the presumption of capacity in the Draft Bill itself – unless there is cogent evidence to displace the presumption of capacity, then a person cannot be treated against their will.
129. Although “refusal of treatment” is removed from criteria in cl 70 and 71, the fact it is included later in cl 125(1)(a) indicates the Draft Bill intends to authorise involuntary treatment for a person precisely **because** they are refusing treatment.
130. We note that Principle 11(6) of the Mental Illness Principles states that where a person has the relevant capacity to consent or refuse treatment, they may nevertheless be subjected to involuntary treatment if an independent authority is satisfied that, having regard to the person’s safety or the safety of others, the person is “unreasonably” refusing treatment which is in the “best interests” of the person’s health needs.

131. The Mental Illness Principles however, date from 1991 and in this respect at least, is now anachronistic and affords fewer rights protections than the CRPD, which prevails in the event of inconsistency. It thus no longer reflects current international human rights standards and should be set aside in favour of the more contemporary provisions of the CRPD, particularly at Article 12(4). People with mental illness are entitled to equal recognition and protection of their rights to autonomy and dignity as all other members of the community. In particular it is inconsistent with and arguably in breach of the CRPD's Article 12 (autonomy and equal recognition before the law), Article 17 (physical and mental integrity on an equal basis with others), Article 22 (respect for privacy) and Article 25 (right to health).

132. The interaction between clause 125 and the criteria for compulsory treatment is ambiguous. The criteria for what appears to be a 'parallel' process at cl 125 for involuntary treatment is inconsistent with that for compulsory treatment at cl 70 and 71. For example the criterion relating to risk in cl 125 refers only to "a risk" of harm, without any qualifications as to severity of the risk or imminence or gravity of the harm required. As a result the process and criteria risk being applied inconsistently and in our view ultimately to the detriment of a person's rights. Although the Draft Bill itself is worded otherwise, it would appear from the Explanatory Memorandum that cl 125 is only intended to apply to involuntary patients.<sup>52</sup> If so, we question why cl 125 is necessary at all in the first place. In our view it is confusing, unnecessary and reinforces the discriminatory nature of mental health laws in terms of the right to autonomy. It is completely at odds with the presumption of capacity and the principle of equal rights and empowerment to exercise such rights (cl 7(1) and (2)) discussed above in 'Capacity and supported decision-making'. It is telling that in any event consumers perceive involuntary treatment – in essence - as a means to ensure compliance with treatment for those who would otherwise refuse it.<sup>53</sup>

133. If a person has the capacity to consent to or refuse treatment, they should not be subjected to involuntary treatment. Clause 125 adds nothing to what should not be ordinary factors required by both the authorised psychiatrist and also the MHT in determining compulsory treatment criteria and in the treatment planning process.

134. Therefore we recommend clause 125 be removed and that the factors listed in sub-clause (2) to which the authorized psychiatrist must have regard, should be included in the treatment planning provisions with additional weight ascribed to advance statements as outlined in our submission.

## Second opinions

135. The *Lacking Insight* report highlights the impediments that people face in arranging for a second opinion. We welcome therefore the new provisions requiring mental health services to arrange for a second opinion by a psychiatrist from a panel, pursuant to cl 126. While consumers these provisions as a benefit to people who have been subject to

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<sup>52</sup> Explanatory Memorandum, p14.

<sup>53</sup> See Appendix 1, p5.

continuous involuntary treatment for 3 months or more, there are criticisms of the way the scheme is likely to operate in terms of lack of accountability.

136. We endorse the LIV's submission in calling for the Government to consider further measures to ensure that the panel of second opinion psychiatrists is truly independent of the Department of Health. In addition, we are particularly concerned by the following statement in the Explanatory Memorandum which, although not in the Draft Bill itself, significantly undermines the independence of this process:

"Every attempt should be made by the authorised psychiatrist and the second opinion psychiatrist to reach agreement...."<sup>54</sup>

Needless to say, the provision of such a statement, for example in a code of practice, despite its absence from the Draft Bill, renders the entire process meaningless for people, whose most common complaint is the difficulty in accessing an independent psychiatric assessment.

137. We are also concerned that the outcome of a difference of opinion merely results in a requirement to review the treatment plan. There is no requirement that the MHT adjudicate any dispute. The option of referral to the Chief Psychiatrist for review in the case of a person dissatisfied with the second opinion process, is not sufficiently independent. Similarly, consumers have expressed concern over general accountability for the process. Said one consumer at a recent forum:

If the second opinion comes back differing from the first treatment, there no-one reviewing whether that treatment gets changes or not.... There's no other body that comes over to see if the doctor took on board any of the [other] opinion.<sup>55</sup>

138. We are concerned that the reasons for the second opinion may be withheld from the person pursuant to sub-clause (3) and that this is a mandatory provision, not discretionary. In our view, the reasons for the second opinion should never be withheld from the person themselves.
139. We recommend also that the Draft Bill be amended to specifically articulate the general and fundamental right to a second opinion, irrespective of a person's eligibility for assessment by a panel psychiatrist pursuant to cl 126.

## **Electroconvulsive therapy (ECT)**

### ***General comments & the role of the MHT***

140. ECT is an invasive treatment which carries with it a risk of both short and long term side effects, including memory loss. In MHLC's view, ECT should never be performed without the full, free and informed consent of the person. Involuntary ECT (see cl 142(7)(b) & 142(8)) has been recognised as a violation of a person's human rights by the

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<sup>54</sup> See Explanatory Memorandum p.  
<sup>55</sup> Appendix 1 p7.

UN Special Rapporteur on Torture, who, in his interim report to the Human Rights Committee in July 2008 recommended (at p15):

it is of vital importance that ECT be administered only with the free and informed consent of the person concerned, including on the basis of information on the secondary effects and related risks such as heart complications, confusion, loss of memory and even death.

141. We welcome the additional safeguards for ECT generally, namely that ECT can only be performed once the MHT has heard and determined an application made by the psychiatrist. It is significant, given the intrusiveness of this treatment and the side effects, that a decision to perform ECT cannot be determined solely by the authorized psychiatrist. Consumers are likewise resoundingly in favour of the introduction of a transparent, new system of prior Tribunal authorisation.<sup>56</sup> Given the invasive nature of the treatment and the commensurate strong public sentiment, the MHLC supports the MHT's involvement even when the person may appear to be consenting to the treatment. This is an important system of checks and balances which is long overdue in Victoria.

### ***Information to be provided to the person – informed consent***

142. There is no equivalent provision in the Draft Bill to s53B of the MHA which sets out the requirements for obtaining informed consent for ECT. This is a concern.
143. Written information about ECT, the purpose of the treatment, its duration and frequency, its intended benefits and the discomforts and side effects of the treatment, as well as details of other alternative treatments must be given to the person and this information explained to them in a manner in which they can understand. This is distinct from the mere oral explanation required by the general clause 'Information about treatment' cl 123 of the Draft Bill, which we recommend be amended as described above. These matters should also be documented in any application to the MHT.

### ***Penalties***

144. We welcome the articulation of penalties for failure to comply with the relevant sections pursuant to s142(1), 143(1) and s144(1) and (2). The current MHA is deficient in this respect.

### ***Number of treatments***

145. The Draft Bill at cl 142(10) doubles the number of treatments which can be authorised in each 'course' of treatment from 6 to 12 – a change which is strongly opposed by the MHLC, as well as by consumers themselves.<sup>57</sup> There does not appear to be justification for this increase. This effectively diminishes a person's right to withdraw their consent part-way through treatment. Consumers have also suggested the

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<sup>56</sup> Appendix 1, p 12.

<sup>57</sup> See Appendix 1 p.12.

MHT be required to regularly review ECT treatments mid-course.<sup>58</sup> Empowering the MHT with the ability to vary a person's treatment plan is also critical in this regard. In the MHLC's experience, the only other option is to apply to the Supreme Court for an injunction, which carries with it the risk of an adverse costs order, which has been enough in some cases to dissuade a client from pursuing such a course of action.

### ***ECT and young people***

146. We note the inconclusive evidence around the effects of ECT on the still-developing adolescent brain.<sup>59</sup> We reiterate the concerns of Youthlaw in calling for a prohibition on the use of ECT for persons under 18 years old. Consumers themselves have also criticised the use of ECT in young people and questioned the evidence of beneficial outcomes of ECT in such circumstances.<sup>60</sup>

### ***Emergency ECT treatment***

147. Clause 145 authorises emergency ECT in circumstances where the psychiatrist is satisfied it is "necessary to save the person's life". We query the claim that ECT is ever administered to save a person's life in the same way as a blood transfusion for example. ECT is not generally used as a treatment of 'first resort' and thus the emergency treatment provisions, which effectively remove the important safeguard of prior authorisation by the MHT, cannot be justified.

As we found in the consumer forum on the Draft Bill:

Consumers doubted whether ECT ever needs to be used in circumstances of an emergency where there would not be time to have the matter considered first by the Tribunal in a hearing. Some consumers questioned how, in any event, one would determine what is "necessary to save person's life". One consumer cited the fact that currently ECT is not generally conducted on weekends as evidence that describing ECT as "emergency treatment" can be a misnomer.<sup>61</sup>

148. The MHLC shares the view of consumers that there is a very real risk that the emergency provisions will simply be used by services as a way of avoiding the increased paperwork and "fuss" of making an application to the Tribunal for prior authorisation.<sup>62</sup> A requirement to notify the MHT after the fact is a wholly inadequate safeguard.

149. We note that VCAT is empowered to hear and determine urgent applications. Were the Government to consider applying such provisions to ECT, we recommend the person must be provided with legal representation and the MHT should have only limited power

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<sup>58</sup> Ibid.

<sup>59</sup> This is also acknowledged in the RANZCP position paper on ECT

<sup>60</sup> Appendix 1, p 12.

<sup>61</sup> Appendix 1 p. 13

<sup>62</sup> Ibid.

to order a maximum of 3 courses of treatment. (See for example the ACT Mental Health Act).

### ***Refusal of ECT in an advance directive***

150. People with mental illness should have the same common law right to refuse treatment as people with physical illness and an advance directive to refuse ECT must be respected. In such circumstances, ECT cannot be administered involuntarily and nor can “emergency treatment” provisions be used to override the person’s refusal. McDougall J in the recent NSW Supreme Court decision of *Hunter* clarified the enforceability of such an ‘advance refusal’ such that the doctrine of ‘emergency medical treatment’ does not apply where the person has “signified that he or she does not wish the treatment, or treatment of that kind, to be carried out”.<sup>63</sup> Consumers have similarly identified refusal of ECT in an advance statement as a directive which clinicians must follow and cannot override.<sup>64</sup>

### **Seclusion and restraint**

151. Restraint and seclusion by definition restrict many of a person’s rights under the Charter, such as the rights to liberty and security of person (s21), freedom from torture (s10(a)), freedom from cruel, inhuman or degrading treatment (s10(b)), freedom of movement (s12) and humane treatment deprived of liberty (s22). The use of such interventions is invariably experienced by people with mental illness as humiliating and punitive, resulting in further trauma, even death.

152. We question the therapeutic benefits and “effectiveness” of restraint and seclusion and note that the National Mental Health Consumer and Carer Forum contends that “both the prevalence and execution of seclusion and restraint demonstrate its current use in Australia is far more widespread and pernicious than as a last resort emergency measure”<sup>65</sup>.

153. We do not believe that the cultural shift in clinical practice to eliminate the use of these practices will be achieved by the apparent safeguards in cl 139(1)(b) in the case of bodily restraint and cl 141(1)(b) in the case of seclusion. Merely stating that less restrictive options need to have been “considered **or** tried” and determined “not suitable” is not sufficient. The focus must be on training workers in alternatives and providing opportunities for alternative strategies to be put in place, such as a person seeking, for example, solitude. We note the Coroner’s Court is currently investigating a cluster of reportable deaths of people in public mental health services, including Justin Fraser who died in circumstances of having been restrained by mental health staff.

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<sup>63</sup> *Hunter and New England Area Health Service v A* [2009] NSWSC 761 (6 August 2009), para [40].

<sup>64</sup> See Appendix 1, p 10 and p 12.

<sup>65</sup> Ending Seclusion and Restraint in Australian Mental Health Services A Position Statement by the National Mental Health Consumer & Carer Forum (NMH CCF), (2009), p7.

<http://www.nmhccf.org.au/documents/Seclusion%20&%20Restraint.pdf>

154. We reiterate our earlier submission to the MHA which calls for removal of seclusion provisions as, only then will clinical practice be forced to change.
155. We note with disappointment that the Draft Bill only covers use of mechanical restraint, eg. Belts, harnesses, straps to body to restrict movement – as does the MHA. Chemical restraint is not referred to in the Draft Bill, which is remiss. We would also like to see included a prohibition on the use of chemical restraint and a reference to the prohibition of its use.
156. We do however, welcome the removal of prevention of persistent destruction of property as a ground for restraint. Similarly the removal of ‘preventing a person from absconding’ as a ground for seclusion. Though, as previously noted, in our view such improvements do not go far enough to ensuring the Draft Bill’s compliance with promotion of a person’s human rights.
157. We note that in the Draft Bill the monthly reports to the Chief Psychiatrist about use of restraint and seclusion are no longer mandated. Whilst these provisions do not protect the rights of individuals, they are an important measure to ensure transparency in the provision of services generally. If restraint and seclusion provisions remain in the bill, we strongly urge mandatory reporting be reinstated.

## **Complaints & the Mental Health Commissioner**

158. We support the introduction of a consistent centralised local or internal complaints system at Div 1, Part 11 of the Draft Bill, which is sorely lacking under the MHA.
159. We welcome the introduction of a complaints body - the Mental Health Commissioner – separate from the Chief Psychiatrist, which removes the untenable conflict of interest of the Chief Psychiatrists current dual roles of clinical advisor to mental health services and complaints body.
160. However, as we articulated in our submission to the consultation paper *Because Mental Health Matters*, “an optimal model for accountability must sit outside a departmental context – an ombudsman type structure, or one along the lines of the New Zealand Mental Health Commission” to ensure that the complaints body can adequately monitor and influence systemic issues in service provision. It is crucial that the Commissioner’s office is robust and independent and we are concerned that such independence is compromised due to its location within the Department of Health.
161. We welcome the provisions in cl 187 (1)(a) and (2) which provide complaints may be made orally and time limits for services to respond to the Commissioner throughout the process.
162. We are pleased that the Commissioner’s powers are clearly articulated in the Draft Bill and that they are broad enough to deal with complaints beyond conciliation, including investigation and the powers of investigators, and the issuing of compliance notices (cl

223), with accompanying penalties for non-compliance within the specified time frames (per cl 225).

163. We are disappointed however, that the Commissioner does not have the power to issue directions or compliances notices for a broader range of issues. We are concerned that compliance notices may only be issued for a mental health service's failure to comply with limited "prescribed requirements" listed pursuant to cl 223(5). We consider this list to be unnecessarily restrictive and note that consumers are keen for the Commissioner to have the power to issue compliance notices for example to compel implementation of a person's advance directive or advance statement.<sup>66</sup> We recommend for example, the Commissioner have the power to issue notices in such circumstances as the psychiatrist's failure to comply with a valid advance refusal of treatment.
164. We are also disappointed that there is no access to VCAT for unresolved complaints. We recommend also that the Commissioner have responsibility for referral of matters for prosecution by responsible agencies. We further recommend that, like the Disability Services Commissioner, the Commissioner be empowered to initiate investigation/inquiry of its own motion.
165. In addition, we are disappointed there is no express obligation to include in its annual report to the parliament, the use, including the circumstances, reasons and frequency of advance statement overrides (see cl 16).

## **The Chief Psychiatrist**

166. As previously stated, we welcome the Chief Psychiatrist being divested of its role in handling complaints. We also welcome the new power to give directions to a mental health service in relation to the provision or cessation of treatment for both voluntary (cl 20(6)) and involuntary patients (cl 20(3)).
167. We would like to see greater accountability and transparency in the exercise of these powers, for example providing a person can apply to access the documents held by the Chief Psychiatrist and apply for any statement of reasons for a determination. We note the LIV's concern about reportable deaths and the lack of response from the Chief Psychiatrist, which is deeply concerning.

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<sup>66</sup> See Appendix 1, p 11

# What consumers want from new mental health laws

## Report on the consumer forum conducted by the Mental Health Legal Centre

February 2011

### Background

The Mental Health Legal Centre is a Victorian statewide specialist community legal centre based in Melbourne. It is a non-profit organisation run by an independent Committee of Management and receives the majority of its funding from the Victorian Department of Health and Victoria Legal Aid.

The MHLC provides telephone legal advice and referral to callers from around Victoria, direct legal advocacy and community education about mental health and the law for people in Victoria with, or labelled as having, a mental illness. The MHLC also undertakes substantial research, law reform and policy work in relation to mental health and the law. All MHLC activities aim to further the rights of people with mental illness in Victoria.

### Introduction

On 17 February 2011 the Mental Health Legal Centre (MHLC) conducted a forum for mental health consumers on the Victorian Government's proposed new mental health laws, entitled the Exposure Draft Mental Health Bill 2010 (Draft Bill). Since the release of the Draft Bill in October 2010 the MHLC had heard anecdotally that many consumers, although keenly interested in and concerned about the proposed new laws, were unclear about the detail of the laws and what it might mean for them as consumers of mental health services in Victoria. One of the aims of the forum therefore, was to inform consumers about key aspects of the proposed laws and provide an opportunity to discuss the potential effect of such laws.

The MHLC was also particularly keen to hear directly from consumers themselves what they thought about the laws and what benefits and disadvantages they saw in the proposed laws. We also wanted to find out, assuming there was going to be a separate 'Mental Health Act, what consumers wanted such laws to do. The views gathered at the forum would therefore assist the MHLC in preparing its submission to the Draft Bill.

This report is a summary of the views and concerns of the 20 consumer participants at the forum on the following key topics:

- 1. Compulsory treatment, refusing treatment and “treatment planning”**
- 2. Reviews and appeals, and the Mental Health Tribunal**
- 3. Supported decision-making, “advance statements”, advance directives and the nominated person scheme**
- 4. Electro-convulsive therapy**

#### **General comments:**

Many people remarked that the laws appeared “convoluted” and “confusing to understand”. Some people were disappointed that the Draft Bill was written in a language that was not accessible to the very people it concerns – “consumers” – people with or labelled as having a mental illness. Throughout the day it was clear that people felt strongly the importance of the Government understanding how the law impacts or may impact on consumers themselves. One person was critical of the consultation process itself, describing it as merely a “rhetoric” consultation. The same person took the view that the laws should be reviewed in five years time, not a further 20 years time.

Consumers felt that the purpose of mental health laws should be to protect the rights of people with mental illness. Some people were disappointed, and in some cases angry, that under the Draft Bill mental health laws would fundamentally stay the same – they focus on and authorise involuntary psychiatric treatment. Some people asked, “Why do we need a separate Mental Health Act anyway?” One group expressed the view that involuntary treatment can be beneficial for some people.

It was argued that any mental health laws must be consistent with the promotion and protection of consumers’ rights under the Victorian Charter of Human Rights, otherwise there would be no benefits to consumers.

People felt that mental health laws should be “empowering and participatory” for consumers and be more holistic in their approach to “treatment”. There was doubt about whether the Draft Bill would achieve this.

Some people felt strongly that there should be greater access to services, both in terms of the types of care and treatment available (including alternatives to pharmacological treatments), as well as the circumstances in which people can effectively access such care and treatment. Many people questioned whether the Draft Bill would provide better access to services by shifting the focus from coercive to voluntary treatment. In practice it was felt there needed to be sufficient services including hospital beds made available to people who sought such care and treatment, before they were in acute distress or need. In practice more and varied services should be available to people, including a greater range of less restrictive options. People should also have a choice of public mental health services and not be limited to attending only the service in the region where they live. As one person commented:

Is there anything in this Act that’s going to change what happens now ‘cos you can... get attended to at a clinic if you are made ‘involuntary’.  
Everyone talks about voluntary patients but [try] showing up saying, ‘I’m in distress’ and you won’t get in if they don’t see you’re serious enough... [as a voluntary patient] you’ll be the first one kicked out.

One other person explained that:

We’ve lost asylum which was very healing for a lot of people... – to be able to just step out of your life for a little while, sit under a tree and think about what’s going wrong before everything has completely fallen apart... – it’s such a shame that that’s no longer built into the system.... [A]n occasional weekend off from your life may stop that stuff from happening, but you can’t get it.

There was skepticism that the draft laws would improve this situation. As one person explained:

[the distinction between] voluntary versus involuntary is a farce unless the system’s funded properly; pretending that there’s a difference is just ridiculous.

## 1. Compulsory treatment, refusing treatment and “treatment planning”

### Compulsory treatment

Despite the move in the Draft Bill to a staged system of involuntary treatment orders (now “compulsory orders”) and some changes to the process and criteria for such orders, many people clearly felt there was unlikely to be any really significant change in the compulsory treatment regime. Some consumers thought the effect of the new laws would be the same, as one person explained:

Either being involuntary or the threat of being involuntary will lead to compliance just as it does now.

As one group commented after discussing both the compulsory treatment and treatment planning provisions:

We’re not sure that the changes are that vast that they would have really any significant change in what happens but certainly the second opinion [after 3 months of involuntary treatment] and the going for review [at the Mental Health Tribunal before extending certain orders]... is actually a different change that will happen but we’re not sure that any of the other changes are significant enough to create a change on the ground

For some consumers, the only benefit they saw in the changes to the compulsory treatment and treatment planning processes, was the ability in the Draft Bill to legally nominate a person to be informed of certain events – such as the making of a compulsory order – and be consulted on particular issues, such as treatment planning. As one group said:

... the only benefit we could see really was being able to nominate somebody. We’re a bit cynical [but]... that’s about the only thing we could say is a benefit. Otherwise it looks much the same, just in different wording.

As people commented later on however, there were concerns about the overall limitations of the nominated person scheme in the Draft Bill (see below at topic 3).

Some consumers liked the concept of an “assessment order” with a limited (maximum) period of 72 hours which would allow time for a person’s recovery. One group of consumers saw the more explicit ‘capacity’ test in the criteria for involuntary

treatment under the Draft Bill – the test of “significant impairment” in a person’s ability to make decisions – as an improvement.

The fact that an (initial) CTO is limited to no more than 3 months was seen by some consumers as a benefit of the new laws, compared with the current Mental Health Act which provides for an initial CTO of up to 12 months’ duration.

Consumers did support the fact that the authorised psychiatrist could no longer extend a person’s community treatment order. They liked the fact that the Mental Health Tribunal had to conduct a hearing upon application by the authorised psychiatrist before the making of orders which would authorise a person’s continued involuntary treatment in the community beyond an initial six-month period (Extended Community Treatment Order). Similarly, consumers also supported the time limit of 28 days on an Inpatient Treatment Order (ITO), after which time only the Mental Health Tribunal could authorise further involuntary detention and treatment in hospital after conducting a hearing and making an Extended Inpatient Treatment Order.

It was acknowledged however that currently the average stay in hospital is around 10-12 days, implying that, for many inpatients the new safeguards of a time limit on an ITO and prior Tribunal authorisation for extended detention may very well be meaningless.

### Refusing treatment

Although under the Draft Bill a person can no longer satisfy the ‘consent’ criteria for involuntary treatment, merely by “refusing treatment”, the Bill nevertheless allows a person to be forcibly treated if they are refusing treatment. The Explanatory Memorandum to the Draft Bill makes it clear this provision is intended to apply only to involuntary patients. In discussing the effect of these provisions in the Draft Bill, consumers felt it was far from clear how such provisions were intended to operate in practice.

Some people questioned the point of having a section separate from the criteria for involuntary treatment, which was about refusing treatment when an involuntary patient. Because that is precisely how involuntary treatment is perceived – as a way of ensuring compliance for those who would otherwise refuse treatment.

Some people felt very strongly that a person should have the right to refuse certain treatments by way of an (enforceable) advance directive made when a person had capacity. Such directives it was felt, could in some cases avoid the need for a person to be made subject to involuntary treatment. (See further on “advance

statements” discussion below)

### Treatment planning

Some people were of the view that the changes to the treatment planning provisions which required, among other things, the treating team to consult and collaborate with the person themselves, their nominated person and the person’s carer provided the person gave their consent, was a good thing. They were in favour of a wider perspective and involvement in planning treatment, but there was concern that treatment planning was restricted to purely medical issues whereas it should be broader. There was a feeling that the term “treatment” was too limiting and that the phrase “care and treatment” or “protection care and treatment” may better reflect a person’s needs.

Some consumers were disappointed that, despite the new “collaborative” treatment planning requirements, psychiatrists and others in the treating team still had a great deal of power to determine how this would occur – how much information to give, and to whom, and how much weight to give to different people’s views. Many people expressed a concern that evidence provided to the treating team by other people – which was not directly observed by the team – was not treated with adequate skepticism, particularly if the person has not been given a chance to consider the evidence and comment on it. Some consumers were also keen to have the option, at least, of psychiatric assessments being recorded. Precisely what safeguards are needed to balance a person’s privacy, with the transparency of the process, it was acknowledged, required further discussion.

One group felt strongly that reviews of a person’s treatment plan should occur on a weekly basis and that the treating team must have an obligation to explain what treatment is planned, not merely what the treatment is. As one consumer explained:

[the treatment plan] should be looked at at least weekly and [the person] should have explanations given to them as to what decisions are being proposed and why they’re being proposed so they are then in a position to give informed consent. Its’ very hard to give informed consent if you do not know and have not had it explained to you the reasons... why the decisions are being made.

Some people took the view that under the proposed new laws there would still be inconsistencies in the provision of information and in the way treatment planning occurs, depending on the person’s status as voluntary or involuntary, and also how

the person is perceived by the treating team, regardless of their legal status. As one person explained:

...the care plan is restricted.... You're not going to get the same care plan if you're not cooperative or if you're refusing treatment or if you've got a [psychiatric] history.

There was also a concern that “care shouldn't stop and start at the door” of hospital, or be dependent on the path you took to get to there. The fact that a treatment plan was only mandated for people in the community or at the point of discharge, but no longer for inpatients – particularly those on involuntary ‘Inpatient Treatment Orders’ – was seen by many as a distinct disadvantage of the Draft Bill.

### Second opinion panel of psychiatrists

Some consumers saw a benefit in changes to the law to require a second opinion be arranged after three months of involuntary treatment, and that the opinion be provided by a psychiatrist who is not from treating clinic or hospital. Some people felt these new provision would benefit consumers, even if the process didn't result in changes to the person's treatment. Some people were concerned however about the lack of accountability in the process. The fact that a different second opinion means only that the authorised psychiatrist must review, or look again at the treatment plan, was not sufficient. As one group described:

If the second opinion comes back differing from the first treatment, there no-one reviewing whether that treatment gets changes or not.... There's no other body that comes over to see if the doctor took on board any of the [other] opinion.

## **2. Reviews and appeals of compulsory orders, and the Mental Health Tribunal**

### Review hearings and the Mental Health Tribunal

People felt the effect overall of the Draft Bill was to take away a person's autonomy and many people could see little if any benefit in the changes to the review process and the (renamed) Mental Health Tribunal.

The fact that under the Draft Bill, a person could be subject to involuntary treatment and detention in hospital for up to 7 weeks before their order was reviewed, concerned many people. It was felt that 7 weeks was too long before a review took place and represented no meaningful difference from the current Mental Health Act's 8-week statutory review period. One group felt that a 2-week review period was more appropriate. Similarly, a person living in the community on an Extended Community Treatment Order should have their order 'automatically' reviewed at least every 6-12 months, rather than up to 18 months as envisaged by the proposed Extended Community Treatment Order scheme.

The fact that the Mental Health Tribunal would not have the power to conduct a hearing to review an Assessment Order – even on appeal – was seen as a disadvantage of the Draft Bill.

If the Draft Bill resulted in hearings being conducted more frequently than the current, general fortnightly roster, then some consumers felt that would be of benefit. Also, if the “expert member” of the Tribunal were a consumer, this would, as one group described:

The possibility of a consumer member [on the Tribunal]... would take us in leaps and bounds... it really would.

Consumers felt strongly about the way hearings should be conducted and the process and preparation before the hearing, including getting access to their file. As one person explained:

Certainly I'd want to see that any files are accessible to the consumer... and free of charge. They must be provided 'cos invariably consumers before any Review Board hearings very often they don't get that information within an appropriate time... so they can defend their case in an adequate and appropriate way.

People were gravely concerned about the Tribunal's power to order the person themselves not attend the hearing if satisfied that it would be “significantly detrimental to his or her health”. This is distinct from a person choosing voluntarily not to attend the hearing. Similarly troubling was the Tribunal's new, power to review an order “on the papers” without conducting a hearing and, in particular without the attendance of a representative of the treating team for the purpose of testing the evidence in their report.

Some specific recommendations which people felt should be reflected in the Draft Bill were that:

- If person decides they cannot attend their hearing in person, they should have the opportunity to send a representative of their choice to attend on their behalf ;
- A review of a person’s involuntary order can never and should never take place “on the papers” – it represents a clear disadvantage to consumers and breaches their human rights;
- The treating team has an obligation to give a person timely information about their right to see their file prior to their hearing. The person must also be given adequate time to see their file to allow them to prepare their case. The treating team should have specific obligations to facilitate this so a person’s exercise of their rights should not be dependent on whether they have a lawyer assisting them or not;
- Access to files before a hearing should be provided free of charge;
- The Tribunal should have the power to direct the mental health service to trial alternative medications – in other words, not be limited to merely ordering the authorised psychiatrist “take another look at” the treatment plan;
- The Tribunal should be able to make corrections to material on a person’s file at their request;
- There should be a “consumer ombudsman” whose job it is to hear and determine complaints by a consumer, not only about their treatment but also about the conduct of the Tribunal itself. The Tribunal and its members should be accountable through a clear and transparent process under the law itself;
- Past decisions of the Tribunal/Mental Health Review Board should be made available to consumers, appropriately deidentified to ensure the person’s privacy is protected;
- In order to ensure mental health services “do things ethically”, one person suggested the government consider ‘interactive clinical documentation’ which would allow people the opportunity to correct any information gathered and noted about them on their file; the Tribunal should have the power to do this.

### Review Officers

The lack of independence of Review Officers was a very real concern to many people. Many consumers expressed concern that the role of the Review Officer was confusing in particular because their lack of independence was not clear to people reading the Draft Bill – some people had had the impression that Review Officers were independent of the Department of Health.

Some consumers commented that although Review Officers ostensibly “appeared” to be a good system of checks and balances, it was concerning that there was no requirement they act for the person’s benefit. It was also unclear whether they had any actual power to intervene in the decision-making process. As one consumer explained:

...you wouldn’t need a Review Officer if everyone’s doing their job!  
Why’s the person there in the first place?... Are they going to review the decision?

Some consumers liked the idea of a person whose role it was to meet with a person made subject to an involuntary order and explain their rights, but they felt such a role demanded additional qualifications including legal qualifications. One person commented that it would be impossible to effectively review whether orders had been made properly and the process followed without there being objective evidence such as the recording of the assessment interview with the person.

### **3. Supported decision-making, “advance statements”, advance directives and the nominated person scheme**

Some consumers felt very strongly that, fundamentally, the law should provide for enforceable advance directives. In this respect, consumers saw the new provisions for advance statements and a nominated person scheme as a distinct benefit in the Draft Bill, though they had some clear concerns about aspects of the proposed laws and some specific recommendations.

At least when it comes to refusing certain treatments, consumers were of the view that advance directive should be enforceable. As one group explained:

What do we want the law to do? Advance directives that override everything else, ie. If I say I don’t want ECT or a certain medication in my advance directive when I’m capable, that should be respected even if I’m made involuntary. It shouldn’t be able to be overridden.

Despite the limitations and criticisms of the “advance statement” scheme in the Draft Bill, consumers felt overwhelmingly it was important that for the first time the law will formally recognise a document in which they can voice their own opinions about how to and how not to be treated. One consumer described it as preparing your own “care plan”. As one person explained:

It's great to have that process in the [draft] law to encourage people to do their advance statements.

Some consumers were adamant they did not like the fact that “advance statements” under the Draft Bill referred to the term, “wishes and preferences” as it devalues the person’s own experience and views. Some people were concerned that the way that advance statements were defined under the Draft Bill – limiting general personal preferences to those related to the person’s treatment – was not as broad as how consumers had conceived of the documents. They were concerned about what people could include in the document and felt that people should have the right to put “whatever is most important to them in the document”.

Many consumers thought that “advance statements” needed to be given stronger weight in the Draft Bill. Some people took the view that it was not enough to say a person’s advance statement must be considered, rather the language should be stronger. One group said:

We really dislike the language.... We want it to be stronger. We want it to say that ‘[the advance statement] must be followed unless there are compelling reason not to’, rather than they ‘must have regard to’ because that’s wishy washy and we want it to be more “person first”.

There was a keen interest in the accountability for overrides of advance statements by the Mental Health Commission. It was unclear if and how the Commission would intervene if a person’s advance statement was being overridden. There was considerable support for the Commission having the power and resources to investigate overrides and issue a compliance notice in relation to an advance statement.

People were very interested in the nominated person scheme and were generally supportive of such a scheme. Criticisms however included the fact that you can nominate only one person. Instead, a person should have the capacity to nominate both multiple people and also someone to act in the alternative if the first was unavailable or otherwise unwilling to act in that role.

As one person described:

I actually think that limiting it to just one person... is really limiting. In my own life I think that doesn't quite work and I'd like the capacity to nominate a few people. Like have my 3 people who are my support network... kept in the loop [which] is my understanding of the nominated person's main function.

Participants discussed whether, overall, the new law will have the effect it says it will – namely ‘adopt a supported decision-making approach’. In general, it was felt that more was required to strengthen in particular the advance statement / advance directive provisions. As one consumer explained:

The advance statement to me... it's like me in my strength supporting me when I'm struggling. So I get to say, when I'm strong, what it is that I want and that to me ought to be... much more strongly involved in the decision making, rather than the psychiatrist saying what's in my best interest. I've already said what's in my best interest. I think advance statements ... need to be strengthened in the law... [because] that to me captures what supported decision making could be or how it could be operationalised.

#### **4. Electro-convulsive therapy (ECT)**

Although some consumers opposed the use of ECT in any circumstances, people were resoundingly in favour of the introduction of a system of prior authorisation of ECT by the Mental Health Tribunal, after conducting a hearing. Although some people may be wary of the Tribunal process because of past experiences, it was felt loudly and clearly that adding this step is an important system of checks and balances.

People were opposed to the increase in the maximum number of treatments which could be consented to in the one course – from six, to 12 in the Draft Bill. Some people felt this could be more harmful to people. Some were of the opinion that the Tribunal must also regularly review ECT treatments mid-course.

Furthermore, some consumers strongly believed that there should be a definite onus on the authorised psychiatrist to actually explore less restrictive alternatives before ECT goes ahead. One group suggested an obligation to specifically monitor the use of ECT in each mental health service, to ensure ECT was not being used inappropriately to meet hospital Key Performance Indicators to move people out of acute wards quickly.

As previously mentioned in relation to advance statements, many consumers took the view that advance statements or advance directives in relation to ECT must be followed, including an advance refusal of ECT. Consumers were also very critical of the use of ECT on young people and their still-developing brain and that there was no proven beneficial outcome of ECT in these circumstances.

Emergency ECT

Consumers doubted whether ECT ever needs to be used in circumstances of an emergency where there would not be time to have the matter considered first by the Tribunal in a hearing. Some consumers questioned how, in any event, one would determine what is “necessary to save person’s life”. One consumer cited the fact that currently ECT is not generally conducted on weekends as evidence that describing ECT as “emergency treatment” can be a misnomer.

Consumers were very concerned about the risk that the psychiatrists would simply use the “emergency ECT” provisions to get around the obligation to seek prior Tribunal authorisation. As one person explained:

I don’t see how there would ever be a need for emergency ECT without going through the Tribunal. I think it may just be used as a way of getting around using the Tribunal – declare it an emergency and not go through all of the fuss.

People therefore strongly supported removing the emergency ECT provisions altogether to ensure that ECT cannot be performed without going through the Tribunal. At the same time, strengthening the weight of advance statements such that if a person refuses ECT in their valid advance statement, the Tribunal must follow this.

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