



Review of the *Mental Health Act 1986*

February 2009

Submissions of the Mental Health

Legal Centre Inc

Mental Health Legal Centre Inc
9th Floor 10-16 Queen Street
Melbourne Victoria 3000
Ph: 03 9629 4422

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ACRONYMS AND ABBREVIATIONS

- The Charter Victorian Charter of Human Rights and Responsibilities 2006
- The Convention UN Convention on the Rights of Persons with Disabilities, adopted by UN GA Res 61/106, 24 January 2007, entry into force 3 May 2008
- CTO Community treatment order
- DHS Department of Human Services
- ECT Electroconvulsive therapy
- GAA *Guardianship and Administration Act 1986 (Vic)*
- MHAct *Mental Health Act 1986 (Vic)*
- MHLC Mental Health Legal Centre
- HRLRC Human Rights Law Resource Centre
- ITO Involuntary treatment order
- LIV Law Institute of Victoria
- The Board Mental Health Review Board
(the MHLC submission refers to ‘the Board’ however we do not conclude that this is the appropriate review body. For simplicity we have adopted this term)
- MI Principles UN Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care, adopted by UN GA Res 46/119, 17 December 1991
- NGO Non-governmental organisation
- OCP Office of the Chief Psychiatrist
- OPA Office of the Public Advocate
- Standard Rules Standard Rules on the Equalization of Opportunities for Persons with Disabilities (1993)
- VCAT Victorian Civil and Administrative Tribunal
- VEOHRC Victorian Equal Opportunity and Human Rights Commission

- VLA Victoria Legal Aid
- VLRC Victorian Law Reform Commission
- VMIAC Victorian Mental Illness Awareness Council
- WTO World Health Organisation
- YL Youthlaw
- Unless otherwise indicated, all references to ‘the Act’ refer to a reformed ‘Mental Health Act’ to the extent that such an Act will exist.

The Mental Health Legal Centre

The MHLC is a statewide community legal service that for 24 years, has provided a free and confidential legal service to anyone who has experienced mental illness in Victoria where their legal problem relates to their mental illness. MHLC was established in response to the introduction of the MHAct to ensure that people with mental illness had access to legal representation to assist with their navigating the new Act.

MHLC is a non-profit organisation run by an independent Committee of Management. MHLC receives the majority of our funding from the Victorian Department of Human Services and Victoria Legal Aid. In addition project funding has been secured from philanthropy and other one of funding sources for a range of projects. The Legal Centre provides telephone advice and referral, direct advocacy - in some cases, education and general inquiries about mental health and the law for consumers in Victoria. MHLC undertakes research, law reform and policy work in relation to mental health and the law, based on community consultations. Policy is both reactive in response to government law reform initiatives and proactive in response to consumer initiative or requests. Of significance for the purposes of the Mental Health Act review, in the last 12 months MHLC has:

- published a review of the Mental Health Review Board, from the perspective of consumers;
- auspiced advance directives research in two phases - documenting the views and experiences of consumers and then documenting the views and experiences of clinicians in private and public sector and trialing the documents with some clinicians;
- researched the experience of the courts from the perspective of people with mental illness; research highlighted issues form arrest to imprisonment and is soon to be published
- commenced a legal service for prisoners with cognitive impairment located within the assessment units of selected prisons.

All MHLC activities aim to promote the rights and experiences of people who experience mental illness.

EXECUTIVE SUMMARY

- We do not endorse the consultation paper
- We make the following recommendations:
 1. The government consider a holistic approach to capacity and review the interaction between the *Instruments Act 1958*, the *Guardianship and Administration Act 1986* (**‘GA Act’**), the *Disability Act 2006*, the *Medical Treatment Act 1988* and the MHAct
 2. The government to consider whether guardianship is a more appropriate mechanism than involuntary detention in the event that a person is unable because of disability (mental disorder) to consent, where there is no advance directive and where there is a need for a supported or substituted decision maker.
 3. The review of Act is transferred to the Victorian Law Reform Commission (**‘VLRC’**) as part of a review of all capacity legislation and to examine:
 - Justification for limitations to the human rights of people with a mental illness in accordance with s 7 of the *Charter of Human Rights and Responsibilities Act 2006* (**‘the Charter’**);
 - whether separate statutes are required to govern treatment of people with disability and people with mental disorder;
 - whether there is a need for stand-alone Mental Health legislation;
 - whether an involuntary scheme should be maintained; and

- any law reform necessary to promote and protect advance directives, to include documents prepared by people with general health and mental health experiences.

4. We recommend the reference include:

- Protections to ensure the right to autonomous decision making and bodily integrity to people with a mental illness consistent with that accorded to people in the general health sector
- The right to protection against discrimination within the health sector on the grounds of mental illness
- Protections for people experiencing mental illness in the private sector
- Obligation on the public sector to work collaboratively with any private practitioner involved with a persons treatment - if the person consents
- Regulation of mental health care consistent with the general health provisions
- Proper assessment and regulation of ‘risk of harm’ to ensure that the tension between this and what is deemed in a person’s best interest is regulated and accountable, consistent with the regulation of chemical and mechanical restraint encapsulated in the *Disability Act* and *Guardianship and Administration Act*
- Forensic provisions
- Respect for advance directives – articulated in accordance with Advance Directive legislation, to include a statement of purpose consistent with the *Medical Treatment Act*

- Regulation of restrictive practices - consistent with general health and disability standards
- Independent complaints and audit mechanisms
- Increased penalties for service provider breaches

5. Ongoing review

- consistent with the provisions under s 44 of the Charter - a mandatory review of any mental health legislation every 3 years to consider compatibility with human rights
- any limitation of rights, such as those proposed by the discussion paper must be transparent and monitored and reviewed rigorously

6. National response to Mental Health reform

- the Act is reviewed upon finalization of Federal Health Policy and emerging National Mental Health Legislation
- the Victorian government explore Medicare provided counseling and support services to ensure flexible funding and increased access and support to augment early intervention and devise a method of joint planning/funding and mutual obligation

7. In relation to the issues raised through the MHLC experience of the present Act, we also make the following recommendations:

7.1. Definition of mental illness

- To be tightened in line with MI Principles 9 and 16 so that it refers to a ‘serious’ disturbance and as set out further below

7.2. Voluntary treatment

- people voluntarily detained have the right to:
 - review their file upon request
 - a treatment plan
 - a second opinion and
 - support or legal advice prior to co-signing the documents
 - appeal a refusal to provide treatment

- people requesting service voluntarily have the right to an assessment of their mental health

- further exploration of voluntary provision of services to young people experiencing mental health crisis- seeking their views as to the preferred model

- prior to involuntary detention all less restrictive options must be explored

- And compatible with the right articulated MI Principle 1.3 ‘to have a chosen person present during the procedure of informed decision’

- People have a right to request, specific case manager (on the basis of gender or culture) to request a transfer of case manager, to continue treatment with their nominated (private) practitioner and to request transfer to another support service

8. Advance Directives

We submit the new Act provide the following:

- Recognition of advance directives as a less restrictive alternative and in the best interest of the person consistent with principles of self determination and respect for human dignity without discrimination

- Recognition of advance directives in providing information to health care providers to optimize treatment
- Advance directives to be respected, to the greatest extent possible (prior to investigation of a legal framework) except in circumstances of proven emergency
- Where an advance directive is overridden in an emergency, that the course of action or treatment is justified, proportionate and in the person's best interests
- A person whose advance directive is not followed should be given the reasons for the decision and have the right to appeal and have the decision reviewed by an independent body
- In the event that the person in their advance directive specifically refuses ECT, that this must be given effect to
- Ethically contentious treatments, including ECT, should be included under special provisions, Division 4 of the Guardianship and Administration Act
- Reference to be given to the VLRC to investigate a legal framework for creation, implementation, promotion and protection of advance directives with the aim of introducing legally binding advance directives

10. Supported decision making

- If there is no advance directive or clear articulation of the persons wishes, then consistent with the Disabilities Convention, if a person cannot consent, supported decision making mechanisms must be explored

11. Substituted decision making

- In the event that a special procedure such as ECT, and there is no advance directive of the persons wishes, a guardian may need to be appointed by VCAT to investigate treatment options and if necessary make application for ECT
- In the event that there is conflict and it is established that the person is unable to consent a substituted decision maker, a guardian may need to be appointed by VCAT. Orders should be limited in time and scope

12. Involuntary treatment

- prior to involuntary detention all less restrictive options must be explored, evidence of this exploration must be on the file
- immediate treatment to be codified
- to the extent that there are provisions for involuntary treatment
- only contemplated once person satisfies threshold test of incapacity
- only on the grounds of ‘proportionality’ balancing impact of intervention and compulsory treatment against dignity of risk and potential harm, humiliation and degradation
- only on the grounds the benefits of treatment outweigh the side effects
- only by decision of an independent review body
- and by application of S56 of the Northern Territory Act principles to authorize treatment, the Tribunal must be satisfied that:
 - the treatment is in the best interests of the person;
 - the anticipated benefits of the treatment outweigh any risk of harm or discomfort to the person;

- alternative treatments that would be likely to produce equivalent benefits and with less risk of harm are not reasonably available; and
 - the treatment represents the least restrictive and least intrusive treatment option reasonably available.
- A system of staged orders should be articulated in the Act, to separate the intervention and allow consent where possible and avoid coercion
 - The CTO cannot be extended beyond 2 years

13. Legal representation

- Legal and other advocates to act in accordance with their primary duty - in an ethical manner on client instructions
- Free legal representation should be available to all consumers who wish to have it
- If an involuntary treatment order is extended twice the Board should recommend to the consumer that they obtain legal advice and should confirm that the consumer has access to information about available legal services and assistance from the case manager to arrange representation if required
- If Charter arguments are to be made at a Board hearing, a person must be provided with legal representation

14. Second opinion

- A system to facilitate access to independent second opinions should be developed
- It should be mandatory that the Board requires an independent second opinion if an Involuntary Treatment Order is extended twice
- Provisions similar to Section 190 of the Queensland Mental Health Act (2000) that the Tribunal must, if a person has been subject to involuntary status for more than 6 months, consider “whether an examination and report should be obtained from a psychiatrist other than the psychiatrist responsible for the patient’s treatment”

15. Review of voluntary treatment

- We recommend the MHAct include provisions relating to voluntary treatment governing:
 - Access to treatment
 - Rights upon refusal of access to treatment
 - Access to information
 - Statement of rights
 - Information to be provided
 - Treatment plans
 - Second opinions
 - support or legal advice prior to co-signing the documents

- We recommend further exploration of voluntary provision of services to young people experiencing mental health crisis - seeking their views as to the preferred model

16. Review of involuntary detention

- Further consideration needs to be given as to whether further statutory provisions are necessary in light of existing common law principles

- In circumstances where a person has capacity to make decisions regarding treatment, that person cannot be made subject to involuntary treatment

- To the extent that the Act will provide for involuntary treatment, we agree that there should be a staged approach beginning with the provision of an assessment order and if the criteria is met, an involuntary treatment order

- We recommend the MHAct expressly provide that a person has a right to an independent second opinion as soon as the person is made subject to an assessment order
- We recommend that the MHAct similarly require treatment not be administered on the person until the person is made subject to an involuntary treatment order
- We recommend that the review body be charged with the power to decide whether or not a person should be made subject to an involuntary treatment order
- To the extent that the MHAct will provide for circumstances in which involuntary treatment may be administered, we make the following comments regarding the grounds for involuntary treatment:

a) Definition of mental illness

- The definition of ‘mental illness’ should refer to ‘serious’ disturbance of thought, mood, perception or memory, rather than merely ‘significant’ disturbance.
- The grounds for involuntary treatment should not expand to persons with a personality disorder
- An involuntary treatment order must only be made in relation to a person who has actually been diagnosed with a mental illness.
- In making and/or reviewing the involuntary treatment order, caution must be exercised in relying on second hand, un-corroborated and historical events as the basis for a diagnosis.

b) Consent:

- Capacity to consent or to refuse treatment should be the first threshold question to be determined in any criteria for coercive intervention

- The criterion for consent to treatment must therefore delete reference to 'refusal of treatment'
 - The MHAct should also articulate the right in MI Principle 1.3 to have a chosen person present during the procedure of obtaining informed consent to treatment.
- c) The person needs immediate treatment and that treatment can be obtained by the person being subject to an involuntary treatment order
- The authorised psychiatrist must establish that any risks to the person or pain caused by the treatment is outweighed by its benefits
 - The authorised psychiatrist must also identify the time frame in which the treatment should have its intended benefits and provide evidence that alternatives have been explored
- d) Risk of serious and imminent harm
- There must be a real risk of imminent and serious harm to the person
 - The prevention of deterioration in the person's physical or mental condition is far too low a threshold to justify involuntary treatment and recommend this be removed from the criterion
 - In the instance where there is said to be a real risk of serious and imminent harm to others if the person is not subject to involuntary treatment, the order must only be made where the treatment would also provide some therapeutic benefit to the person
 - There must be some proportionality between the negative impact of the treatment and its benefit to a person's health or safety

- e) Person cannot receive adequate treatment in a manner less restrictive of his or her freedom of decision and action
 - This criterion should be amended to read “. . . in a manner less restrictive of his or her rights and freedoms”
 - f) The involuntary treatment is in the best interests of the person
 - A person cannot be subject to involuntary treatment unless it is in his or her best interests, taking into account the wishes of that person
- We recommend that ss 12A – 12D be removed from the MHAct.
 - We submit that community treatment orders should be limited to a shorter time period than what is presently provided for under the MHAct.
 - The CTO (with extensions) should lapse automatically at the expiration of 2 years from the commencement date of the CTO and cannot be extended any further.
 - Upon the request of the person, the person must be provided as soon as practicable, an independent second opinion.

17. Statement of reasons

Consumers must be informed of their right to request a Statement of Reasons at the closure of each hearing

Statements of reasons must be provided in each matter where the order has been extended more than once

Review hearings should be taped, and the tapes made available upon request

18. Treatment Plans

- In addition to those elements outlined in s19A, treatment plans should include:
 - Statement of wishes, such as an advance directive
 - least restrictive treatment goals
 - voluntary services available to the person
 - the treatment's intended benefits to the person
 - details of monitoring of any relevant side effects
 - onus to be placed on authorized psychiatrist to obtain consent from person before taking into account family/carer's wishes
 - the persons Individual Program Plan

- Review provisions under s35A should be reformed so as to:
 - Empower the Board to vary the treatment plan in addition to ordering it be revised by the authorized psychiatrist
 - Empower the Board to make an order declaring that the authorized psychiatrist, in preparing, reviewing and revising a person's treatment plan, has not acted in a way that is compatible with that person's human rights
 - Empower the Board to make an order declaring a person's treatment plan or part thereof is in breach of the person's human rights under the Charter
 - Compel the Board to order a revision of the treatment plan if any part of the treatment plan breaches the person's human rights under the Charter or if the authorized psychiatrist has not acted in a way that is compatible with that person's human rights
 - Provide strict time limits for compliance with any order to revise the treatment plan, by which time the matter must be brought back before the Board to determine effective compliance

19. Restrictive treatment

- abolition of seclusion
- regulation of both chemical and mechanical restraint

- Any provisions for restraint and seclusion compatible with the guidelines for treatment of general medical provisions and in the absence of such the provisions of the Disability Act
- ECT – to be defined as a special procedure within the meaning of the Guardianship Act, with the appointment of an independent guardian to contemplate the persons best interest
 - Not to be used against the persons wishes if articulated in an AD or similar document
- Other ethically contentious or experimental treatment to be defined as a special procedure, a guardian to be appointed
- DHS to provide a crisis response service reactive to the needs of people experiencing a mental health crisis as part of ‘000’ response and to travel with police in the event that someone needs transportation

20. Review / Appeal Mechanisms

Legislation should be amended to establish a review and appeal system with the following features:

- Greater independence
- Timely automatic reviews – initially at three days then each 6 months
- The review body to make all orders beyond initial assessment orders
- There is a legislative obligation on treating team members to advise the authorised psychiatrist when a person no longer meets criteria
- Single member hearings must not be increased without adequate safeguards and with access to a legal advocate
- Legislative guarantee of adequate numbers of members with experience of involuntary treatment and the mental health system
- A right to merits review at the Supreme Court
- The Board should have power to:
 - Vary treatment plans
 - Review a refusal to transfer a patient
 - Review voluntary patients after 6 months
 - And it should become an offence to fail to comply with a Board order
- Involuntary treatment orders should have a maximum duration of six months

- A failure to conduct a mandatory review should invalidate the order
- A legislative guarantee and resourcing of legal representation for all who want it
- If a person is ordered not to attend their hearing they should be appointed a lawyer
- A number of specific procedural forms essential to give effect to natural justice and therapeutic jurisprudence and which emerged from “Lacking Insight”¹ are set out below
- There should be legislative clarification of non-disclosure applications consistent with natural justice
- Appellants/reviewees should be given increased capacity to rely on evidence from hearings to pursue their rights
- Participation by parties other than the appellant/reviewee should always be subject to the appellant/reviewee’s consent

21. Monitoring and Complaints

The establishment of a monitoring, accountability and complaints system with the following features must be pursued:

- It will sit outside the DHS – potentially as either an independent commission or division of the Ombudsman’s office
- It will have jurisdiction over complaints about all psychiatric disability health and support services
- It will subsume all the role of the Office of the Chief Psychiatrist, except perhaps the development of clinical guidelines and provision of practice advice to clinicians
- Failure to comply with a direction of the body will be an offence, to be prosecuted by either the Ombudsman (if it is a separate commission) or the Department of Justice
- It will provide guidelines on the MHAct’s implementation to services
- It will perform a proactive random and unannounced audit function and analyse complaints for systemic reform
- It will have be responsible for prosecuting breaches of the MHAct and be properly resourced to do so

- It will report annually on collated complaints data from all services and on all its other functions
- There will be legislative timelines for response to complaints and a legislative obligation to assist complainants with the process
- There will be access to VCAT for unresolved complaints
- It will develop guidelines for and provide advice about internal complaints processes within mental health services.
- Its processes will be flexible enough to accommodate the needs of complainants
- It will employ consumer advisers and investigators;
- It should be authorised to deal with complaints made by others in some circumstances, including systemic complaints
- If the Quality Assurance Committee is maintained, its activities should become subject to reporting annually
- The MHAct should contain provisions setting standards for internal service complaints processes

22. Confidentiality

- We do not support broadening the circumstances in which confidential information may be disclosed without the person's consent
- We recommend that section 120A(3)(ca) should be tightened read that information can only be provided if it is necessary for a person's day to day care
- We recommend also that s 120A(3)(c) which permits the giving of information concerning the condition of a person who is receiving psychiatric services if communicated in 'general terms', be amended to state that such information may only be communicated "*in the most general terms only*"

- We recommend people receive clear and accurate information about the extent to which their confidentiality rights are limited

1. INTRODUCTION

Terminology

Consumer

We note the discussion paper refers to people with mental illness as ‘consumers’. Although this is the preferred term of many people who experience mental illness there are many people who do not acknowledge this naming and prefer ‘users and survivors of psychiatry’. Neither term is presently articulated in statute. It is the view of the MHLC that these terms belong to consumers and cannot be altered by other than consumers. We propose to adopt person first language and the terminology of the *Disability Act 2006* – ‘people with mental illness or mental disorders’. Consistent with that Act we propose the use of other legal terms in relation to any action such as appellant, reviewee or detainee.

Many people diagnosed with 'mental illness' or 'mental disorders' are seeking a way of positioning themselves within national debates about the efficacy of their own treatment, recovery and related law and policy. In doing so, they feel disadvantaged by both the language of 'patient' and the language of 'client'. There is a perception that the language of 'patient' has been colonised by doctors and that psychologists and social workers have laid claim to the term, 'client' (Our consumer place, Our community (2008)). It needs to be recognized, though, that the word ‘consumer’ is not the preferred terminology of all people who experience psychiatric disability.[Lacking Insight]

Consumer has been chosen to describe people who:

- self identify as users of mental health services;
- have been diagnosed with mental illness or psychiatric disorder, or

- have been active within a mental health service user movement that is aiming to bring change - both radical and incremental - to the way people labeled with mental illness are treated by services and society. [Lacking Insight]

Carer

The discussion paper identifies ‘carers’. Without wishing to diminish the important role of support to a person with a mental illness, particularly a person who is a family member or loved one, it is important language that infantilises patronises, demeans or degrades a person be avoided. It is the view of clients that ‘carer’ implies that a person cannot make their own decisions, requires caring and is a burden.

Deegan (1988) articulates the dual nature of relationships, the importance of the support, caring and love from families, friends, and professionals:

We do remember that even when we had given up, there were those who loved us and did not give up. They did not abandon us. They were powerless to change us and they could not make us better. They could not climb this mountain for us but they were willing to suffer with us. They did not overwhelm us with their optimistic plans for our futures but they remained hopeful despite the odds. Their love for us was like a constant invitation, calling us forth to be something more than all of this self-pity and despair ... One day, something changed in us. A tiny, fragile spark of hope appeared and promised that there could be something more than all of this darkness ... This is the mystery. This is the grace. This is the birth of hope called for by the possibility of being loved. (p. 15)²

We propose ‘significant other’ ‘support person’ or ‘nominated person’ (if there is a delegated decision maker assisting the person). We believe that consumers are comfortable with these terms – reflected too in the *Disability Act*. We are comfortable with terms articulated in the *Guardianship and Administration Act 1986* (‘GA Act’). It is crucial however that the nomenclature has dignity and respect for both parties.

Severity of mental illness

The discussion paper purports to address only the treatment and care of Victorians with a ‘serious mental illness’. We are perplexed by this definition and have not managed to find any citation to assist us with the scope of this terminology. The severity of distress or not experienced by a person is not a diagnostic label but an individual experience. Anyone experiencing mental health issues must be taken seriously, consistent with the better outcomes document an immediate response and early support to people experiencing mental health issues must be provided- not categorisation of seriousness. The MHLC experience is that the most ill people are often denied a service. Those maintained under orders are people who are institutionalized and who the services fail to engage in a meaningful way resorting to a coercive, punitive model of service delivery. We submit that services provided under statute should where ever possible be reactive to a persons request for assistance and not on the basis of subjective view of ‘serious’. This will be further explored in our submission.

Recovery

‘Recovery’ needs to be carefully defined. Recovery is intended to mean that the person maintains well-being, that they manage their mental health and are able to participate in our community in a way that they feel comfortable.

Recovery is a process, a way of life, an attitude, and a way of approaching the day’s challenges. It is not a perfectly linear process. At times our course is erratic and we falter, slide back, regroup, and start again. . . .The need is to meet the challenge of the disability and to re-establish a new and valued sense of integrity and purpose within and beyond the limits of the disability; the aspiration is to live, work, and love in a community in which one makes a significant contribution” (Deegan, 1988, p. 15).³

However the term ‘recovery’ risks viewing mental illness as a state that must be overcome. In fact achieving well-being and if necessary managing mental health is an individual process. If recovery is a term articulated in legislation we need to state:

- Recovery is a contested idea (Clinical vs Consumer understanding)
- Recovery must *not* be understood in a clinical sense. The clinical definition views recovery as the process of returning to a prior state (this is an unfortunate application of general medicine to mental health practice). Recovery does not mean returning to a ‘pristine state’ before harm was done / ill health occurred, rather, recovery means regaining a sense of self, no longer valuing one’s worth by using the destructive criteria that was used by others to diminish you
- Understood from a consumer perspective, recovery refers to an acceptance of who one is, what has happened in the past, an appreciation for what one has done with one’s life – and what one’s strengths are (not a focus on what is unable to do)

The iatrogenic effect

Iatrogenesis is any adverse or physical condition induced in a patient through the effects of treatment by a physician or surgeon. Ivan Illich, first wrote on the subject in 1976. He proposed that modern medicine had become detrimental to society, by amongst other things, "launching ... an inhuman attempt to defeat death, pain and sickness".[5] By doing so, he argued, medicine had deprived individuals and societies of their ability to cope with sickness and death.

The provision of mental health treatment in Victoria does little more than regulate involuntary treatment – it wounds and scars those captured by it. It strips the person of independence, autonomy and dignity. The humiliation and degradation of involuntary detention cannot be denied. The iatrogenic effects remain.

2. BACKGROUND

We thank you for the opportunity to comment on the Review of the *Mental Health Act* 1986 dated December 2008. We note the consultation paper expressly recognizes that it is not intended to limit the debate to the specific issues expressly addressed but is open to any matter related to the MHAct. We make the following comments in addition to our response to the Department of Human Services ('DHS') consultation paper '*Because Mental Health Matters*', May 2008

We make no apology for the limitations to the MHLC response, we are astounded however, by the haste and lack of rigor of the review. We would ideally have sought the views of clients on the many aspects of the MHAct that impinge on their daily lives but time has not permitted. In addition, no additional resources were given to consumers and their advocates to allow a satisfactory response. The 'consultations' organised by the review team highlighted the dearth of information and knowledge of the present Act and offered little opportunity to assist with this. Clearly there needed to be clarification about complimentary capacity provisions, health and information privacy regulations, and what can be achieved by legislation. People left the forums frustrated and disappointed with the lack of scope of the review and the haste of its conduct.

The discussion paper claims to address the Charter. It fails to do this. It fails to justify the limitation that the protection of that a person must not be subjected to medical treatment without his or her full, free and informed consent can be limited.

Section 7 of the Charter permits the limitation of a Charter right only when it can be "demonstrably justified in a free and democratic society".

At the very least, medical treatment without consent must be considered one of the most serious Charter rights that should not be limited.

In the context of growing worldwide recognition of the fundamental importance of human rights, it is becoming increasingly difficult to see how a stand-alone legislation authorising the

involuntary treatment of persons living with a mental illness, notwithstanding that person's capacity to make decisions, can exist justifiably.

The present Act is outdated. It was designed to protect people with mental illness at that time who were housed in large institutions and did not anticipated their closure and the move to community based services which occurred a decade on. Nevertheless as noted in the second reading speech of the Honourable T W Roper dated 30 May 1985 to the Mental Health Bill, ‘... the fundamental principle on which the legislation is based is that of the “least restrictive alternative”.’⁴ We agree that ‘... involuntary admission has serious consequences, and should be contemplated only as a matter of last resort.’⁵

In reflecting upon archival material we are reminded that the MHAct was introduced with a rights based focus with the aim to move decisions made on behalf of people with mental illness from a largely unaccountable medical model that assumed that the doctor knows best to an accountable transparent model that established a system of protection for the ‘patient’, described at the time as a social model. Current MH law derives from 18th century statues where people were declared infirm stripped of all decision making responsibility- integrity of mind body and legal and financial and assigned to asylums on the grounds that they were dangerous.

What followed in the mid 80’s- mid 90’s was a rapid period of deinstitutionalisation and a desperate attempt to manage some of its worse consequences which included an increase use of community treatment orders to ensure that people continued with treatment.

So, although the institutions have gone they have been substituted by a widely used model of civil detention. And more than 20 years later Victoria leads the world in terms of its use of involuntary treatment primarily as community treatment orders. The present system has been accused of merely altering the face of mental health services, leaving the mind-set unchanged and the type of care provided by psychiatric units of general hospitals still institutional in nature. Research suggests that there is an inability to conceive of the provision of mental health services beyond the institutional setting.⁶ This claim is supported by other research which adds that the treatment offered by Area Mental Health Services leaves people no freer to participate in the

community.⁷ Psychotropic medication – so heavily relied upon because of a lack of funding for alternative therapies – perhaps heftier detention than imposed by blue stone walls.

Perceptions of mental illness must be challenged and discrimination perpetuated by the stigma of segregated and punitive legislation with its emphasis on risk of dangerousness must cease. Stand alone legislation merely perpetuates the myth that people with mental illness must be treated differently and isolated, in apprehension of events and reactions they might display.

The challenge is to demystify mental illness and encourage the community to embrace and accept people with mental health issues. Support must be offered when a person is experiencing ill health, and offered in a way that is recommended by the person who has the mental health issue. It must be an objective and at all times treat people with dignity and respect, and to apply human rights principles.

The review paper fails to address the philosophical, ethical and moral framework that alienates people who experience mental illness and fails to reflect current trends nationally and internationally that question the relevance and appropriateness of stand alone mental health legislation. It is anachronistic given current human rights obligations and the current psychiatric knowledge and best practice. A rights-oriented approach would create a more generic capacity-based legislation that does not discriminate between ‘mental’ and ‘physical’ illness.⁸

MHLC has previously urged the Minister to refer review of the Mental Health Act to the Victorian Law Reform Commission (‘VLRC’). This recommendation was also made by Office of Public Advocate (‘OPA’), the Law Institute of Victoria (‘LIV’), Victoria Legal Aid (‘VLA’) and many consumer and carer groups and mental health practitioners but was ignored. As heralded by these groups the review lacks independence. In our submission the DHS, as the sole provider of public mental health services and the funding body for many NGOs who provide public mental health services is unable to conduct a proper and rigorous review. It is significant that the discussion paper fails to inform the community of options beyond tweaking the present MHAct.

It is clear that DHS has little awareness of the notion of independence as it continues to maintain that the only available review and complaint bodies:

- Mental Health Review Board
- Health Services Commissioner
- Office of Chief Psychiatrist

All funded by DHS and thus incapable of conducting a fair independent review; or independent investigation and complaint handling.

Framework for reform

The consultation paper has framed the review so that it presumes already that stand-alone legislation is needed. It does not reflect on whether a generic capacity-based legislation would be sufficient given the existing legislative framework. The consultation paper fails to acknowledge all previous reports and reviews and cries for reform to address the inequities in health care and provision of mental health services.

We must acknowledge the stigma of mental illness and the discrimination that people suffer. The fear of persons with mental illness creates a hidden bias against them that prevents equal justice, it is a form of discrimination (Perlin, 2000).[Lacking Insight]

Fusion of incapacity legislation

The consultation paper correctly addresses that there are debates surrounding whether or not it is justifiable to have stand-alone legislation for involuntary treatment rather than a generic capacity-based legislation. Further than this there is now movement in Australia to develop legislation along these lines. We consider greater thought needs to be placed on this issue - it cannot be taken for granted that a stand-alone MHAAct is justified or necessary particularly given

the existence of the Charter and the existing substituted-decision making regime. We support the creation of a generic capacity-based legislation which does not discriminate between treatment of physical or mental illness.

We would support legislation that also expressly reflects that treatment should be voluntary wherever possible and that any decision about a person with a mental illness must evaluate and continue to re-evaluate the persons capacity in the event that are made involuntary. The aim of any substitute decision making is always to encourage and assist the person towards independent autonomous decision making, as well as take into account the person's views, wishes, beliefs and values.

And now the interim report of the National Health and hospitals commission released 16 February, 2009 suggests Federal control of health services.

In this climate it is a challenge for the Victorian Government to seriously and genuinely review the need for stand alone mental health law - to take leadership and initiative and to develop new and innovative generic capacity legislation. Such legislation could provide a model of best practice for National law reform.

The most recent and thorough review springs from the ACT - at this stage articulated in a Model Legislation Paper, November 2008. The ACT evaluated their Act and in an attempt to modernize it prepared a discussion paper April 2008. It made some recommendations for change along the lines of the present Victoria review. The ACT government heard resoundingly from the community that more was needed and rewrote their vision for reform in the Model Legislation Paper. Under their proposed model they have adopted the general trend in other jurisdictions toward a fusion model of incapacity legislation.

In Western Australia there is discussion supporting the development of generic capacity legislation or incorporating decisions about psychiatric treatment into guardianship regime.⁹

Mental Capacity Act 2005 (England and Wales) was developed following an extensive consultation period commencing in 1998. It was designed to encourage the treatment of mental ill health according to principles similar to those which govern the treatment of general ill health.

Unified capacity-based legislation should articulate the common law presumption that a person 18 years or older has the capacity to make decisions about their own body and their affairs. Unless this presumption is rebutted and the person is deemed to lack capacity to make the particular decision, the law should not presume the right to intervene to treat a person against their will, even if the treatment could be “justified” as being within the person’s “best interests”.¹⁰

This desire to promote nondiscrimination on grounds of mental health has led inevitably to an emphasis on patient autonomy. In the context of physical health a patient with capacity is free to choose whether or not to accept treatment: his or her autonomy is respected.

These are admirable principles and we recommend that they are accepted by the Victorian Review.

Involuntary treatment under the MHAct is largely based on clinical considerations. However any limitations to human rights should include consideration of social, cultural and legal matters.

The impact of transition from being a respected community member to a person detained involuntarily, stripped of independent decision making and treated in a coercive environment cannot be ignored. Goffman’s ethnographic study of a mental institution in the 1960s presented hospitalised treatment as an example of the ‘total institution’.¹¹ He describes the way patients give up one role and take up another – that of the patient. They adopt this role in order to survive.

As stated by one MHLC client ‘you learn to walk the walk and talk the talk’ - otherwise you never get out. And it only once you are out that you can start to try and pull your life together.

So treatment is not a contract it is an exercise of authority over which the person has no control.

The medical model of involuntary treatment under the MHAct empowers the clinician rather than the consumer. A legal model privileges the persons rights and applies rigorous protections and procedures.

How best do we protect the person's rights and dignity and ensure that they are protected that their wishes are if possible acted upon?

As does involuntary treatment, guardianship ultimately involves increasing state intervention to protect people deemed disabled and by reason of disability unable to make decisions. It appoints a substitute decision maker to make specific decisions in the person's best interests upon consideration of their wishes and interests. Increasingly this proxy role has been augmented by greater provision and respect for documents made in advance of a person becoming incapacitated. Enduring powers of attorney, documents under the Medical Treatment Act, advance directives, advance care plans and advanced statements are some such documents.

In terms of minimizing the scope of intervention, promoting participation and tailor making orders in time and scope guardianship, offers a far more flexible model than involuntary detention within a mental health regime. Moreover guardianship tribunals are required to choose the least restrictive option available on the day- not speculate about the future.

Guardianship involves the appointment of an independent person who is to investigate options on behalf of the person and consider their wishes prior to making a decision to address the issue that needs resolution. The applicant is not automatically appointed as the guardian. More often than not the applicant is a social worker or case manager who has identified a problem or conflict about the treatment, accommodation or care of a person with a disability. And a family member, friend or the public advocate is then appointed.

Emergency guardianship orders can be made at very short notice.

- So, why is it that if your disability is anything other than mental illness, a family member, a friend or an independent advocate (the public advocate) may make important decisions on your behalf , if you are incapable of making them yourself?
- If your disability is a mental illness these decisions are entrusted to the authorized psychiatrist, who is likely to delegate this authority to a junior trainee psychiatrist. Who asks questions about treatment on your behalf? Who balances the benefits and harms of proposed treatment on your behalf?
- Who ask questions consistent with your prior expressed wishes and interests? Who is acting in your best interests?
- Why does the MHAct permit guardianship legislation to appoint a guardian in relation to non psychiatric decisions but not in relation to psychiatric treatment?
- Why is guardianship tailor made – limited to time and scope whereas the MHAct is plenary in relation to mental health treatment?

Involuntary treatment orders authorise the proposed treatment of the applicant. In our view this is a highly flawed model with the treating practitioner making recommendations and then acting upon them. There is no accountability except for the Mental Health Review Board (**‘the Board’**) that rubber stamps the practitioners recommendation or independent analysis.

When formal legal coercion is invoked what is the best model?

Adult guardianship law is designed to revolve around perceived need. Trust and participation should be the underpinnings of this model, and ways to ensure that the person’s wishes and interests are respected.

Much needs to be examined about the use of law and different experiences of model of coercion.

In our submission the best model, in the absence of an advance directive is supported decision making. This should always be contemplated prior to the appointment of an independent substituted decision making. This involves a process to support the persons expressed wishes and preferences. It may involve seeking information from a person's friends and family to establish previous expressed preferences wishes and interests so as to act as possible in accordance with these views. (see OPA decision in relation to Maria Korp, - the processes applied to understand her wishes and preferences - the realization and acceptance of these views)

The guardianship regime already creates substituted decision-making in relation to non-psychiatric medical treatment.

We acknowledge that guardianship law would need significant adjustment and urge that the government advance this reform agenda contemporaneously with the VLRC reference on Guardianship.

Alternative models

We recommend exploration of a framework that includes:

- Protections to ensure the right to autonomous decision making and bodily integrity of people with a mental illness is consistent with that accorded to people in the general health sector
- The right to protection against discrimination within the health sector on the grounds of mental illness
- Protections for people in the private sector
- Obligation on the public sector to work collaboratively with any private practitioner involved with a persons treatment- if the person consents

- Regulation of mental health care consistent with the general health provisions
- Proper assessment and regulation of ‘risk of harm’ to ensure that the tension between this and what is deemed in a persons best interest is regulated and accountable, consistent with the regulation of chemical and mechanical restraint encapsulated in the *Disability Act* and GA Act
- Forensic provisions
- Respect for advance directives – articulated in accordance with Advance Directive legislation, to include a statement of purpose consistent with the *Medical Treatment Act*
- Regulation of restrictive practices- consistent with general health and disability standards
- Independent complaints and audit mechanisms
- Increased access to legal representation and advocacy
- Increased penalties for service provider breaches

Human Rights Framework

A range of international human rights instruments set out the rights of people with disabilities, the most recent being the Convention which was adopted by the General Assembly in 2006 and ratified by Australia in July 2008. The UN Principles for the protection of persons with mental illness and the improvement of mental health care (1991), generally referred to as the ‘MI Principles’, deal specifically with the rights of people with psychiatric disability. Another U.N. standard relevant to people with psychiatric disabilities is The Standard Rules on the

Equalization of Opportunities for Persons with Disabilities (1993), generally referred to as just the ‘Standard Rules’.

The MI Principles have been the prevailing human rights standard for mental health services throughout Australia, but these now must be read in light of the more recent developments including the Convention. This was highlighted in the March 2008 issue of the UN Enable Newsletter of the UN’s Secretariat for the Convention, where it stated:

It is important to note that some provisions of the Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care have been criticized and the Convention on the Rights of Persons with Disabilities now supersedes these standards to the extent that there is any conflict between the two instruments.

The UN Convention on the Rights of Persons with Disabilities in its preamble reaffirms the need for persons with disabilities to be guaranteed their full enjoyment of all human rights and fundamental freedoms without discrimination¹² and that discrimination on the basis of disability violates the “inherent dignity and worth of the human person”¹³. State Parties to the Convention, including Australia, are required to “recognize that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life”¹⁴. Furthermore, paragraph (n) of the preamble highlights “the importance for persons with disabilities of their individual autonomy and independence, including the freedom to make their own choices”¹⁵. These fundamental principles are reinforced in the general principles of the Convention in Article 3 and expounded in articles 5 (equality and non-discrimination), article 12 (equal recognition before the law) and article 14 (liberty and security of the person).

Similarly, the Disability Act 2006 (Vic) clearly articulates in its Principles in s 5, that:

- (1) Persons with a disability have the same rights and responsibilities as other members of the community and should be empowered to exercise those rights and responsibilities.

The Disability Act goes much further than the current MHAct in articulating the collective rights of people with a disability and the obligations on service providers consistent with the promotion of those rights¹⁶. For example the Disability Act specifically articulates that people with a disability have equality of rights when it comes to respect for human worth and dignity (s5(2)(a)), exercising control over their own lives (s5(1)(d)) and to participate actively in the decisions that affect their lives and have information and be supported where necessary(s 5(1)(e)).

It is also interesting to note that the Disability Act acknowledges the right of people with a disability to participate in activities involving a degree of risk and that services should be provided in a way which “reasonably balances” this right against considerations of safety.¹⁷

We know anecdotally from our clients that people often feel punished under the mental health system for their lifestyle decisions which may appear to be ‘risky’ but would be tolerated by health professionals and the community if the person did not have a mental illness.

International human rights instruments, most notably the legally binding Convention, can be used alongside the Victorian Charter to interpret legislation like the MHAct to ensure that it is compatible with human rights.

The Charter came into force on 1 January 2007. Obligations of public authorities to consider and act consistently in regard to human rights, and the powers of the courts to interpret and apply legislation in accordance with the Charter, came into force on 1 January 2008. The Board is obliged as a tribunal to apply and interpret the MHAct consistently with the Charter. As ‘public authorities’ hospitals, clinics and mental health professionals providing treatment under the MHAct, including involuntary treatment, must ensure all acts and decisions are consistent with the Charter. We note the Board is also a ‘public authority’ when acting in an administrative capacity and so is bound in those circumstances to act in accordance with the Charter.

Some of the human rights recognised by the Charter relevant to provision of mental health treatment, voluntary and involuntary, are:

- right to recognition and equality before the law (s8);
- protection from torture and cruel, inhuman and degrading treatment (s10(a) and (b))
- freedom from medical treatment without consent (s10(c));
- freedom of movement (s12);
- right to privacy and reputation of person (s13);
- freedom of thought, conscience, religion and belief (s14);
- freedom of expression (s15);
- right to liberty and security (s21); and
- humane treatment in detention (s22).

The Charter provides that these rights can be subject to reasonable limits where this can be demonstrably justified in a free and democratic society based on human dignity, equality and freedom, and taking into account a number of factors including least restrictive means available to achieve the purpose of the limitation (s 7). [Lacking Insight]

With the advent of the Victorian Charter of Human Rights and Responsibilities and the UN Convention on the Rights of Persons with Disabilities, now more than ever, it behoves the Victorian government to seize this opportunity to make legislative reform to most effectively articulate, promote and enforce the human rights of people with mental illness. It appears to us that the current legal framework under the MHAct cannot hope achieve these aims when people with mental illness are subject to separate and discriminatory legislative provisions based solely on their diagnosis.

Such a framework offends the principle of non-discrimination on the grounds of disability and should be abhorred by the community for entrenching the stigma of mental illness and an involuntary treatment regime which is felt by many to be an experience of profound disempowerment and a denial of their inherent dignity and respect.

The submissions of the LIV, Human Rights Law Resource Centre ('HRLRC') and the Victorian Human Rights and Equal Opportunity Commission ('VHREOC') explore these rights and the government obligations in more detail and we support and endorse their submissions.

3. VOLUNTARY TREATMENT

We submit that the MHAct should incorporate provisions to protect the rights of persons who seek psychiatric treatment on a voluntary basis. This approach is consistent with the *Because mental health matters* green paper which advocates for improving access to services. As mentioned in the consultation paper, one of the objectives of the MHAct should include increased participation by the person and human rights. Therefore rather than focusing on compulsion, we should be focus on engagement that is inclusive, that is driven by the person with the mental health issue.

At present, services are geared towards giving priority to provide treatment to persons when they are most acutely unwell. In our view, a more Charter compliant model of the legislation should ensure any interference with a person's freedom of movement, right to privacy and right to refuse medical treatment is kept to a minimum and any intrusion on a person's rights should be done in a manner less restrictive. The legislation should therefore reflect that treatment should primarily be received on a voluntary basis. As such, it is important that persons with a mental disorder seeking treatment on a voluntary basis are afforded with certain statutory rights.

Upon the commencement of the Act, it had included provisions regulating the admission of persons with a mental illness on a voluntary basis. The *Mental Health (Amendment) Act 1995* subsequently removed these provisions. The second reading speech to the Mental Health (Amendment) Bill 1995 says

... the admission of a person voluntarily seeking treatment for a mental illness should be treated in the same way as a person voluntarily seeking treatment for any other medical condition. As in-patient mental health services are increasingly provided by general hospitals this separate regulation is no longer appropriate and contributes to the stigma surrounding mental illness'¹⁸

We would say that the creation of a MH Act which revolves primarily around involuntary treatment creates greater stigma surrounding mental illness than an Act which guarantees rights

and protections for persons with a mental illness. The legislation as it presently exists perpetuates the misconception that persons with a mental illness are incapable of making decisions regarding treatment. By including provisions relating to voluntary treatment, the legislation shifts the focus toward care and treatment for the person, and narrowing the circumstances in which involuntary treatment is permissible.

We highlight that these rights not only extend to persons with a mental illness but should also to persons with a mental disorder. This ensures that persons with personality disorder are afforded with the same rights.

Some of our clients have indicated that they have acquiesced to treatment in fear that if they do not, they will be made subject to an involuntary treatment order. In such circumstances, the quality of the person's consent is compromised. The person is effectively receiving treatment on a de facto involuntary basis without having the review mechanisms and other protections afforded to persons subject to an involuntary treatment order. The purpose of including these legislative rights is also to provide protection for those persons who are effectively receiving treatment on a de facto involuntary basis.

In our view, the MHAct should include provisions regulating the following.

Access to treatment

In our experience, we have encountered clients who have been turned away from accessing psychiatric treatment as they are not considered sufficiently unwell to receive treatment. We recommend that the MHAct include provisions to give people the right to request an assessment of their mental health needs.

Some Australian jurisdictions currently include provisions relating to admission into a mental health facility on a voluntary basis.¹⁹ We consider that it would be appropriate to include provisions providing the person with certain rights in circumstances where a person is seeking admission and admission is refused, similarly to the provisions offered in the Tasmanian *Mental*

Health Act. Section 20 of the *Mental Health Act 1996* (Tas) says that if a medical practitioner determining admission refuses a persons request to be admitted on a voluntary basis, the practitioner must:

- tell the person why admission is refused;
- if the medical services appropriate to the person’s case may be available elsewhere, give the person appropriate information about how to obtain those services; and
- advise the person of his or her right to have a second opinion.

We recommend that the MHAct should be reformed to incorporate these same rights.

We submit that the MHAct should include provisions giving persons seeking treatment on a voluntary basis, a right to apply to the independent review body, the authorised psychiatrist’s decision to refuse treatment and/or discharge the person.

People are concerned that the term “informal” is not only less clear than “voluntary” but also connotes too few rights and lesser status than “voluntary”. Consistent with this and our recommendations generally we recommend the former terminology be reinstated.

The MHAct should also expressly provide that a person receiving psychiatric treatment on a voluntary basis may cease treatment at any time.

Access to information

Presently, persons receiving psychiatric treatment on a voluntary basis from the public sector can only receive information through a *Freedom of Information* request. We contend that a person should have a more ready access to his/her file. We consider the person should be able to inspect and photocopy the file at any time, to enable that person be keep informed of his/her medical records. This may also facilitate greater participation by the person in his or her treatment.

Persons accessing health records in the private sector pursuant to the *Health Records Act* are afforded greater access and flexibility than under the *Freedom of Information Act*. We consider that persons accessing mental health records in the public sector should also have the same protections as provided for under the *Health Records Act*. Arguably this would make access to information more Charter compliant.

Accordingly, we recommend that provisions governing access to mental health information in the public sector be in line with the *Health Records Act*.

Statement of rights

Section 18 of the MHAct presently provides that a ‘patient’ must be given a statement advising the person of his/her legal rights and entitlements, including a right to legal representation and a second opinion, in a manner and language that the ‘patient’ is able to understand. ‘Patient’ is defined in the Act as a forensic patient, an involuntary patient or a security patient.

We recommend that a person receiving psychiatric treatment on a voluntary basis should also be provided with a statement of rights outlining a persons’ legal rights and entitlements under the Act.

Information to be provided

Under s 19 of the MHAct, the following information must be kept at a place readily accessible to all ‘patients’:

- Copies of the Act and the GA Act and any publications prepared by DHS for the purpose of explaining the provisions of the MHAct;
- Copies of the Statement of Rights, and

- The address of the Board, the MHLC, OPA, the chief psychiatrist, the community visitors and VLA.

We recommend that the MHAct should expressly include an obligation that this information should also be readily accessible to persons receiving psychiatric treatment on a voluntary basis.

We further recommend that the MHAct explicitly provide that all patients, voluntary and involuntary, be provided the opportunity to nominate a person to whom the statement and explanation must also be given²⁰, and that any person upon being made involuntary must be given a statement as to why they are being made involuntary as well as what they can do about it.

Right to treatment plans

As already mentioned above, in some instances, although a person is not subject to an involuntary treatment order or community treatment order, a person may nevertheless perceive themselves to be coerced. Winnick relevantly points out that this can have an adverse impact on the effectiveness of the therapeutic relationship between and the person and the service-provider, as well as impede the ability to achieve therapeutic goals.²¹ Conversely, where people perceived that clinicians ‘acted out of concern for them, treated them fairly, in good faith, with respect, and without deception, provided them with an opportunity for voice and gave serious consideration to what they said’ were less likely to feel coerced. Clinicians should therefore ‘involve the patient in hospital admission and treatment decision-making to the greatest extent possible’, while ‘legal rules should be structured so as to facilitate voluntary admission and treatment’²²

In broad terms, s 19A of the MHAct provides that the authorised psychiatrist must prepare and regularly review and if needed, revise a treatment plan for each ‘patient’. We submit that a person seeking treatment voluntarily should also have a right to a treatment plan if she or he wishes. The treatment plan should also include the availability of a case manager if the person wishes to have a case manager.

We recommend that persons seeking treatment voluntarily also be provided with the right to have their treatment plan reviewed by the Board.

Second opinion

We recommend the MHAct provide that persons seeking treatment voluntarily have a right to an independent second opinion and that this second opinion be provided as soon as practicable.

Voluntary treatment of young persons

We know anecdotally through our legal work and the work of Youthlaw ('YL') that many young people do not wish to advise that they have mental health issues, they do not contact the MHLC, preferring to attend YL and generally for reasons other than mental health related legal matters. These may involve debt, criminal matters, income support or accommodation – it is only when they give instructions mental health issues may emerge. Clients seen at the MHLC are generally diagnosed, labeled and 'in the system'. It is our experience that many young people try to avoid the mental health system.

We consider there should be express provisions relating to the voluntary treatment of young persons.

As stated by Professor Patrick McGorry in the Age newspaper, 18 Feb 2008, 'Paradoxically, young people with the greatest need and capacity to benefit from care are the least likely to achieve access'.

The review must consult with young people, on the fringes of mental health services, to establish their views and ensure that their needs and interests are heard. We recommend exploration of voluntary services to young people experiencing a mental health crisis in a non stigmatized setting. Young people must be involved in the design of such services.

4. INVOLUNTARY ORDERS

The Convention is silent on whether or not involuntary treatment is consistent with human rights. There is argument therefore that involuntary treatment is not permitted under the Convention.

Bearing in mind the Charter and the Convention, the government must rigorously consider the threshold issue of whether the existence of involuntary treatment is consistent with human rights. The review has proceeded with the presumption that the MHAct is necessary without first outlining the fundamental question of whether the limits on a person's rights when placed under an involuntary treatment order, are such reasonable limits as can be demonstrably justified in a free and democratic society based on human dignity, equality and freedom.²³ Anecdotal evidence also indicates that the existence of involuntary treatment regime deters some people from seeking treatment on a voluntary basis for fear of the risk later being made involuntary.

We recommend that further consideration needs to be given as to whether further statutory provisions are necessary in light of existing common law principles. In broad terms, the common law provides that a medical practitioner may provide emergency medical treatment where a person lacks capacity and the medical treatment is necessary to prevent death or serious harm and the treatment could not be delayed.²⁴ Where such common law principles apply in circumstances where the treatment is non-psychiatric, we see no reason why such principles should not also apply to psychiatric treatment.

We are mindful that involuntary treatment may undermine the efficacy of treatment. Professor Bruce J Winnick says that '[p]sychological theory therefore would support the hypothesis that choice in matters of treatment and hospitalization will work better than coercion. Self-determination promotes commitment, intrinsic motivation, satisfaction, and effective functioning.'²⁵ He says further '[t]reating patients as incompetent objects of paternalism may strongly reinforce feelings of incompetence and hopelessness, destroying intrinsic motivation and feelings of self-efficacy and even producing the syndrome of learned helplessness.'²⁶ We consider these matters need to be carefully considered in determining whether a MHAct permitting involuntary treatment is justifiable and necessary.

To the extent that the government will provide for a regime of involuntary treatment, as already mentioned, we envisage that the Act should be framed so that it is non-discriminative, that there is minimum intrusion on a person's individual liberty and bodily integrity and that the central concern is for advancing the wellbeing and best interests of the person.

In this context, we consider it is important to ensure that involuntary treatment apply only to persons who do not have decision-making capacity. Just as we respect the decision of persons with capacity to refuse non-psychiatric treatment²⁷, similarly, there is no basis for denying a person's right to refuse psychiatric treatment, if a person has capacity to make the decision. It is essential for removing any discrimination and is in line with the person's rights under the Convention.

We recommend therefore that in circumstances where a person has capacity to make decisions regarding treatment, that person cannot be made subject to involuntary treatment.

We acknowledge that there is debate surrounding the issue of whether the Act should provide for the involuntary treatment of persons who have capacity and refuse treatment, but pose a significant and imminent risk to others. It may be considered unjustifiably preemptive to make a person subject to involuntary treatment where there is only an anticipated risk of harm, particularly where there may be problems with accurately predicting behaviour. We note this issue is explored in the ACT Consultation paper.

To the extent that the Act will provide for involuntary treatment, we agree that there should be a staged approach beginning with the provision of an assessment order and if the criteria are met, an involuntary treatment order.

Assessment orders

Where a request and recommendation is made to place a person on an involuntary treatment order, we propose it is appropriate to firstly assess whether a person has a mental illness. We

recommend that the MHAct should expressly provide that within 24 hours of a request and recommendation being made, the person must be reviewed by the authorised psychiatrist and an assessment order made. The MHAct should provide that if an assessment order is not made within the 24 hours, the person must be discharged. We consider it is appropriate for the purposes of making request and recommendation and assessment order that the person 'appears to be mentally ill'.

During the period the person is under the assessment order, the person may be detained involuntarily but cannot be made subject to involuntary treatment. We endorse the views of the LIV that emergency treatment may be necessary whilst a person is under an assessment order. We agree that provisions relating to emergency treatment should be governed by ordinary medical law principles of necessity.²⁸

Within 72 hours of the request and recommendation being made, the person must be assessed by the authorised psychiatrist to assess whether person meets our revised version of the s 8(1) criteria, which includes that a person has a mental illness. The 72 hour limit is in line with the making of an assessment order under the *Sentencing Act*.²⁹

We recommend the MHAct expressly provide that a person has a right to an independent second opinion as soon as the person is made subject to an assessment order. If a second opinion is requested, it must be provided as soon as practicable.

Grounds for the involuntary treatment order

Under the Northern Territory *Mental Health and Related Services Act*, treatment must not be administered to a person who is admitted into an approved treatment facility as an involuntary patient unless authorised by the Tribunal.³⁰

We recommend that the MHAct similarly require treatment not be administered on the person until the person is made subject to an involuntary treatment order. We recommend that the

review body be charged with the power to decide whether or not a person should be made subject to an involuntary treatment order.

We acknowledge that treatment may be necessary in emergency situations before the involuntary treatment order has been made. In these circumstances we consider that the doctrine of necessity may come into play.

To the extent that the MHAct will provide for circumstances in which involuntary treatment may be administered, we make the following comments regarding the grounds for involuntary treatment. We recommend these grounds apply whether a person is involuntarily treated in hospital or in the community.

Definition of mental illness

We recommend the definition of 'mental illness' should be tightened in line with MI Principles 9 and 16 so that it refers to 'serious' disturbance of thought, mood, perception or memory, rather than merely 'significant' disturbance.

We note that we have recommended that provisions relating to voluntary treatment apply to persons with a mental disorder, thereby encapsulating persons with personality disorders. However we recommend that the grounds for involuntary treatment do not expand to persons with borderline personality disorder or any other type of personality disorder given that personality disorders are not in general treatable in medical terms. In this context, and given their extremely infrequent use and the reasons set out below, we recommend the removal of sections 12A- 12D.

Further, in light of our recommendation for a staged approach, we do not consider it is appropriate to place a person subject to an involuntary treatment order if he or she merely 'appears to be mentally ill'. We recommend this be amended so that an involuntary treatment order may only be made in relation to a person who has actually been diagnosed by the authorised psychiatrist as having a mental illness.

We recommend the MHAct also reflect that in making and/or reviewing the involuntary treatment order, caution must be exercised in relying on second hand, un-corroborated and historical events as the basis for a diagnosis.³¹

Finally, we recommend that additional exclusionary criteria be added to section 8(2) as follows:

“that the person pursues their rights and entitlements or that they pursue them in a particular manner”

Too often people find that their efforts to establish their legal and other rights become a significant factor in their diagnosis.

Consent

We reiterate our position that coercive treatment should be considered only as a last resort, and that it should be governed by a truly human rights-oriented framework which necessitates a single, generic capacity-based legislative scheme.

In light of this, we make the following points about the characterisation of and test for capacity or ‘consent’ to treatment.

In our submission, capacity to consent or to refuse treatment should be the first threshold question to be determined in any criteria for coercive intervention. It is a well-established principle (in general healthcare) that a person cannot undergo medical treatment without free and informed consent³², and that a person with capacity has the inherent right to consent to or refuse treatment. This is founded on the principles of respect for a person’s inherent rights to liberty, autonomy and self-determination.

As the High Court in ‘Marion’s case’ stated:

Those rights can only be altered with the consent of the person concerned. Thus, the legal requirement of consent to bodily interference protects the autonomy and dignity of the individual and limits the power of others to interfere with that person's body.³³

These rights underpin the following fundamental tenets of the law and medical treatment:

- That, without first obtaining the consent of the person concerned, or the consent of a substitute decision-maker appointed by the person or the court, a clinician may be liable in battery, assault or negligence (or professional misconduct at the very least)
- That a person, provided they do not lack capacity to make the decision, may refuse treatment and their decision is respected,³⁴ however 'unreasonable' the decision may appear to the clinician or others and even if the treatment is life-sustaining³⁵

We note that the Victorian provisions for substitute decision-making are potentially complex and fragmented, contained as they are within various legislation: the *Instruments Act* 1958 (Vic), the *GA Act* 1986 (Vic), *Medical Treatment Act* 1988 (Vic). Although it is beyond the scope of this review, we reiterate our position that the government must conduct a comprehensive review of substituted decision-making laws, taking into account contemporary human rights norms and the implementation and efficacy of a single combined legislative framework.

Traditionally however, and under Victorian law currently, where the treatment proposed is for mental illness and the person is subject to involuntary treatment, different criteria and standards apply, as compared with physical illness. In our view this renders the formulation under the current MHAct discriminatory and incompatible with human rights. In particular it is inconsistent with the right enshrined in the Convention at article 12:

...

- (2) States Parties shall recognize that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life

...

In relation to treatment for a mental illness, Victoria currently has no provision which recognizes a decision of a substitute decision-maker who may have been nominated or appointed by the person.³⁶ We support the implementation and recognition of advance directives in this regard to facilitate optimal treatment and to ensure decisions are made in accordance with the person's wishes (discussed below).

Further, we are concerned by the current criterion's inclusion of refusal to consent as grounds for involuntary treatment.

Section 8(1)(d) of the MHAct reads:

the person has refused or is unable to consent to the necessary treatment for the mental illness;

Refusal of treatment alone is insufficient to indicate a person's incapacity to consent. This formulation of the criterion does not fully embrace the content of the right to personal autonomy and decision-making in the same way as if the treatment were for a physical illness. This, in our view, denies people with a mental illness a core aspect of the rights discussed above – the right to refuse treatment where person has capacity – in a manner which discriminates arbitrarily on the grounds of a person's diagnosis.

Dawson and Kampf argue that, “[n]o clear case has been made that lack of capacity to consent, where it exists, differs in any essential respect in physical and mental disorders”.³⁷

Section 8(1)(d) as it is currently formulated discriminates against persons with a mental illness and perpetuates the misconception that persons with a mental illness do not have capacity to make decisions.

This is clearly not the case. The episodic nature of most mental illness means that people will by and large, at some point in their life, retain capacity to make treatment and other decisions about their life.³⁸ Many physical illnesses may affect cognitive capacity in ways similar to mental

illness. It is clear that capacity cannot be determined purely by reference to diagnostic criteria,³⁹ or the fact that a person has or does not have a mental illness.

We recommend the criterion for consent to treatment must therefore delete reference to 'refusal of treatment'.

As Wand and Chiarella point out:

A true right to choice means that an individual must have the right to make a decision even if others do not agree with that decision. However, in relation to mental health, it appears that health professionals have an intellectual difficulty with the concept that not only does an individual have a right to participate in and control the ultimate medical decision, he or she has a right to make the 'wrong' medical decision.⁴⁰

We submit that the MHAct be reformed to expressly articulate the common law presumption that an adult has capacity to make decisions, which can only be rebutted if there is clear evidence that the person is significantly impaired in their ability to make the particular decision.⁴¹

As is found in the Queensland *Guardianship and Administration Act* 2000 (Qld) and the UK's *Mental Capacity Act* 2005, there must also be a presumption of capacity and the onus is on the authorised psychiatrist to demonstrate a lack of capacity.

Capacity is a functional test - that is, it should be determined by reference to a particular decision and at a particular time.⁴² A person's capacity may fluctuate over time and one cannot assume that simply because a person has a disability or condition which *may* impair their decision-making ability, that they invariably lack capacity in all areas.⁴³

Although there is no single test for the required standard of capacity, applicable to all circumstances, we endorse the contemporary international standard for assessing decision-making capacity⁴⁴ which by and large involves the ability to:

- Understand and retain relevant information about a decision to be made
- To appreciate the possible consequences of the decision
- To use or weigh the information as part of the decision-making process
- To communicate a choice

In our submission, a person must not be made subject to an involuntary treatment order unless the authorized psychiatrist can prove that the person lacks the capacity to consent to or to refuse the treatment.

There needs to be clarification in any capacity or ‘consent’ provision so that it is clearly expressed that lack of insight alone is not indicative that a person is unable to consent to treatment, or lacks the capacity to consent.⁴⁵ We consider a person need not have a full clinical understanding of the illness to be able to ‘appreciate the consequences’ of the decision. For example, the Board has found that a person is ‘able to consent’ to treatment even when they may not agree fully with the diagnosis, but could appreciate that remaining compliant with treatment kept them from being hospitalised.⁴⁶

We recommend the Act bolster the obligation on the authorised psychiatrist to provide the person sufficient information to enable an assessment as to whether a person is able to consent. We suggest provisions such as those outlined under s 53B of the MHAct to enable them to make an informed decision. In broad terms, this includes an obligation to give clear explanation of sufficient information, an adequate description of benefits, discomforts and risks and any beneficial alternative treatments.⁴⁷ As the High Court said in *Rogers v Whitaker*, citing the House of Lords:

[T]he “duty to warn” arises from the patient’s right to know of material risks, a right which in turn arises from the patient’s right to decide for himself or herself whether or not to submit to the medical treatment proposed.⁴⁸

The Act should also articulate the right in MI Principle 1.3 to have a chosen person present during the procedure of obtaining informed consent to treatment.

The person needs immediate treatment and that treatment can be obtained by the person being subject to an involuntary treatment order

In determining whether or not a person needs immediate treatment under an involuntary treatment order, we recommend the Act include that the authorised psychiatrist must establish that any risks to the person or pain caused by the treatment is outweighed by its benefits.⁴⁹ The authorised psychiatrist must also identify the time frame in which the treatment should have its intended benefits. The authorised psychiatrist also needs to provide evidence that alternatives have been explored.

Risk of serious and imminent harm

As found by the Board in the decision of *Re the Review of 03-057 [2002] VMHRB 11* that the Board's role is not to paternalistically determine what is in the 'overall best health and welfare interests of a patient' but to examine whether there are 'compelling reasons to intrude upon the liberty interests of a patient'.

We recommend the criteria for involuntary treatment be amended so that the treatment must be necessary to prevent a real risk of imminent and serious harm to the person. We consider that the prevention of deterioration in the person's physical or mental condition is far too low a threshold to justify involuntary treatment and recommend this be removed from the criterion.

We highlight that there is some debate as to whether or not the MHAct, in circumstances where it is intended to promote the best interests of the person, should permit involuntary treatment of a person where there is a serious and imminent risk to others. We note this issue is considered in the ACT consultation. We also note that it was an issue of concern raised prior to the introduction of the Disability Act. It states that the need to protect others and the need for care

and treatment have been inappropriately conflated. It may have the effect of perpetuating the misconceived connection between mental illness and dangerousness. As already mentioned, there are also difficulties in accurately assessing risk of harm.⁵⁰

In the instance where there is said to be a real risk of serious and imminent harm to others if the person is not subject to involuntary treatment, we recommend the Act provide that the order may only be made where the treatment would also provide some therapeutic benefit to the person.

For the purpose of this criterion, there must be some proportionality between the negative impact of the treatment and its benefit to a person's health or safety. In the decision of *Re the Review of 04-124* (unreported, MHRBD (Vic), 21 April 2004, the Board says that:

.... the law recognizes that enforcing compulsory treatment does impinge on a person's civil liberties, and sets out criteria which must be satisfied to justify that restriction in liberty.

There is a balance to be struck between ensuring a person has the best possible treatment and minimizing the intrusion and restriction imposed by the form of treatment provided.

As found also in the decision of *Re the Review of 02-060* (unreported, MHRBD (Vic)), 7 November 2001, an element of proportionality is involved in the assessment of risk such that, a gradual deterioration in a person's mental state or a relatively minor act of harm is far less likely to justify involuntary detention than if a rapid relapse was predicated or there was a threat of serious harm to others.

Person cannot receive adequate treatment in a manner less restrictive of his or her freedom of decision and action

This criterion should be amended to read:

“ . . . in a manner less restrictive of his or her rights and freedoms”

The Charter enshrines includes “freedom of decision and action”, but also others which can be impacted on by involuntary treatment. Section 8(1)(e) is arguably incompatible with the Charter without the suggested breadth.

The involuntary treatment is in the best interests of the person

We recommend the grounds for involuntary treatment include an additional requirement that the authorised psychiatrist cannot make an order unless satisfied that the order would be in the best interests of the person whom the order is made. This is modeled on the criteria for appointing a guardian under the Victorian GA Act and is intended to entrench the fundamental purpose of the Act which is to act in the best interests of the person.

Sections 12A – 12D of the MHAct

As discussed above, we recommend that ss 12A – 12D be removed from the Act. This section provides that a person with a mental disorder may continue to be involuntarily detained or treated notwithstanding that the person does not meet the grounds for involuntary treatment, if that person, having regard to recent behaviour, would cause serious harm to him or herself if discharged. We consider that detention in these circumstances is contrary to the Charter and the intended spirit of the MHAct.

Community treatment orders

We submit that community treatment orders should be limited to a shorter time period than what is presently provided for under the MHAct. Under the Western Australia *Mental Health Act*, community treatment orders lapse after 3 months.⁵¹

We recommend that there are limits to the number of times a CTO may be extended. We recommend the CTO (with extensions) should lapse automatically at the expiration of 2 years from the commencement date of the CTO and cannot be extended any further. This will ensure that a person’s CTO cannot be extended indefinitely. In this instance, a new CTO must be made.

Second opinions

The MHAct currently provides that the person has a right to a second psychiatric opinion. As mentioned in MHLC's submissions to the *Because mental health matters* consultation paper, to ensure impartiality, it is appropriate that a person be provided with a right to an *independent* second opinion. As mentioned in 'Lacking Insight', one person experienced difficulty obtaining an independent second opinion saying, 'I've tried getting second opinions. No matter how hard you try, and in all my hearings, I've never had one psychiatrist go against the other.'⁵²

We recommend the MHAct expressly provide that upon the request of the person, the person must be provided as soon as practicable, an independent second opinion.

5. PATIENT PARTICIPATION

People with mental illness are frequently disempowered by the experience of involuntary treatment and feel as if their right to participate in decisions about treatment in particular, are not adequately promoted or respected.

Winnick relevantly quotes that:

Allowing people with mental illness the opportunity to exercise self determination in matters of treatment can therefore be therapeutically beneficial, helping to achieve the goal of restoring them to as high a degree of functional capacity as may be possible so that they may resume life the community.⁵³

The involuntary treatment regime by definition involves a power imbalance in the doctor/patient relationship which, when combined with often poor access to independent information and advice can contribute to the person's feeling of disempowerment.

Timely access to independent information, advice and representation is crucial to a person's understanding of and ability to exercise their rights, and nowhere is this more crucial than for people subject to involuntary treatment and detention.

We recommend there be significant reforms in the following areas designed to maximize patient participation in decision-making:

- Information about and access to advocacy and independent legal representation
- Advance directives
- Treatment plans

Advocacy

The MHAct articulates the right to have a legal representative at a MHRB hearing, but there are other areas in which people should also have the right to an independent lay advocate. We acknowledge the role that organisations such as OPA (through Community Visitors) and VMIAC (lay advocates) play and, in our submission, the Act should also include the right to have a lay or legal advocate present when the authorized psychiatrist is making an assessment of a person's capacity.

Provision of timely information about their rights to and how to access advocacy, legal representation and other advice services is crucial to enhancing people's full enjoyment of their rights.

Winnick says '*[p]atient choice in matters of treatment may bring a degree of commitment, which mobilizes the self-evaluative and self-reinforcing mechanisms that facilitate goal achievement.*⁵⁴ As noted by Winnick, the greater participation by the person in seeking and formulating the treatment, the greater tendency to achieve goals.

We discuss legal representation in greater detail below in our submissions regarding external review.

Advance Directives – what are they?

An advance directive is a document that a person completes while they are well – when they have capacity – and which outlines their preferences for treatment in the event that they become unwell and lose capacity to make decisions about their treatment.

Typically, advance directives contain information outlining a person's unique circumstances, personal preferences and information about practical aspects of the person's life. Advance directives may encompass “instructional” directives (which tell treatment providers what to do in

a mental health crisis situation) or “proxy” directives (which appoint a health care proxy or power-of-attorney) or may be a combination of the two.

The document can articulate support and treatment preferences – for example it may state the negative effects of particular treatments, and the reasons that other medications are preferred. Such information may not necessarily be available to clinicians at the point at which crisis intervention is considered. Advance directives for people with a mental illness aim to extend beyond medical treatment to all aspects of the persons life, for example to articulate support needs in employment

People raise the possibility that advance directives could be used in relation to many other issues associated with a crisis situation eg. temporary responsibility for childcare during a crisis, vetting of visitors, passing on important information – for instance who the person wants staff to talk to and who they don’t. If extended more broadly than treatment an advance directive could address problems regarding continuity of care, discharge planning and support in all aspects of a person’s life.⁵⁵

Respect for human dignity and right to self-determination

Advance directives are founded on the principles of respect for human dignity, and the rights to self-determination and individual autonomy – principles which, as discussed above, are the rationale for adopting broad capacity-based legislation which we advocate should govern the process for general healthcare and other treatment decision-making.

Advance directives with appropriate legal recognition can be an effective tool in moving towards a ‘supported’ decision-making regime, as required by the Convention.⁵⁶

Appropriate legislation to govern advance directives

As discussed above, advance directives as we see them, are intended to address many aspects of a person’s life and are not limited to decisions about medical treatment. Given the multifaceted

nature of advance directives, and because these documents are not a clinical tool but a legal tool, we do not consider it appropriate for an Act that relates to treatment creates or governs them. It is enough that the Act make reference to advance directives.

Given their similarity to other instruments, such as Enduring Powers of Attorney, which are based on the principles of autonomy and dignity and are also intended to apply when a person loses the relevant decision-making capacity, legislation governing advance directives may sit more comfortably under the umbrella of a broad guardianship-style regime than being limited to healthcare or treatment.

Recognition of advance directives in the Act

Regardless of the ultimate form of legislation governing mental health and involuntary treatment it is crucial however that the legislation focuses on maximizing a person's right to autonomy, liberty and self-determination. Advance directives by definition embody these principles and we therefore recommend the Act provide for clinicians to recognize a person's advance directive and give effect to it to the greatest extent possible.

We recognize that there may be circumstances in which a person's advance directive may be overridden, provided the course of action or treatment is justified, proportionate and in the person's best interests and there are appropriate safeguards and review provisions (see below).

Advance planning and refusal of treatment

Advance directives draw on provisions in general healthcare whereby a person can actively plan for future decisions, either through healthcare proxy (under the *Medical Treatment Act* or GA Act) or through statements articulating the person's wishes (which may be drafted when appointing an enduring power of attorney for example).

The episodic nature of mental illness means that people with mental illness may, at some time, have impaired capacity to make particular decisions. This is precisely where the use of advance

directives is so compelling – an advance directive is drafted primarily by reference to the fact that the person has in the past experienced becoming unwell and has reflected on the experience, their treatment and how they felt at the time.

In a sense, the advance directive becomes the voice of the person at a time when they may not be able to convey their preferences. In the general healthcare setting - where they are sometimes called advance care or treatment plans – the document is recognized and respected as if the person had capacity and made the decision at the time the treatment is proposed.⁵⁷ In a general health setting the document is to inform clinicians about preferred treatment in the event that the person becomes unwell at a later date.

Benefits of advance directives

The benefits of advance directives are numerous not only for the person receiving better treatment but also for those they may rely upon in times of stress - carers, clinicians and society as a whole.

For the consumer the main benefit of writing an advance directive is the better clinical outcomes that come about when a person is genuinely involved in their own treatment. Better clinical outcomes are also facilitated if the person knows that practical measures are being taken care of while they receive treatment.

For carers, advance directives are an excellent reminder to assist them to act in accordance with the persons wishes. Preparation of the documents may encourage and facilitate discussion between parties and avoid uncertainty and tension in the event that the person becomes unwell. Advance directives may also reduce the likelihood that the carer will have to make a decision that is based solely upon speculation.

For clinicians, advance directives allow a decision to be informed by the lived experience of the patient. This experience will alert clinicians to what has worked and what hasn't in terms of medications and other treatment of the person and thus provide for better clinical outcomes. It

also invites a conversation which allows the clinician opportunity to respectfully understand the consumer's views and interest.

Society as a whole will benefit from a more efficient, cost-effective health care system in which the rate and duration of hospitalization is reduced⁵⁸ due to informed clinical decision making and care planning.

Use of advance directives internationally

Countries such as the United States and the United Kingdom have progressed much further than Australia in taking up advance directives as a means of increasing the autonomy and self-determination of consumers of mental health services.⁵⁹ What is clear from overseas studies is that, contrary to the fears of carers and clinicians, that legally enforceable advance directives would be a license to refuse all treatment, consumers resoundingly use advance directives as a means of receiving better treatment.

From two recent studies it is apparent that people who complete advance directives do so in a manner that ensures they first receive treatment that is applicable to their circumstances and needs, and, second, receive treatment that incorporates the vast knowledge they possess about their own illness.⁶⁰ In addition to this consumers were very much aware of the importance of requesting the kinds of treatment that could reasonably be provided by their mental health treatment team.

Much thought was given to ensuring that the advance directives were feasible and that preferences fell reasonably within the range of options of the mental health system. Participants were intent on not compromising mental health professionals with either the content or the style of the directive.⁶¹

Typically, a consumer's reluctance to receive treatment is interpreted as confirmation of a person's illness. Research from the United States shows that people are reluctant to receive

treatment in a system that completely undermines their autonomy. They are *not* reluctant to receive treatment per se.⁶²

When might an advance directive be overridden?

We propose that, where a person lacks the capacity to make a particular decision that their advance directive be given effect to as far as possible and in the event that a person's advance directive specifies a refusal of ECT, their advance directive **must** be given effect to. Given that advance directives do not presently enjoy legal enforceability in Victoria, the new Act should contain interim provisions that recognize advance directives and articulate limited circumstances when a person's advance directive may be overridden.

We submit that advance directive may only be overridden in cases of proven emergency.⁶³ In such circumstances it would be incumbent upon the authorized psychiatrist to be satisfied that:

- Serious and imminent risk of harm to the person or to someone else;
- There is clear evidence of such a risk;
- The treatment or course of action proposed is in the person's best interests, that is has a proven therapeutic benefit which must outweigh any adverse effects of the intended treatment or course of action; and
- The treatment or course of action is the least restrictive of that person's freedom and liberty in the circumstances.

The person should be given a copy of the reasons why their advance directive has been overridden and there should also be a mechanism to appeal a decision to override a person's advance directive to an independent body with determinative powers.

Where a person's advance directive is not adhered to in such cases, the above considerations should be clearly recorded in the person's treatment plan should outline the intended aim of the treatment. Such an obligation is clearly commensurate with the need for service providers to

remain accountable and to limit a person's human rights only where the intervention is reasonable, necessary and proportionate.

We are currently in the midst of conducting research into the use of advance directives in Victoria – consulting with consumers, clinicians and other stakeholders to determine the most appropriate model for the creation, implementation and legal enforceability of advance directives – with a view to spurring law reform in the area.

Given the substantial and broad-ranging legal, clinical and other resource issues surrounding the creation of advance directives and in particular the models for their implementation and enforcement, we strongly urge that the VLRC be given the Reference to investigate these issues in greater detail and to develop a legal framework for creation, implementation, promotion and protection of advance directives..

Treatment plans

The Chief Psychiatrists Guidelines to Community Treatment Orders (2005) provide that

... the purpose of treatment plans is to provide a brief clear statement about the treatment and services to be provided to a patient, to establish mutual expectations and in doing so, improve communication between treating teams and patients.

We are concerned that, since the introduction of mandatory provision of treatment plans and their review by the Board, their effectiveness has been minimal in providing meaningful participation by the person: they aren't often signed by the person, nor are they always discussed with the person prior to the Board hearing. MHLC lawyers, as well as clients, have at times been frustrated that the Board appears to give too much weight to the views of the treating team. In some cases Boards have not even exercised their limited power to order the authorized psychiatrist to revise the plan, and have preferred to seek verbal assurances from the treating team that, for example, they would discuss alternative medications with fewer side effects.

The Board should take a more holistic approach to its review and take into account all the legal, social and clinical considerations in determining whether a person is receiving effective care in the manner least restrictive of that person's civil liberties.

The practical reality is that the MHAct provides insufficient accountability and enforceability of the treatment plan provisions. In particular, given the authorized psychiatrist is clearly a public authority⁶⁴ under the Charter and is therefore under an 'obligation ... to act in a way that is compatible with human rights'⁶⁵, we believe the Board's power should widen to include the following:

- Power to vary the treatment plan itself
- Declaratory power to include recommendations on an order for review. The Board should have to stipulate a time frame within which the revision must be completed and then be brought back on before the Board to ensure compliance with law, imposing fines if yet non-compliant
- If the Board find non compliance with the treatment plan sections, the reasons why should be given to the person
- The Board should also be required to consider the effect of the person's treatment itself on their human rights and have the power to make a declaration in the event that such treatment breaches a person's human rights
- Compel the Board to order a revision of the treatment plan if any part of the treatment plan breaches the person's human rights under the Charter or if the authorized psychiatrist has not acted in a way that is compatible with that person's human rights; and

- Provide strict time limits for compliance with any order to revise the treatment plan, by which time the matter must be brought back before the Board to determine effective compliance

People despair that their views are not taken into account in the preparation of the treatment plan and that the details read more like a ‘proforma’ document than an individualised plan. The requirement under s19A to merely ‘take into account’ a person’s wishes falls short of the more robust provisions in other legislation and we submit this provision be strengthened to say must ‘give effect to, to the fullest extent possible’ to the wishes of the person.

We propose the following reforms to maximize a person’s participation in the process and to provide for a more detailed, personalised plan:

The treatment plan itself should include:

- A statement of a person’s wishes, which could be attached to the treatment plan, it could include a copy of an advance directive if the person had prepared one and requested it to be included
- Details of the least restrictive approach to treatment which is being worked towards, including proposed timelines and persons responsible
- Document in treatment plan non-clinical supports and services available to the person on a *voluntary* basis
- A copy of the persons individual program plan (IPP)
- Statement of the benefit that the person is expected to receive from the treatment in line with section 153(2) of the Victorian *Disability Act*, which relates to persons with an intellectual disability who are admitted into a residential treatment facility for compulsory treatment; and

- Provide detailed plan of treatment for and monitoring and supervision of side effects as appropriate.

In addition, section 19A(2)(b) should be amended so that it reads that ‘if the patient consents, the wishes of any guardian, family member or primary carer ...’. The onus should be on the psychiatrist to obtain consent not on the consumer to object.

6. ELECTRO CONVULSIVE THERAPY (ECT)

The present Victorian MHAct fails to provide an appeal mechanism or independent accountability on the use of ECT. The criteria at present allows for administration of ECT, without consent.⁶⁶

ECT is still a controversial treatment in the sense that it causes concern in the community.⁶⁷ In New South Wales, the Northern Territory, Queensland, South Australia and Western Australia the tribunals have jurisdiction to over-rule decisions of clinicians to perform ECT. In Victoria the Board has no such power.[Delaney 2003] Because of consumer and community views of ECT we recommend that if the person has expressed verbally or in a written advance directive that they oppose ECT this must be respected.

The Victorian Act contains particularly complex criteria which must be met before someone can be given ECT against their will. What it lacks is access to a tribunal to seek to show that those criteria are met or not.

MHLC previously proposed that a person should be able to challenge ECT if administered against their will and that they should be able to appeal to an independent tribunal.

MHLC recently had cause to seek injunctive relief to prevent ECT for a client who was an involuntary treatment order and an inpatient at a metropolitan hospital. This experience gave cause for us to alter our previous concern that the MHRB was the appropriate body to hear such appeals. The Supreme Court process was accessible and expedient. The Presiding Judge advised that ECT warranted close scrutiny as the community was concerned that such treatment was considered intrusive and barbaric and that its administration must be carefully monitored.

We submit that it is essential that any proposed ECT or other controversial, potentially harmful, restrictive treatment must be reviewed prior to its administration.

Further that a person must have access to immediate appeal against the use of any controversial treatment.

Although the Supreme Court was exemplary in this case, realistically an independent Tribunal response, if it can occur with such timeliness and dignity, is appropriate. Given the need for urgency in these types of matters, the Board is not the appropriate body as matters generally cannot be brought quickly before the Board.

We examined the provisions under the GA Act. We recommend that ECT is listed as a Special Procedure in accordance with s42C of the Act. The GA Act allows for an application can be heard urgently, and can organise a hearing within 24 hours (the Board cannot).

We recommend guidelines to assist a treating practitioner proposing such treatment to prepare a report to the Tribunal. In the event that the person objects then the Tribunal must be provided with a second opinion.

We recommend that if a persons advance directive states that they oppose ECT this must be respected (except if the advance directive is set aside in accordance with the provisions outlined on pg 63).

We recommend listing as a special procedure of any other ethically contentious treatment.

7. RESTRAINT

The consultation paper rightly identifies that restraint may both be mechanical and physical. We highlight that the consultation paper has not mentioned that restraint also includes chemical restraint. We recommend the Act provide for the use of both mechanical and chemical restraint as it appears in the Victorian *Disability Act*.

The use of restraint is a significant intrusion on the person's right to liberty, freedom of movement and security. If the Act is to provide for circumstances in which restraint may be permissible, whether it be chemical, physical or mechanical restraint, the Act must narrow the grounds in which it may be used and provide for rigorous protective measures to ensure it is used as a last resort in very limited circumstances. The use of restraint should never be punitive and the section specifically regulating ECT should state this. Section 6A(h) only applies the "non-punitive" principle to prescription of medication and also should be amended to refer to treatment more generally.⁶⁸ People report that restraint and seclusion are used particularly punitively.

In this context, the Act should also provide that people are given, in appropriate written and/or spoken form, the reasons why they are being restrained. This would both provide greater opportunity for the restraint to be avoided and to ensure accountability in terms of compliance with the criteria.

We submit, the grounds for the use of restraint for persons receiving psychiatric treatment should not differ from the grounds governing the use of restraint in non-psychiatric settings. In the absence of such provisions, we recommend that provisions governing the use of restraint be amended to follow the provisions contained in the *Disability Act*. Broadly speaking, the *Disability Act* provides that restraint can be used only if:

- The use of restraint is necessary to prevent the person causing physical harm to themselves or any other person; and

- The use and form of restraint is the option which is least restrictive of the person as is possible in the circumstances; and
- If the use of restraint is included in the person's behaviour management plan⁶⁹.

We recommend the Act adopt the same grounds for applying restraint.

The *Disability Act* further provides that if the disability service provider proposes to use restraint on a person, it must be included in a person's behaviour management plan. 'Behaviour management plan' is defined in the *Disability Act* as 'a plan developed for a person with a disability which specifies a range of strategies to be used in managing the person's behaviour including proactive strategies to build on the person's strengths and increase their life skill.'⁷⁰

The *Disability Act* further outlines the obligations of the disability service provider in preparing the behaviour management plan and the content of the plan.⁷¹ The provision stipulates that the plan must state the circumstances in which the proposed restraint is to be used, explain how the use of restraint will benefit the person and demonstrate that the use of restraint is the option which is least restrictive to the person. The section also provides that the disability service provider must consult with the person with a disability. The Act also includes more protective measures:

- The person may at any time request for a review of the plan;
- The person may make an application to VCAT for a review of the inclusion of the use of restraint in the plan; and
- An independent person must be made available to explain to the person the inclusion of the proposed use of restraint in a person's proposed management plan and that the person may apply to VCAT for a review of the plan.

We recommend similar protection for a person with a mental illness, where the authorised psychiatrist proposes to use restraint on a person, and that there also be a legislative guarantee that a person will be offered debriefing following use of restraint.

The *Disability Act* also outlines the circumstances where restraint may be used in emergency situations. It seems the *Disability Act* provides for a higher threshold for the use of restraint when it is not provided for under the behaviour management plan. It may only be used where there is an ‘*imminent risk of a person with a disability causing serious physical harm to themselves or any other person; and it is necessary to use restraint ... to prevent that risk*’ (emphasis added). Further, restraint may only be used where

Principle 11.11 of the MI Principles says that physical restraint should be employed only when it is the only means available to prevent immediate or imminent harm to the patient or others and that it should not be prolonged for the period which is strictly necessary for this purpose. This provides for a high threshold for the use of restraint which seems more restrictive than the grounds currently provided for under the Act.

At present, the MHAct provides that mechanical restraint may be used to prevent the person from persistently destroying property. There is no requirement under the MHAct that the destruction of property be linked to preventing harm to the person or others. We do not consider the destruction of property sufficiently justifies the use of restraint given the significant human rights implications on a person freedom of movement and bodily integrity. Further, if the legislation is based on a 'best interests' model, we do not consider it is appropriate to permit the use of mechanical restraint to prevent a person from persistently destroying property. Accordingly, we recommend this be removed.

We recommend the Act retain the provisions requiring the authorised psychiatrist to report on the use of mechanical restraint as stipulated in s 81(3) of the Act. The provision should however also extend to the use of chemical restraint.

We acknowledge that restraint may be necessary in an emergency situation. Again, we recommend that the use of emergency restraint be in line with the practice in general medical settings. In the absence of such provisions, we recommend the use of emergency restraint be in line with the provisions under the *Disability Act* that restraint may be used in an emergency where there is an imminent risk the person causing serious physical harm to themselves or any other person and it is necessary to use restraint to prevent that risk. We recommend the Service be obliged to report to the independent commission in the event restraint is used in an emergency.

We do not consider it is appropriate to use restraints on a person who is receiving treatment on a voluntary basis.

Police powers

We note that the review paper makes no reference to the police and their involvement with people with a mental illness. However the MHAct contains quite extensive police powers, the power to apprehend and transport (s10) and if necessary use reasonable force (s9B). This can include grounds of reasonable belief that the person is incapable of caring for themselves (s11) The police Protocol between Victoria Police and the DHS Mental Health Branch (the Protocol) states that police transport should be used only as a last resort.⁷² MHLC is concerned that often in practice this does not occur.

We recommend that the Protocol should be given legislative effect and that the Act includes a provision that police transport should be used only as a last resort.

We have many reports of incidents where police involvement is harmful, inappropriate and distressing, where people are in fear of being humiliated or injured.

As a general comment, it is crucial that police are equipped to deal as constructively, sensitively, and from as well informed a position as possible with people with mental illness. Officers

clearly assume a health system role in that they are the statewide 24 hour, "crisis" equipped service called on to make up for the inadequacies of the mental health system. This is clearly difficult in many respects.

The CAT team is presumed by the community to provide an immediate response to mentally ill people. However, we are informed by DHS that crisis intervention is not the role of the CAT team.

We recommend the introduction of a DHS crisis response service - reactive to the needs of a person experiencing a mental health crisis, and that this forms part of the '000' response to the community. A model similar to this offering 'crisis support units' existed in Victoria in the 1990's. The roles and responsibilities of this service should be articulated in legislation. This reform must be adequately resourced.⁷³

8. SECLUSION

We oppose the use of involuntary seclusion. Seclusion has been found to be degrading, humiliating, an intrusion on human rights and at times used as punishment.⁷⁴ We recommend the Act should remove the provisions outlining the circumstances in which seclusion is permissible. This is consistent with the World Health Organisation Mental Health Care: Ten Basic Principles which recommends that states pursue the elimination of seclusion and train workers in alternatives. We note seclusion has been abolished in some parts of the United States.

We highlight that we make a distinction between seclusion and solitude. A person may seek solitude on a voluntary basis and may find it has some therapeutic benefit.⁷⁵

In the event the government opts to include provisions in the Act permitting seclusion, we propose that the recommendations discussed above relating to the use of restraint, also apply to seclusion. We highlight that we consider it is particularly inappropriate to permit seclusion to prevent absconding. The use of seclusion in such circumstances is a service-system shortcoming and may not necessarily serve a therapeutic benefit.

9. EXTERNAL REVIEW AND APPEALS

This section makes reference to the Board. The problematic lack of independence of the Board discussed above could arguably be addressed by its placement in a government portfolio other than Human Services – either as a separate tribunal or as a list of VCAT. Whatever its ultimate structure, the body responsible for ensuring people are legitimately involuntary must have the features set out below. We have used the language of ‘the Board’ for the sake clarity but we do not endorse that this is the best model (see recommendations).

The current review procedures of the Board do not comply with the Charter or international instruments. The new Act must address this by implementing the following reforms:

Timeliness of reviews and appeals

The review must address the fact that around 70% of involuntary treatment orders are not reviewed at all, and Victoria has amongst the longest time periods in Australia. We advocate that the approach recommended by the World Health Organisation be implemented – initial reviews within 3 days and automatic reviews every 6 months⁷⁶. In the majority of cases, the initial review is crucial in protecting the rights of inpatients, and the 6 monthly hearing will have particular significance for the many Victorians on CTOs. Bringing both reviews forward is essential.

The Charter only serves to strengthen the position that services must also take responsibility to ensure that, as soon as a person does not meet the criteria for involuntary treatment they should be discharged from the order. A provision should also be added which clearly obliges members of the treating team to advise the authorized psychiatrist as soon as they believe the criteria are not met.

Board to make involuntary treatment orders

The twin objectives of more timely review and a more authoritative and independent source of confirmed involuntary status would be met by:

- Clinicians making initial assessment orders which cannot exceed three days in duration, and
- the Board having the role of making involuntary treatment orders or discharging assessment orders within three days.

Constitution of the Board

Many consumers value the multidisciplinary nature of multi-member hearings, and a change to more single member hearings should not be made lightly. We identify the following essential attributes of a single member process if it is to be adequate:

- Psychiatric members should not sit alone
- “Psychiatrists assisting”, from a panel constituted for this purpose, should be available at short notice
- The irrefutable case for increased advocacy and representation is arguably strengthened in the case of single member hearings

There should be a guaranteed level of consumer membership on the Board

People with experience of involuntary treatment and the mental health system have a unique and vital perspective to bring to the hearing process. We understand that, on an ad hoc basis, the Board appoints members with such experience. It should be ensured that this is a permanent and adequately valued feature of the Board’s constitution by amending clause 2 of schedule 1 to provide that the Board’s membership must include people with experience of involuntary treatment and the mental system.

Right to merits review by Supreme Court

A significant “natural justice” deficiency in the current review process is the fact that appeals to the Supreme Court can only be on the basis of questions of law. Given the significant human rights issues at stake, it should be possible to have the merits of matters determined judicially.

What powers should the Board have?

The Board should be given power to vary treatment plans

The MI Principles require this⁷⁷ and the power exists in a number of Australian and overseas jurisdictions⁷⁸. The likelihood is that this power would only be exercised in a small minority of cases. It makes a mockery of the process that the Board can make significant clinical decisions such as that a person has a mental illness and is likely to deteriorate without treatment, but cannot, in no doubt rare cases, order a change in treatment.

Board to review refusal to transfer involuntary patient as well as order to transfer

Anecdotal evidence indicates that clients in some circumstances wish to be transferred to a different area mental health service if unsatisfied with the service they are receiving.

The MHAct currently provides that a person may appeal to the Board against a decision by the authorised psychiatrist or the chief psychiatrist to order a transfer. We recommend that the Act also provide that the person has a right to appeal to the review body a decision by the authorised psychiatrist or chief psychiatrist to *refuse* to order the transfer. We are aware of situations where people have sought transfer and this has been refused. It should be made clear that this applies to involuntary patients on community treatment orders as well as inpatients, as this right is equally relevant to both groups.

Review of voluntary inpatients after a prescribed period

The Act should be brought in line with the position in the Northern Territory – voluntary inpatients are reviewed by the Tribunal there every six months upon the request of the person⁷⁹.

Offence to fail to comply with a Board Order

The Act should provide specifically that it is an offence to fail to comply with a Board Order. Such a provision exists under the Tasmanian scheme⁸⁰.

Failure to conduct mandatory review within time invalidates involuntary order and limited duration of ITOs

The new Act should provide that a person is no longer involuntary if the prescribed reviews do not take place. To enable persons to be properly represented at reviews, persons should receive sufficient notice of hearings so that the person may arrange for representation if she or he wishes to have it.

Another essential protection is the provision of a time limit on involuntary inpatient status as there is for CTOs. The Act should provide that either type of involuntary status cannot last longer than 6 months unless lawfully extended.

Enhanced participation by consumers

Legal representation and advocacy at hearings

Victoria's low level of representation of consumers at hearings must be addressed, particularly in light of the Charter and Convention. International jurisprudence, now of direct relevance in Victoria under the Charter, provides that there is a right to representation in civil cases where the seriousness of consequences, complexity or high emotional content demand it and a person would be unable to put their case effectively themselves⁸¹. Commentators have recognised the

great value of representation, not only to ensure that the persons rights are recognised but also facilitating a more therapeutic process⁸². President of the Board John Lesser observed representation levels of over 90% in the jurisdictions he visited for his Churchill Fellowship⁸³. That Victoria's representation levels (10% or less) are dramatically lower than a number of other jurisdictions in Australia⁸⁴ and internationally is unacceptable. It is disappointing that the Consultation Paper did not contain reference to figures in other Australian jurisdictions – the representation rate of over 90 % in the Northern Territory being the starkest example.

MHLC's pro bono representation scheme uses volunteer lawyers from private firms, is likely to at least double the number of clients we represent and fulfils a vital role in educating the legal community. Recurrent funds for this project are a bare minimum requirement – but much more will be required to bring levels to an acceptable point.

Though resources and service system issues are probably the bigger consideration than legislative provision, legislation must lead the way. The MHAct must be amended to strengthen the right to representation such that all persons who wish to have representation can. Such a reform would certainly have resource and service implications, but there can be no justification for a weaker provision than those in South Australia⁸⁵ and the Northern Territory⁸⁶. Though it may take some time to bring levels of representation to their optimum, legislation must take the lead in allocation and prioritisation of resources and development of the most viable and effective methods of providing such assistance. We recommend that legal aid be extended to provide for any person who has a matter before the Board (as is provided in Western Australian).

Furthermore the Charter highlights the need for increased legal advocacy and representation. Charter Practice Guidelines issued by the Board require a high level of expertise and skill to negotiate. It would be impossible for any lay person to understand and satisfy the requirements under the Practice notes without legal representation. A person in hospital in particular has little access to proper resources to understand and research Charter arguments that may be made at the hearing. At present, there are teams of senior counsel involved to interpret and understand the case law and international conventions.

People detained under the Act are unaware of their Charter rights. We recommend that every person detained under the Act must be fully informed of their rights under the Charter. Such information must include information about legal representation.

At present, if the Board hears a Charter argument the matter is adjourned for a special fixture. In this event, legal representation must be provided to the person.

There are many more benefits to securing legal presentation for persons who are receiving mental health services beyond a Board hearing. For example in negotiating a treatment plan, exploring less restrictive options and negotiating for a private practitioner to take over the management of a person's treatment. This was thoroughly explored in 'Lacking Insight'.

Patient attendance at hearings – section 26(6)

Ordering that a patient not attend a hearing due to the risk to their health is likely to be in breach of the “fair hearing” right under the Charter. At the very least, we suggest that this section be amended to require that a legal representative be appointed to ensure that such a person's views and appropriate legal argument and advocacy be put to the Board.

Essential procedural reform to enhance consumer participation

As consumer confidence in and satisfaction with the review process grows, attendance at hearings may also increase. Implementing the recommendations of the report “Lacking Insight⁸⁷” would involve both legislative and non-legislative change. Priorities amongst the legislative features which should form part of the new Act include:

- Section 32(1) must be amended to require that notice of hearings be provided within 2 days of a matter being listed as well as at least 7 days before the hearing to facilitate notice as soon as possible;

- The Act should articulate an obligation for case-managers to advise all people who receive notice of a hearing of how they can access legal advice and assistance and to facilitate this;
- Access to the clinical file should be provided at least 7 days before the hearing;
- There should be a legislative requirement for the case manager to advise of the right to and arrange access for the consumer;
- There should be a legislative entitlement to photocopies of documents on the file as well as perusal access⁸⁸;
- The provision of a statement of reasons should be mandatory at the second and subsequent periodic review;
- As in the Northern Territory⁸⁹, New South Wales⁹⁰ and Western Australia⁹¹, tape recordings should be made of hearings and copies made available to parties on request – if this is appropriate in relation to police records of interview it is all the more so with Board hearings;

The Board should be legislatively required to inform people of their right to appeal and request a statement of reasons at the conclusion of hearing;

The Board should provide an oral statement of reasons at the end of every hearing; and

- A second opinion should be part of a person's second periodic review. People who have been subject to involuntary status for 12 months, and so have a second six monthly review, should be provided free of charge, with an independent second opinion.

Non-disclosure applications and consumer participation

The fair hearing rights under the Charter and related jurisprudence question the validity of provisions allowing material going to the Board to be withheld from consumers. The MHLC has received legal advice that denying access to information at Board hearings due to confidentiality concerns is particularly inconsistent with natural justice. There is established legal precedent to this effect⁹². It also contravenes the MI Principles which does not include any provisions permitting the denial of access to information on the grounds of confidentiality.

There is also an unacceptable level of inconsistency and uncertainty on the part of mental health services and Board members as to how section 26(8) works in practice. The Act should be amended to:

- Provide that material sought to be exempted from disclosure must, on the consumer's request, be provided to their representative on the representative's undertaking not to disclose them to the consumer unless the Board determines they should not be exempt;
- Provide that, unless the Board determines this is contrary to the interests of justice in the particular case, the Board should not have access to or place any reliance on material which has been exempted from disclosure to the consumer;
- If the consumer does not have a representative, once must be provided free or charge for the purposes of determining whether the material should be exempted and whether it should be available to the Board; and
- This approach will ensure that a person's case is not prejudiced by the Board's consideration of material on which a person is not able to view and/or respond to. In these circumstances, the person's legal representative can, where appropriate, seek to challenge the withholding of information from the person and disclosure to the Board. The legal representative can also, where the information may be favourable to the client's case, argue for the disclosure of the information to the Board.

Consumer's right to elect to rely on evidence at Board Hearing

In broad terms, the MHAct presently prohibits persons from using evidence which has arisen from Board hearings. In some circumstances, use of this information may only be used if the person obtains approval from the Board.

We consider that the person with the mental illness should be free to use the information which arises from Board hearings. The person should not be required to first obtain approval from the Board.

We consider also that where a person is de-identified, the Act should permit the use of information arising from Board hearings for legitimate community education and policy discussion. This may also have the effect of rendering the Board more accountable and subject to public scrutiny.

Participation by Carers and other Parties

Participation to be subject to consumer's consent

The current practice of the Board is to limit those who have a right to attend at hearings to the consumer and the treating team. Anyone else may only attend with permission of the consumer. This practice should be maintained. We recognise the crucial role that carers play in the lives of many consumers, the difficulty of that role and the inadequacy of supports for it. However, it is crucial that the person at the centre of the hearing process has confidence in its integrity, has freedom to have open dialogue with the Board and knows that their privacy will be respected. We suggest that section 26(4) (a) be amended to provide that the following people may be present at the Board hearing:

- The patient
- The treating team
- Any person to whose presence at the hearing the patient freely consents.

Section 32 should also be amended to include that notice should go to:

“any person nominated by the patient as a person to whom notice should be provided”.

This should replace section 32(1) (e) in that it makes it clearer that notification of additional people should be entirely at the consumer’s discretion. In many cases the consumer may nominate a carer to have notice in this way, and may consent to their attendance also. Where this does not occur, and carers are concerned that they have important information to convey to the Board, they are able to pass that information on to the treating team to be incorporated in the material which goes before the Board, provided there is no confidentiality condition on its provision. Even if the material is subject to confidentiality and not provided to the Board as suggested above, it still informs the treating team’s approach, and carers have an ongoing entitlement to communicate with the treating team and receive information where they need to for their caring role under section 120A(3)(ca).

10. MONITORING PATIENT WELLBEING AND COMPLAINTS

As is acknowledged in the consultation paper, Victoria's current quality assurance, monitoring and complaints system is fragmented and flawed. This deficiency has been recognized by commentators⁹³. We hope that the opportunity created by this review will be seized and a best practice system developed.

The Office of the Chief Psychiatrist is unacceptably limited by its lack of independence, lack of appropriate processes and powers and lack of adequate resourcing for what is a very significant role. Though more removed, the Health Services Commissioner is a DHS body and likewise lacks optimum powers. The MHLC has experience of cases where complainants have had to resort to complex and stressful legal action to vindicate their rights when the existing complaints processes have failed them, and where the Office of the Chief Psychiatrist has advised services before consumers have sought to have complaints investigated about the same issue. Systems based on investigation and conciliation but not determination offer little justice unless there is overwhelming evidence or concession of wrongdoing. The MHAct contains numerous penalty provisions but no-one has ever been prosecuted and many people have no idea which body has responsibility for prosecutions. Consumer and advocate confidence in the existing systems is very low.

Rather than two inadequate avenues, Victorians with psychiatric disability deserve an independent specialist accountability and complaints body. Our first preference is for an independent, specialist mental health commission with the following features and functions:

- It will sit outside the DHS – in the same way as the Ombudsman, OPA and VHREOC do
- It will have jurisdiction to handle complaints about all health and support services for people with psychiatric disability including under the MHAct, the Health Services (Conciliation and Review) Act and the Health Services Act (in the case of the latter, for example, relating to supported residential services). We are mindful that this review is limited to the parameters of the MHAct. It is clearly possible and desirable, though, for

consideration to be given to how amendments to other legislation can help achieve this review's objectives

- It will subsume all of the functions and powers of the Office of the Chief Psychiatrist, except perhaps the development of clinical guidelines and provision of practice advice to clinicians
- There will be a legislative provision stating that a failure to comply with a direction of the body is an offence. The Ombudsman (if the body is a separate commission) or the Department of Justice will be responsible for prosecution
- It is important that a central authoritative body provide guidelines on the translation of provisions of the MHAct into practice. To the extent that development of guidelines or policies has been devolved to services this should be reversed. There is a great risk both that legislation will be applied incorrectly, and resources wasted, if each service devises its own guidelines. In a recent case handled by our centre, we identified in the course of proceedings an error in the lengthy policy developed by the North Western Mental Health Service on ECT. That guideline states, at 3.80.3, inconsistently with section 73, that "all involuntary patients will be deemed incapable of providing consent"
- It will have powers, resources and obligations to perform a proactive random and unannounced audit function and analyse collated complaints data to recommend systemic reform
- It will have legislative responsibility for prosecuting breaches of the Act and be properly resourced to do so
- All mental health services will be required to provide annual complaints data outlining nature of complaints and outcomes to the commission and the commission must publish that data annually, along with a report on all its complaints and auditing work and the practices such as ECT, restraint and seclusion on which it receives data

- There will be provisions in the Act establishing timelines for response by the Commission to complaints
- There will be access to VCAT for complainants whose complaints are not resolved at the Commission (as there currently is for health information privacy and access complaints under the Health Records Act)
- It will develop guidelines for and provide advice about internal complaints services within mental health services. This will include establishment of mandatory features of service based complaints processes such as timelines for response
- Its processes will be flexible enough to accommodate the needs of consumers in terms of issues such as assistance with the process and adjustment of process requirements. There should be staff whose specific role and expertise is in assisting people with the complaints process. The Act should include a provision like section 106 of the *Equal Opportunity Act 1995* obliging the commission or body to assist people in making complaints
- It will employ consumer advisers and investigators
- It should be authorised to deal with complaints made by someone other than the consumer where the consumer consents or where they are unable to consent and it is in their interests and not contrary to their rights for the complaint to be processed
- It should be able to investigate systemic complaints brought by advocates or interested parties about issues which may affect a number of people which are in the interests of the people with mental illness involved and not contrary to their rights; and

- If the Quality Assurance Committee is maintained, its activities should become subject to an annual report. Greater transparency in relation to “adverse events” is the general trend in health services. Whilst it is important that providers feel safe to be as open as possible, the right balance needs to be struck. At the very least, reports which do not identify the particular service or workers should be made annually which outline what quality concerns or adverse events were identified and what was done about them.

There will be some efficiency in combining large parts of the roles of the Office of the Chief Psychiatrist and Health Services Commissioner in one body. Though a specialist mental health commission might be the optimum model, the above functions could equally be performed by a specialist division of the Ombudsman, avoiding the need to establish an entirely new body. Given the Ombudsman’s extensive expertise in complaint handling, that office would be ideally placed to take on this role.

The Act should include provisions similar to those in Part 13 of the Northern Territory’s *Mental Health and Related Services Act* requiring services to establish responsive complaints processes and take steps to ensure people are aware of how they can access them. As well as the sorts of requirement in Part 13 of the Northern Territory scheme, the Act should include a provision obliging services to assist people make complaints along the lines of section 106 of the *Equal Opportunity Act*.

11. CONFIDENTIALITY AND INFORMATION SHARING

The confidentiality provisions of the MHAct are important in preserving the person's right to privacy. The right to privacy is enshrined in the Charter, the CRPD and the MI Principles.⁹⁴ Principle 6 of the MI Principles expressly states that '[t]he right of confidentiality of information concerning all persons to whom these principles apply shall be respected.'

The disclosure of confidential information without the person's consent may also have the counter-therapeutic effect of diminishing the relationship of trust between the clinician and the person.

Accordingly, we do not support broadening the circumstances in which confidential information may be disclosed without the person's consent.

We have long been concerned that the exception in section 120A(3)(ca) does not exist in relation to the parallel section governing confidentiality in the provision of general health treatment under the Health Services Act 1988.⁹⁵ This distinction is arguably discriminatory. We are certainly mindful of the difficult situations many carers find themselves in, but any expansion of this exception to confidentiality could not be supported. Indeed, we recommend that section 120A(3)(ca) should be tightened read that information can only be provided if it is necessary for a person's day to day care. Ultimately, services must work with people to facilitate genuine and well informed consent to necessary disclosures – and this is another area where advance directives can play a vital role.

We recommend also that s 120A(3)(c) which permits the giving of information concerning the condition of a person who is receiving psychiatric services if communicated in 'general terms', be amended to state that such information may only be communicated "*in the most general terms only*". Though this provision was only intended to apply to very general information, such as for example that the person is in hospital, when a person can visit, or whether the person is improving or deteriorating, we are aware of a situation where, for example, a service has tried to justify provision of much more specific information under this section.

People have expressed general concern to us about the large number of exceptions under section 120A. It is important that people receive clear and accurate information about the extent to which their confidentiality rights are limited.

¹ Topp, Thomas, Ingvarson, 'Lacking Insight: Involuntary patient experience of the Victorian Mental Health Review Board, October 2008.

² Deegan, FIE. (1995). *Coping with voices: Self-help strategies for people who hear voices that are distressing*. Lawrence, MA: The National Empowerment Center.

³ Ibid

⁴ Roper, T. H. T. W. (1985). Explanatory Second-reading Speeches on the Mental Health Bill, Intellectually Disabled Persons' Services Bill and Guardianship and Administration Board Bill.

⁵ Ibid.

⁶ Chesters, Janice. 'Deinstitutionalisation: an unrealised desire', *Health Sociology Review*, vol.14, issue3, December 2005.

⁷ Richmond, Kate and Savy, Pauline. 'In sight, in mind: mental health policy in the era of deinstitutionalisation', *Health Sociology Review*, vol.14, issue 3, December 2005.

⁸ See John Dawson and George Szmukler, 'Fusion of mental health and incapacity legislation', *British Journal of Psychiatry* (2006) 188, 504 – 509.

⁹ [See submissions of the Royal Australian College of Psychiatrists to the review of the WA Act in 2003 and Murray Allen writing as President of the WA Mental Health Review Board in 2005.]

¹⁰ Refer Butler-Sloss LJ in *Re MB(An Adult: Medical Treatment)* [1997] EWCA Civ 1361, following generally the judgment of Donaldson LJ in *Re T*[1992] 3 WLR 782.

¹¹ Goffman, Erving (1961) *Asylums*, New York: Doublebay & Company

¹² CRPD Preamble para (c)

¹³ Ibid para (h)

¹⁴ Article 12(2)

¹⁵ These rights are expounded further in the

¹⁶ See for example s5(3), in particular paragraphs (a), (c), (m), (p) and s5(5).

¹⁷ Disability Act s5(3)(n)

¹⁸ Mental Health (Amendment) Bill 1995 Second Reading Notes.

¹⁹ See Mental Health Act 2007 (NSW), ss 5 and 6; Mental Health and Related Services Act (NT), ss 25 – 27; Mental Health Act 1993 (SA), s 11; Mental Health Act 1996 (Tas), s 19.

²⁰ See UN Principles 19(1)

²¹ Winnick p...

²² Ibid, p. 36.

²³ See s 7(2) the Charer

²⁴ ACT consultation paper, p 36

²⁵ Winnick p 32

²⁶ Ibid

²⁷ *Medical Treatment Act*

²⁸ LIV Disability Law Committee

²⁹ Section 90 *Sentencing Act*

³⁰ Section 55

³¹ See the decision in *Re the Appeal and Review of 03-049* (unreported, MHRBD (Vic), 7 November 2002

³² See also Victorian Charter s10(c)

³³ *Secretary, Department of Health and Community Services v JWB and SMB* (1992) 175 CLR 218, per McHugh J at 309-310.

³⁴ *Re T (Adult: Refusal of Medical Treatment)* [1992] 3 WLR 782 per Lord Donaldson, *Re MB* (2005) 797 NYS 2d 510

³⁵ *Re B (Adult: Refusal of Medical Treatment)* [2002] 2 All ER 449 at [2]

³⁶ MHA s 3A

³⁷ Dawson, J., and Kampf, Annegret (2006) 'Incapacity principles in mental health laws in Europe' *Psychology, Public Policy and Law*. 12(3), 310-331 at 312.

³⁸ Jeste, D.V, Depp, C.A., Palmer, B.W., (2006) 'Magnitude of impairment in decisional capacity in people with schizophrenia compared to normal subjects: An overview', *Schizophrenia Bulletin*. 32(1), 121-128

³⁹ Ibid., at 122

⁴⁰ Tim Wand and Maria Chiarella, (2006) 'A conversation: Challenging the relevance and wisdom of separate mental health legislation' *International Journal of Mental Health Nursing* 15, 119 at 125..

⁴¹ Wong, J.G., Clare, I.C.H., Gunn, M.J., Holland, A.J, (1999) 'Capacity to make health care decisions: its importance in clinical practice' *Psychological Medicine* 29, 437-446.

⁴² Ibid, at 439.

⁴³ Dawson and Kampf 2006, 312, Appelbaum & Grisso 1995.

⁴⁴ See for example, *Burke, R (on the application of) v The General Medical Council* Rev 1 [2004] EWHC 1879 (Admin) QB 424

⁴⁵ See Re the Review of 01-039 [2000] VHRB 1

⁴⁶ See Re the Review of 01-079 [2001] MHRB 1

⁴⁷ See also *Medical Treatment Act* 1988 (Vic) which provides that a person (or their agent if they are deemed incompetent⁴⁷) can refuse treatment only if:

they have been informed about the nature of the person's condition "to an extent which is reasonably sufficient to enable the [person] to make a decision about whether or not to refuse medical treatment generally or of a particular kind" and if they understand the information (s 5(1)(c) and s5B(1) and (2)

⁴⁸ *Rogers v Whitaker* (1992) 175CLR 479, [10]

⁴⁹ See the decision 'Re the Appeal of 0199-616 (unreported, MHRBD (Vic) 27 April 1999 or the appeal of PX (1998) 2 MHRBD p 334.

⁵⁰ ACT consultation paper

⁵¹ Section 68 *Mental Health Act* 1996 (WA)

⁵² Lacking Insight, p 59

⁵³ Winnick, Bruce J. (2008) 'A therapeutic jurisprudence approach to dealing with coercion in the mental health system' *Psychiatry, Psychology and Law*, 15(1), 25-39 at p 33

⁵⁴ Winnick 2008, p 32

⁵⁵ Mental Health Legal Centre, 'Advance Directives: Maximising consumers autonomy dignity and control' http://www.communitylaw.org.au/mentalhealth/cb_pages/living_wills.php

⁵⁶ Minkowitz, Tina, Foreward to Lacking Insight, Mental Health Legal Centre, October 2008, p. 7.

⁵⁷ See for example UK's Mental Capacity Act 2005 s26.

⁵⁸ Henderson, C., Flood, C., Leese, M., Thornicroft, G., Sutherby, K., Szmukler, G. (2004) 'Effect of joint crisis plans on use of compulsory treatment in psychiatry: single blind randomized controlled trial.' *British Medical Journal* 329, 136

⁵⁹ See for example Patient Self Determination Act (US) and 'advance statements' in *Mental Health (Care and Treatment) (Scotland) Act 2003* s 275

⁶⁰ Srebnik, D., Rutherford, L.T., Peto, T., Russo, J., Zick, E., Jaffe, C. & Holtzheimer, P. (2005) 'The content and clinical utility of psychiatric advance directives.' *Psychiatric Services*. 56, 592-598.

⁶¹ Amering, M., Stastny, P. & Hopper, K. (2005) 'Psychiatric advance directives: qualitative study of informed deliberations by mental health service users.' *British Journal of Psychiatry*. 186, 247-252.

⁶² Backlar, P., McFarland, B.H., Swanson, J.W. & Mahler, J. (2001) 'Consumer, provider and informal caregiver opinions of psychiatric advance directives.' *Administration and Policy in Mental Health*. 28, 427-441. See also Swanson, J.W., Swartz, M.S., Elbogen, E.B., VanDorn, R.A., Ferron, J., Wagner, H.R., McCauley, B. & Kim, M. (2006) 'Facilitated psychiatric advance directives: A randomized Trial of an intervention to foster advance treatment planning among persons with severe mental illness.' *American Journal of Psychiatry*. 163, 1943-51.

⁶³ For example, s26(5) of the UK *Mental Capacity Act* 2005 provides that life-sustaining treatment, or treatment which is reasonably believed necessary, may be performed, pending a court determination on the issue.

⁶⁴ Authorised psychiatrist, at least in the exercise of their functions under the MHA in relation to involuntary patients satisfies the test for 'functional' public authority pursuant to s4... 'Coercive intervention has long been regarded as a function of a public nature (*Charter* s4(...), *YL v Birmingham Shire Council*), the authorized

psychiatrist is subject to the general direction and control of the Secretary (MHA s96(2A)) and has powers as conferred by the state under the Mental Health Act (Charter s4(...))

⁶⁵ Victorian Charter of Human Rights and Responsibilities 2006 (Vic), s1(2)(c)

⁶⁶ s 72; s73

⁶⁷ See for example K De Brito "So why are we still using electric shock therapy?" Marie-Claire magazine, July 2002.

⁶⁸ {Zealand, 2008 #6} 15

⁶⁹ Section 140

⁷⁰ Section 3

⁷¹ Section 141

⁷² Department of Human Services and Victoria Police, *Protocol between Victoria Police and the Department of Human Services Mental Health Branch*, Part 4 (2004).

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⁷⁴ Human Rights and Seclusion in Mental Health Services, Human Rights Commission Report, June 2008

⁷⁵ {Zealand, 2008 #6}

⁷⁶ World Health Organisation 1996, 'Mental health care law: ten basic principles, WHO, Geneva.

⁷⁷ United Nations Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care. Principle 11(16).

⁷⁸ For discussion of the value of Board's having discretion to vary treatment in appropriate cases see 'Mental Health Tribunals: From crisis to quality care', Fleur Beaupert, *Alternative Law Journal*, 32(4): December 2007

⁷⁹ Mental Health and Related Services Act (NT) s. 122.

⁸⁰ The Tasmanian *Mental Health Act* 1996 (Tas) expressly gives the Tasmanian Mental Health Tribunal power to give directions necessary to ensure compliance the Tribunal's determination or desirable in the interests of the person. The Act then expressly provides that non-compliance with a determination of the Tribunal is an offence.

⁸¹ See United Nations Human Rights Committee General Comment 32[3]; PC and S v UK 5654/7/00[2002] ECHR 604.

⁸² See for example ⁸² Winick B J, 'Symposium: Therapeutic Jurisprudence and the Civil Commitment Hearing' (1999) 10 *Journal of Contemporary Legal Issues* 37, 53.

⁸³ John Lesser/The Winston Churchill Memorial Trust of Australia 'Review and Decision Making for Persons with a Serious Mental Illness: Achieving Best Practice, 2007.

⁸⁴ For example, in 2003/2004 26.9% of people were legally represented in NSW, in 2004/2005 in Tasmania 42% were represented and the figure was 95% in 2004/2005 in the Northern Territory.

⁸⁵ The Northern Territory Mental Health and Related Services Act provides at section 131 that on appeal or review a person may represent himself or herself or may be represented by a legal practitioner or other person, and that the tribunal must appoint a legal practitioner to represent a person at a review or appeal where the person is not represented unless it is satisfied that, in the circumstances of the case, it is not necessary; and may order that the Territory pay all or part of the reasonable costs and disbursements of the legal practitioner in representing the person at the review or appeal. This has resulted in provision by the NT Legal Aid Commission of representation in over 90% of cases.

⁸⁶ The South Australian Mental Health Act 1993 provides at section 27 that in every **appeal** to the Board (not review) the person is entitled to be represented by a lawyer if they so choose, provided pursuant to a scheme established by the Minister, and private lawyers are entitled to receive fees for provision of such services from the Minister.

⁸⁷ Topp, Thomas, Ingvarson, 'Lacking Insight: Involuntary patient experience of the Victorian Mental Health Review Board, October 2008.

⁸⁸ There legal precedent for the proposition that a right to access carries with it the right to obtain copies - Re: STEVEN McGEE and REX HORE And: J.H. SANDERS; C. KEILY; K. WISE; H.S. WEIR; G.R. NEWMAN; B.R. AGG; D. CRUMP; K.J. CONNORS; G. WOOD; J.M. BILTRIS; J.B. WHITE; D.A. PORTER and P. POWER (1991) 32 FCR 397.

⁸⁹ Mental Health and Related Services Act 1998 (NT) section 136

⁹⁰ Mental Health Act 2007 (NSW) section 159

⁹¹ Mental Health Act 1996 (WA) Schedule 2 section 14

⁹² *Re Refugee Review Tribunal; Ex parte Aala* (2000) 204 CLR 82; *Re Minister for Immigration and Multicultural Affairs; Ex parte Miah* (2001) 206 CLR 57; and *Muin v Refugee Review Tribunal* (2002) 76 ALJR 966; *Kioa v West* (1985) 159 CLR 550.

⁹³ See, for example, S. Zifcak "The United Nations Principles for the Protection of persons with Mental Illness and Improvement of Mental Health Care: Applications and Limitations" (1996) *Psychiatry, Psychology and Law* 1, 6.

⁹⁴ See s 13 of the Charter, Article 22 of the CRPD and MI Principle 13(b)

⁹⁵ See Health Services Act 1988 (Vic) section 141.

APPENDIX A: A submission to the Review from a person who attended the consumer forum

Hi People,

I went to the MHA Review Consumer Forum last Thursday and send this email to let you know some of my impressions from what I experienced.

The Agenda was:

1:00pm > 2:00pm Registration and Lunch
2:00pm > 2:50pm General introduction; individual introductions by community panel members; overview of forum & housekeeping; consumer presentation and carer presentation.
2:50pm > 3:25pm Workshop 1
3:25pm > 3:40pm Afternoon Tea
3:40pm > 5:00pm Workshop 2; feedback from workshop 1 & 2 to the whole forum; summary of forum and final comments.

First impression: there were lots of consumers to say hello to, some of whom I knew but hadn't seen in too long. I had several enjoyable chats and a pleasant satisfying lunch before becoming one of the first people to sit at a table because I was hot and didn't want to continue standing. This got things off to a relatively relaxed beginning.

I hadn't originally planned on going to the forum because I thought the process lacked integrity but changed my mind. I didn't prepare for the forum except to have a brief look at the website, after which I printed out the introductory section of the web page. I had intended to use this as a prompt for myself to ask a question. The first thing about the forum proper that left an impression was when the facilitator informed us in her overview of the forum talk that "we're not here to answer questions." I thought: What? How can you have a consultation where the people being consulted aren't allowed to ask questions?

The third person on the community panel to do his individual introduction was a professional footballer who had some lived experience of Depression over several years. He was the only person on the panel with a declared mental illness and seemed to be considered 'the consumer' on the panel. He began "I assume most of you know who I are [no-one said yes, several people murmured no] ... No ... oh ... I'm" and then proceeded to tell us about himself as an elite athlete and inform us that if anyone wanted to discuss football with him that was not okay during the workshops but he was approachable afterwards. He then continued by giving us what seemed to be intended as a motivational pep talk in which we were told things like we didn't need to be ashamed of having a mental illness. While he was talking the person next to me whispered "who does he think he's speaking to?" and a bit later I heard someone at our table whisper "patronizing." Despite what we had been told earlier, one person asked a

question. He did this of his own initiative without waiting to be told if it was okay. He asked if the footballer had ever been an involuntary patient and the footballer replied “I answered that question the last time we spoke.” As he gave this answer he straightened his posture so that he appeared taller and puffed his chest out. This was possibly so he could see across the heads of audience members and look at who had spoken. Or possibly not. The voice tone was consistent with telling off an insubordinate. The footballer’s body language was such that if I had seen it in two individuals in a pub environment I would have concluded a pushing or punching fight was probably about to start. As I perceive it, it was alpha male stuff, aggressive, and overtly inconsistent with demonstrating a safe respectful environment. The question was repeated and the answer given was “No, I haven’t.”

As part of the overview and housekeeping we had a little lecture on the importance of manners at the tables and were told to discuss this at our tables before each table reported back on this issue to the forum and a collective agreement was reached on what good manners at the tables should be. One person at our table said “I think we’re all adults and know how to behave” which I think summed up the attitude of our table and probably the rest of the forum participants. To put this activity in context, it was allocated about 10 – 15 minutes, which was nearly half the time the workshop topic discussions were allocated, and it was basically the same process we later went through with the workshop topic discussions. There were three workshop topics; each table discussed two, one before afternoon tea and one after. The workshop topics were 1) a stronger human rights focus; 2) the Act’s role in promoting recovery; and 3) patient participation in decisions about treatment and care. The workshops were allocated 30 minutes each (there was a little spiel by the DHS staff member appointed as facilitator of our table at the beginning of the first workshop) and 40 minutes for feedback. We were not given the option of coming up with our own workshop topic. To give discussion on the importance of manners at the tables nearly half as much allocated time as discussion on the importance of human rights in the Mental Health Act in my opinion trivialised human rights. Some key points relating to the MHA Review that we were not given opportunity to discuss or comment upon include:

- Do we need a Mental Health Act and if so what should it do?
- Does a Mental Health Act need to include provisions for involuntary treatment and if so why and in what circumstances?
- In a Mental Health Act, how should mental illness be defined?

Discussion of each of these things was treated as less important than discussion of manners at tables and not worthy or allocating time towards.

I didn’t record in my notes who said this and I don’t remember, however, one of the ‘official’ speakers to the forum said in their presentation that they thought in a new Mental Health Act people with a mental illness should be “required to nominate someone who can be their carer and to whom information can be given.” The idea of being required to have an officially registered carer disgusts me. If I thought there was a chance of it happening, I would be horrified.

In the workshops we weren't given much time. We seemed to have enough time to mention and list most (but not all) of our ideas but no time to discuss them or flesh them out. We appointed our own note takers, a different one for each workshop. The notes were handed in at the end; we weren't told what was going to happen to them or offered a copy of our own work let alone a copy of what each table had written. Before we began our 1st workshop discussion a journalist from The Age joined our table, explained who he was, and asked everyone's permission to sit in on our discussion as an observer. We gave him our permission; he appeared a respectful listener. At the end of the forum I briefly spoke with him and asked what he had learned. His immediate comment was that there is a lot of anger from consumers (my word). He also mentioned the difficulty of what to call the people who I had referred to as consumers. I told him that it was conventional to say "consumer/survivor"; he told me that he was writing for the general public and they wouldn't really know what that meant. He gave me his business card and permission to pass his details on to others who may be interested in contacting him but made a point of saying if anyone did contact him he can't promise that any of what they say will end up in an article; it's more a case of helping keep him well informed. At the bottom of the line, he's approachable. I had the sense that we were respectfully listened to by him but only selectively listened to by the bureaucrats.

In the old days mad people and other 'undesirables' were kept out of sight and given something 'fun' to do, for example, draw nice pictures and receive praise and a pat on the head. I had the feeling at the forum that we were being put through a similar process except instead of drawing nice pictures we were writing important sounding words before presenting them in show and tell fashion and being told how good we were. Not everyone at our table had the hang of the condescending style of show and tell etiquette that was expected of us. When our scribe finished his summary of our second workshop discussion another table member started to clarify and expand on a point (which he had originally made in the discussion). At this point of time our report had been much shorter than the previous table's report and the average report. The table member who spoke in clarification was a non-compliant type of consumer who spoke in an articulate, well informed, succinct and assertive way. The facilitator cut him off while he was making his point and prepared to walk away, saying something to the effect of we had to move on. I said "it's still our table", she looked uncomfortable and hesitated, the speaker from our table continued making his points. The important thing here, in my opinion, is that like the earlier instance of the question "have you ever been an involuntary patient?" it was a case of a consumer/survivor taking a 'questioning/challenging' approach and being given the cold shoulder and treated in what I perceive as a disrespectful way while the 'good/compliant' consumers were encouraged to continue speaking and made to feel welcome. One of the points made by our non-compliant consumer was an expression of disgust that in the MHA Review forum consultation process carers were consulted before consumers. One of the community panel members eagerly responded to this point saying that VMIAC had said they would prefer afternoons (inferring any blame should be directed to VMIAC). As a statement of fact this may be true; as a response to the point being made it was nonsense. For example, in Melbourne there is nothing that required the carer forum and

the consumer forum to occur on the same day – the consumer forum could have occurred one afternoon and the carer forum the next afternoon.

There was a lot of time-wasting in the structure of the forum. Whatever the intent, as I experienced it, the main function of this was that it reduced the available time to discuss the review of the MHA. An example of time wasting is that we could have skipped the individual introductions by the community panel members and had the same role fulfilled by an A4 piece of paper amongst the papers we were given when we registered, printed on both sides and containing brief biographies of each community panel member and their goals for the MHA review process.

If I can make the time I am thinking of writing a brief submission on the MHA review. If I do, it won't comment on the MHA itself; I know I won't remotely have enough time for that before the end of February (or March or April). If I make a submission it will be about the MHA Review process currently being undertaken which I believe lacks integrity, credibility & ethics. My participation in the MHA Consumer Forum was to some degree research for my possible submission and it reaffirmed my belief that the process does lack integrity, credibility and ethics. I think I would now add that it also lacks a broad goodwill and respect for human rights from DHS and the Government. This is a comment on the process, not on individuals participating in the process including individual staff of DHS or the Government.

I think the forum was prominently characterised by public service/political manipulation and misdirection. We had the theatrics of consultation without the substance. The community panel included an out-of-sinc ego-fuelled 'celebrity' which attracted media attention towards him and thereby away from others and what they were saying. The topics of discussion were so tightly formulated they seemed more about avoiding discussion of issues than creating opportunity for discussion of issues. The organisers seemed to quickly seek to establish a power dynamic that placed them in the 'superior' position and consumers in the 'inferior' position and tried to enforce this.

I enjoyed my lunch and am grateful for the voucher.

I would have sent this email earlier but I needed a bit of recovery time after the forum and I'm slow at writing. I am aware that some of what I have written isn't properly fleshed out or explained - I have simply run out of time that I can spend writing this for the foreseeable future. I apologise for any lack of clarity in expression this creates.

Regards,

PS. Just an idea: is it worth considering getting together and writing our own 'alternative draft for a new MHA' and publicising it before the 'official draft for a new MHA' is released as a way of generating public discussion and debate? I heard it commented by

a consumer at the forum that the MHA could be scaled back until it became a 'suicide and harm to others prevention act' and I believe that a MHA could be used to give legal authority to advance directives, create a mental health ombudsman, and enshrine in law United Nations principles on mental health. These things, with collective approval, could be the basis or beginnings of an 'alternative draft for a new MHA.' What do people think? It's potential to generate public discussion and debate would be dependent on our ability to publicise it.