Mental Health Bill

Exposure Draft

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About the Human Rights Law Resource Centre

The Human Rights Law Resource Centre is a non-profit community legal centre that promotes and protects human rights and, in so doing, seeks to alleviate poverty and disadvantage, ensure equality and fair treatment, and enable full participation in society. The Centre also aims to build the capacity of the legal and community sectors to use human rights in their casework, advocacy and service delivery.

The Centre achieves these aims through human rights litigation, education, training, research, policy analysis and advocacy. The Centre undertakes these activities through partnerships which coordinate and leverage the capacity, expertise and networks of pro bono law firms and barristers, university law schools, community legal centres, and other community and human rights organisations.

The Centre works in four priority areas: first, the effective implementation and operation of state, territory and national human rights instruments, such as the *Victorian Charter of Human Rights and Responsibilities*; second, socio-economic rights, particularly the rights to health and adequate housing; third, equality rights, particularly the rights of people with disabilities, people with mental illness and Indigenous peoples; and, fourth, the rights of people in all forms of detention, including prisoners, involuntary patients, asylum seekers and persons deprived of liberty by operation of counter-terrorism laws and measures.

The Centre has been endorsed by the Australian Taxation Office as a public benefit institution attracting deductible gift recipient status.

Acknowledgement

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Contents

1. Introduction 2

2. Executive Summary 3

3. General Observations 9

3.1 Compatibility with Human Rights 9

3.2 Implementation of the Legislation – Provision of Adequate Resources and Training 10

3.3 Limitations on Human Rights 12

4. Part 1 – Preliminary 13

4.1 Clause 1: Purpose 13

4.2 Definition of "Capacity" 13

5. Part 2 – Objectives and Principles 15

6. Part 3 – Administration 17

6.1 Public Authorities 17

6.2 Division 2 – Mental Health Commissioner 17

6.3 Division 4 – Mental Health Tribunal 18

6.4 Division 6 – Review Officers 21

7. Part 5 – Compulsory Patients 22

7.1 Principle of Last Resort 23

7.2 Assessment Orders 24

7.3 Treatment Orders 26

7.4 Review by the Mental Health Tribunal 26

7.5 Applications to the Mental Health Tribunal 27

8. Part 7 – Treatment 29

8.1 Treatment without Consent 29

9. Part 8 – Restrictive Interventions 31

9.1 Restraint 31

9.2 Seclusion 32

10. Part 9 – Regulated Psychiatric Treatments 33

10.1 Electroconvulsive Therapy 33

11. Part 10 – Further Protection of Rights 34

11.1 Advance Statements 34

11.2 Nominated Persons 35

11.3 Information about Rights 35

12. Parts 11 to 13 – Accountability and Oversight Mechanisms 35

12.1 Part 11 – Complaints 35

12.2 Part 13 – Public Enquiries and Death Reviews 36

1. Introduction

1. On 8 May 2008, the Minister for Health announced a review of the *Mental Health Act 1986* (Vic) (**Mental Health Act**) and, in December 2008, released the *Review of the Mental Health Act 1986: Consultation Paper* (**Consultation Paper**). In July 2009, the Department of Health released a Community Consultation Report, as well as its response to the Consultation Report. Most recently, in November 2010, the Department of Health released an Exposure Draft of the Mental Health Bill 2010 (**Bill**) for public comment.

2. The Human Rights Law Resource Centre (**HRLRC**) has expertise in the content and operation of the *Charter of Human Rights and Responsibilities 2006* (Vic) (**Victorian Charter**) and significant experience advocating for the harmonisation of domestic laws with international human rights standards. Our experience and expertise in these areas inform the scope and content of this submission.

3. In February 2009, the HRLRC provided a detailed submission on the Consultation Paper entitled *Dignity, Equality, Freedom & Respect: A Human Rights-Based Approach to Mental Health*. In its submission, the HRLRC highlights a number of concerns with the current Mental Health Act and its compliance with both the Victorian Charter and Australia's international obligations under human rights treaties to which it is a party.[1]

4. This further submission by the HRLRC does not respond to all aspects of the Bill. Rather, it focuses on the following aspects:

   (a) the objectives and principles;

   (b) administration of the legislation, including by the Mental Health Commissioner, Mental Health Tribunal and Review Officers;

   (c) compulsory patients;

   (d) treatment orders, restrictive interventions and regulated treatments;

   (e) restraint and seclusion; and

   (f) oversight and accountability mechanisms.

5. The purpose of this submission is to provide recommendations to enhance the Bill's compliance with the Victorian Charter and Australia's international human rights obligations, particularly in relation to the United Nations *Convention on the Rights of Persons with Disabilities* (**CRPD**).

[1] A copy of the HRLRC's previous submission is available at http://www.hrlrc.org.au/content/topics/disability/mental-health-submission-to-review-of-mental-health-act-1986-vic-feb-2009/.

2. Executive Summary

6. As identified in the Explanatory Guide to the Exposure Draft, the current Mental Health Act is more than 20 years old. It reflects an outdated and inappropriate approach to the care and treatment of people with mental illness. The HRLRC considers that the best way to promote the effective, holistic treatment and care of people with mental illness in Victoria is through a human rights framework.[2]

7. While welcoming many aspects of the Bill, the HRLRC considers that there remain a number of significant concerns regarding the Bill's compliance with the Victorian Charter and Australia's international legal obligations. We make the following recommendations to improve the Bill's compliance with human rights standards:

Recommendation 1:

That the Mental Health Bill be amended so as to ensure that its provisions and operation are fully compatible with the UN *Convention on the Rights of Persons with Disabilities* and the *Charter of Human Rights and Responsibilities Act 2006* (Vic).

Recommendation 2:

That adequate resources and training on the new legislation must be provided for all actors in the mental health sector. Training should include an initial and ongoing education program about the legislation and its underlying local and international obligations, namely the Victorian Charter and the CRPD.

Recommendation 3:

That the Bill be reviewed for compliance with the principles for the permissible limitation of human rights contained in section 7(2) of the Victorian Charter and enshrine the principle that any limitations on rights be strictly necessary, reasonable and proportionate.

[2] The HRLRC's acknowledges the continuing debate about the most acceptable terminology to describe people who have mental illness or receive involuntary treatment. For the purposes of our submission, we have chosen to reflect the terminology used in the Consultation Paper and the Exposure Draft.

Recommendation 4:

That clause 1 of the Bill be amended to include specific reference to the purpose of the legislation being to give effect to Australia's obligations under the CRPD.

Recommendation 5:

The definition of capacity must be clarified and applied consistently throughout the Bill.

Recommendation 6:

Clause 3(2) of the Bill should be amended to provide that 'A person has capacity to make a decision for the purposes of this Act if the person is capable, ***with such support they may require***, to…'

Recommendation 7:

The criteria contained in clauses 64(d), 70(d) and 71(d) should be heightened to a capacity test that is consistent with the CRPD and the definition contained in clause 3(2).

Recommendation 8:

That clause 7 of the Bill be amended to:

(a) include all of the principles contained in article 3 of the CRPD, being:

- (i) respect for inherent dignity, individual autonomy including the freedom to make one's own choices, and independence of persons;
- (ii) non-discrimination;
- (iii) full and effective participation and inclusion in society;
- (iv) respect for difference and acceptance of persons with disabilities as part of human diversity and humanity;
- (v) equality of opportunity;
- (vi) accessibility;
- (vii) equality between men and women; and
- (viii) respect for the evolving capacities of children with disabilities and respect for the right of children with disabilities to preserve their identities;

(b) focus on the empowerment of persons with a mental illness; and

(c) provide that the CRPD principles be a paramount consideration for decision-makers when acting under the legislation.

Recommendation 9:

That the Bill explicitly provide that the Mental Health Commissioner, the Chief Psychiatrist, the Child Psychiatrist and the Mental Health Tribunal are "public authorities" under the Charter.

Recommendation 10:

That the powers of the Mental Health Commissioner be extended to include conducting own motion investigations.

Recommendation 11:

That adequate resources be provided to the Mental Health Tribunal to ensure that hearings are expeditious and are not unduly delayed or extended.

Recommendation 12:

An additional sub-clause be inserted into clauses 79, 80 and 117 to provide that:

(a) an extension of time must be justifiable in the circumstances of the case and inadequate resourcing or administrative oversight does not justify an extension of time; and

(b) if the Mental Health Tribunal decides to extend the operation of the existing Order while it determines the application for an Extended Order, the application must be heard and determined *as soon as reasonably practicable* within the 10 day period.

Recommendation 13:

That the Bill be amended to include a provision that all individuals appearing before the Mental Health Tribunal have access to adequate legal advice and/or representation, where appropriate.

Recommendation 14:

That clause 4(1)(a) of Schedule 2 of the Bill be amended to provide that the Mental Health Tribunal is bound by the rules of natural justice and the right to a fair hearing and that clause 4(4) of Schedule 2 be deleted.

Recommendation 15:

That the role of review officers be removed from the Bill and that this role should be replaced by adequate means for legal advice and/or representation to be provided to persons subject to the Mental Health Act.

Recommendation 16:

That an additional clause be inserted at the commencement of Part 5 explicitly providing that the principle of last resort applies to Orders made under this Part.

Recommendation 17:

That clause 65(7) be amended to provide that:

> "If an Assessment Order is made under this section, the person to whom the Order applies must be taken to an approved mental health service as soon as practicable but not later than 24 hours after the Order is made."

Recommendation 18:

That clauses 67(2) and(3) be deleted, such that clause 67 only permit the detention of the person for a maximum of 24 hours to permit the Authorised Psychiatrist to examine the person to assess the need for a Treatment Order.

Recommendation 19:

That clause 68(2) be amended to provide:

> "believe on reasonable grounds that the treatment is necessary
>
> ....
>
> (b) to prevent significant suffering or relieve significant pain or distress."

Recommendation 20:

That clauses 70(b) and 71(b) be amended to include a requirement to consider whether the positive effects of the treatment would outweigh any adverse effects of the treatment, as well as the effects of not providing the treatment.

Recommendation 21:

That clauses 70(b) and 71(b) be amended to include a requirement to consider whether the positive effects of the treatment would outweigh any adverse effects of the treatment, as well as the effects of not providing the treatment.

Recommendation 22:

That clauses are introduced into the Bill to provide that:

(a) All Inpatient Treatment Orders must automatically be reviewed by the Mental Health Tribunal within 48 hours.

(b) All Community Treatment must be reviewed by the Mental Health Tribunal within 7 days.

Recommendation 23:

That clause 87(4) is amended to read:

"The Mental Health Tribunal must hear and determine an application under this section as soon as reasonably practicable and no later than within 10 business days…".

Recommendation 24:

That clause 90 is amended to require the Mental Health Tribunal to have regard to the Mental Health Principles contained in Part 2 of the Act.

Recommendation 25:

That clause 125(1)(a) be removed.

Recommendation 26:

That clause 125 be strengthened to ensure that treatment without a patient's consent is only provided as a measure of last resort.

Recommendation 27:

That clause 139(1)(a) be amended to require that any restraint be "strictly necessary, reasonable and proportionate".

Recommendation 28:

That a clause be inserted providing that the use of chemical restraint is prohibited except as part of a treatment plan approved in accordance with the Act.

Recommendation 29:

That clause 141(1)(a) be amended to require that any restraint be "strictly necessary, reasonable and proportionate".

Recommendation 30:

That clause 145 should be strengthened by the inclusion of an additional sub-clause which provides that no other treatment is reasonably available.

Recommendation 31:

That legally binding advance directives be provided in place of the current formulation of advance statements.

Recommendation 32:

That clause 165 be amended to provide that the Statement of Rights include information about the right to access legal advice and representation, as well as information and contact details for relevant legal service providers.

Recommendation 33:

That provisions be inserted into the Bill which require mental health services to automatically report any serious injuries sustained by patients in their care and which require the Chief Psychiatrist to conduct reviews into such incidents.

3. General Observations

3.1 Compatibility with Human Rights

8. Australia ratified the CRPD on 17 July 2008 and, in doing so, committed the Commonwealth of Australia to "adopt all legislative, administrative and other measures for the implementation of the rights recognized in the present convention".[3] In ratifying the CRPD, Australia also committed to go beyond simply regulating the use of involuntary and other treatments for people with a mental illness and to:

> ensure and promote the full realisation of all human rights and fundamental freedoms for all persons with disabilities without discrimination of any kind on the basis of disability.[4]

9. It is important to note that Australia's obligations under the international human rights treaties to which it is a party, including the CRPD, extend to its states and territories and to all arms of government – executive, legislative and judicial.[5]

10. The Explanatory Guide to the Exposure Draft states that the purpose of the review of the Mental Health Act is to make the legislation "more consistent" with the Victorian Charter and Australia's obligations under the CRPD. We note that the intention of the review of the current Mental Health Act has changed since the Consultation Paper, which stated that "the Act should be *compatible* with the Charter" (emphasis added).[6] The HRLRC emphasises that the Mental Health Act is an important measure by which Australia fulfils its obligations under the CRPD and other human rights treaties to which it is a party and that the purpose and effect of any new legislation must be consistency with international legal obligations and human rights standards.

[3] CRPD article 4(1)(a).

[4] CRPD article 4.

[5] Human Rights Committee, *General Comment 31: Nature of the General Legal Obligation Imposed on States Parties to the Covenant*, UN Doc CCPR/C/21/Rev.1/Add.13 (2004), [4].

[6] Consultation Paper, 11.

11. The HRLRC acknowledges that the Bill provides a much needed shift in paradigm from the substituted decision making model of treatment of patients – which denied patients a meaningful role in deciding how to treat their mental illness – to a human rights based model that emphasises autonomy and non-discrimination. However, the HRLRC remains concerned that the Bill has a long way to go to be compatible with the CRPD.

12. On a general level, the Bill retains a "regulatory" approach to the provision of mental health services, which does not have the effect of empowering individuals who have a mental illness. In this sense, the overall emphasis of the Bill is not consistent with the core principle of the CRPD being to achieve the "full and effective participation and inclusion in society" of people with disability.[7]

13. Further concerns with specific aspects of the Bill are identified throughout the course of this submission.

> ***Recommendation 1:***
>
> That the Mental Health Bill be amended so as to ensure that its provisions and operation are fully compatible with the UN *Convention on the Rights of Persons with Disabilities* and the *Charter of Human Rights and Responsibilities Act 2006* (Vic).

3.2 Implementation of the Legislation – Provision of Adequate Resources and Training

14. As identified above, a core obligation of parties to the CRPD is to adopt all appropriate measures – including legislative, administrative, budgetary and educative measures – for the implementation of the rights contained in the Convention. This includes providing adequate resources and training to ensure that appropriate treatment is provided to all individuals and that the Victorian Government's human rights obligations are met. Indeed, a lack of financial or professional resources is not an excuse for failing to comply with human rights:[8]

> Governments are required to provide adequate funding for basic needs and to protect the user against suffering that can be caused by a lack of food, inadequate clothing, improper staffing at an institution, lack of facilities for basic hygiene, or inadequate provision of an environment.

[7] CRPD article 3.

[8] See World Health Organization, "Resource Book on Mental Health, Human Rights and Legislation – Stop exclusion, dare to care" (2005), 24 (available at http://www.who.int/mental_health/policy/who_rb_mnh_hr_leg_FINAL_11_07_05.pdf). See also Principle 14, UN General Assembly, "Principles for the Protection of Persons With Mental Illness and the Improvement of Mental Health Care" (17 December 1991), UN Doc A/RES/46/119, available at http://www.unhcr.org/refworld/docid/3ae6b3920.html.

15. Under-resourcing has been a major concern for mental health services in Victoria, as well as other Australian jurisdictions.[9] The Community Consultation Report identified that "improving compliance with legislative provisions and ensuring enforcement where provisions are breached" was a key issue raised during the review consultation process.[10] This has also been confirmed by the Mental Health Legal Centre in its report, *Lacking Insight – Involuntary Patient Experience of the Victorian Mental Health Review Board*, which found that:

> Scarcity of resources is certainly a factor in the over-reliance on CTOs by treating teams, who find themselves unable to provide services to those who seek them voluntarily.[11]

16. Inadequate resources have affected the operation of Mental Health Review Board and consumer confidence in the right to a fair and timely review of involuntary treatment orders. In some cases, this may impact on a patient's right to be free from arbitrary detention and rights of liberty and security.[12] The capacity of the proposed Mental Health Tribunal to protect and promote the rights of patients is discussed in this submission under Part 3 – Administration.

17. Article 4(1)(i) of the CRPD provides that parties must also promote the training of professionals and staff working with persons with disabilities in the rights recognised in the Convention so as to better provide the assistance and services guaranteed by those rights. Further, article 26(2) requires parties to promote the "development of initial and continuing training for professionals and staff working in habilitation and rehabilitation services".

18. Implementation of the new legislation, once passed, must involve appropriate training of all actors in the mental health sector on the provisions of the legislation and the international human rights obligations that underpin it. Indeed, particularly given the intended "paradigm shift" of the new legislation, training of health care professionals must also be targeted towards achieving cultural change so that "customary practices" that may raise human rights issues are not continued in under the new Mental Health Act.

[9] See Senate Select Committee 'A national approach to mental health – from crisis to community,' Final Report 28 April 2006 and First Report, 30 March 2006.

[10] Consultation Paper, 1.

[11] Mental Health Legal Centre, *Lacking Insight - Involuntary Patient Experience of the Victorian Mental Health Review Board*, October 2008, 28.

[12] Ibid 73. See also *Kracke v Mental Health Review Board* [2009] VCAT 646 (23 April 2009).

Recommendation 2:

That adequate resources and training on the new legislation must be provided for all actors in the mental health sector. Training should include an initial and ongoing education program about the legislation and its underlying local and international obligations, namely the Victorian Charter and the CRPD.

3.3 Limitations on Human Rights

19. Section 7 of the Victorian Charter recognises that the rights contained in the Charter are not absolute and that rights can be limited in certain circumstances. Section 7(2) states that human rights:

> May be subject under law to such reasonable limits as can be demonstrably justified in a free and democratic society based on human dignity, equality and freedom, and taking into account all relevant factors including—
>
> (a) the nature of the right; and
>
> (b) the importance of the purpose of the limitation; and
>
> (c) the nature and extent of the limitation; and
>
> (d) the relationship between the limitation and its purpose; and
>
> (e) any less restrictive means reasonably available to achieve the purpose that the limitation seeks to achieve.

20. Section 32 of the Charter provides that the normative content of these rights will be developed by reference to international, regional and comparative domestic human rights jurisprudence.[13] Under international law, it is well-established that some rights are absolute and that other rights may be limited in certain circumstances and subject to certain conditions.

21. As a general observation, the HRLRC notes that the concept of "necessity" is used often throughout the Bill.[14] To date, Victorian courts have highlighted that the standard of proof required to justify the limitation of fundamental rights is high. For example, the Supreme Court of Victoria has said that the evidence required to satisfy the elements contained in section 7 must be "cogent and persuasive and make clear to the Court the consequences of imposing or not imposing the limit".[15]

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[13] *Charter of Human Rights and Responsibilities Act 2006* (Vic), s 32(2).

[14] See, eg, clause 321, which permits the sedation of a person for the purposes of transportation to an approved mental health service if it is "necessary" to do so.

[15] *In the Matter of the Major Crime (Investigative Powers Act) 2004* [2009] VSC 381 (7 September 2009) per Warren CJ.

22. In order to ensure compliance with the Victorian Charter, and to create certainty and avoid any doubt that may be created about the interrelationship between the Mental Health Act and section 32 of the Charter, the HRLRC recommends that where "necessary" appears in the Bill it should be replaced with "necessary, reasonable and proportionate".

> ***Recommendation 3:***
>
> That the Bill be reviewed for compliance with the principles for the permissible limitation of human rights contained in section 7(2) of the Victorian Charter and enshrine the principle that any limitations on rights be strictly necessary, reasonable and proportionate.

4. Part 1 – Preliminary

4.1 Clause 1: Purpose

23. As stated above, the Mental Health Act is an important measure by which Australia fulfils its obligations under the CRPD and other human rights treaties to which it is a party. The HRLRC considers that clause 1 of the Bill should be amended to include specific reference to the purpose of the legislation being to give effect to Australia's obligations under the CRPD.

> ***Recommendation 4:***
>
> That clause 1 of the Bill be amended to include specific reference to the purpose of the legislation being to give effect to Australia's obligations under the CRPD.

4.2 Definition of "Capacity"

24. Article 12(4) of the CRPD requires parties to ensure that "all measures that relate to the exercise of legal capacity provide for appropriate and effective safeguards." The HRLRC welcomes the general principle contained in clause 7(2) that a person is presumed to have capacity. However, we note that the Bill contains a number of definitions of capacity. For example:

(a) clause 3(2) of the Bill provides that a person has capacity for the purpose of making a decision under the Bill if the person is capable of—

> (a) understanding the nature and effect of the decision; and
>
> (b) making the decision freely and voluntarily; and

> (c) communicating the decision in a manner such that another person can understand what the decision is.

(b) clauses 64(d), 70(d) and 71(d) of the Bill (relating to Assessment Orders, Compulsory Treatment Orders and Community Treatment Orders respectively) provide that:

> (d) because of the person's (apparent) mental illness the ability of the person to make decisions about the provision of treatment is significantly impaired as the person is unable to —
>
> (i) understand the information relevant to the decision; or
>
> (ii) retain that information; or
>
> (iii) use, weigh or appreciate that information as part of the process of making the decision; or
>
> (iv) communicate the decision in a manner such that another person can understand what the decision is.

25. A determination that a person does not have capacity to make decisions in relation to their treatment engages a number of human rights, including:

(a) the right to not be subject to medical treatment without full, free and informed consent (section 10 of the Charter);

(b) the right to freedom from unlawful or arbitrary interference with privacy (section 13 of the Charter);

(c) the right to equality and non-discrimination (section 8 of the Charter);

(d) the right to respect for physical and mental integrity (article 17 of the CRPD); and

(e) in some circumstances, rights relating to detention and the right to liberty and security of person (for example, article 14 of the CRPD and section 21 of the Charter).

26. Any limitation on these rights must be reasonable, necessary and proportionate and, accordingly, there must be a high threshold for determining whether somebody lacks capacity in order to ensure that there are appropriate and effective safeguards in place. Further, persons should be provided with all necessary assistance and support to make supported decisions before any determination is made that the person lacks capacity, as required by article 12(3) of the CRPD.

27. The HRLRC is concerned that the inconsistent definitions of capacity could potentially lead to differential treatment for different patients. For example, it is conceivable that a person who has freely and voluntarily made a decision to refuse treatment pursuant to the definition in clause 3(2) is subsequently found to be a candidate for an Assessment Order or Treatment Order simply because as a result of their mental illness they have difficulty retaining certain information.

28. The HRLRC considers that the criteria contained in clauses 64(d), 70(d) and 71(d) are incompatible with human rights standards.

29. The HRLRC further considers that clause 3(2) of the Bill should be amended to provide that "A person has capacity to make a decision for the purposes of this Act if the person is capable, *with such support they may require*, to…".

Recommendation 5:

The definition of capacity must be clarified and applied consistently throughout the Bill.

Recommendation 6:

Clause 3(2) of the Bill should be amended to provide that 'A person has capacity to make a decision for the purposes of this Act if the person is capable, ***with such support they may require***, to…'

Recommendation 7:

The criteria contained in clauses 64(d), 70(d) and 71(d) should be heightened to a capacity test that is consistent with the CRPD and the definition contained in clause 3(2).

5. Part 2 – Objectives and Principles

30. Part 2 of the Bill contains the objectives and guiding principles for the operation of the legislation. Clause 6(2) states that the principles contained in Part 2 "should wherever possible be given effect to in the administration of this Act and the provision of mental health services". The HRLRC notes that the principles contained in clause 7 of the Bill do not include all of the principles contained in article 3 of the CRPD. This is despite the Explanatory Guide indicating that the principles contained in Part 2 are consistent with article 3 of the CRPD. Clause 7 should be amended to include all of the CRPD principles.

31. Furthermore, the HRLRC is concerned that the overall approach of clause 7 maintains a "regulatory" approach to the legislation. Instead, the emphasis of the legislation and its general principles should be on the empowerment of persons with a mental illness.

32. In addition to the above, the HRLRC also suggests that clause 7 could be amended to provide that the CRPD principles be a paramount consideration for decision-makers when acting under the legislation. This would assist to ensure that all actors are familiar with, and to the maximum extent possible give effect to, the international human rights obligations that underpin the Mental Health Act.

Recommendation 8:

That clause 7 of the Bill be amended to:

(a) include all of the principles contained in article 3 of the CRPD, being:

  (i) respect for inherent dignity, individual autonomy including the freedom to make one's own choices, and independence of persons;

  (ii) non-discrimination;

  (iii) full and effective participation and inclusion in society;

  (iv) respect for difference and acceptance of persons with disabilities as part of human diversity and humanity;

  (v) equality of opportunity;

  (vi) accessibility;

  (vii) equality between men and women; and

  (viii) respect for the evolving capacities of children with disabilities and respect for the right of children with disabilities to preserve their identities;

(b) focus on the empowerment of persons with a mental illness; and

(c) provide that the CRPD principles be a paramount consideration for decision-makers when acting under the legislation.

6. Part 3 – Administration

6.1 Public Authorities

33. Section 38 of the Victorian Charter imposes obligations on public authorities to act compatibly with human rights and, in making decisions, give proper consideration to human rights. In the HRLRC's assessment, the Mental Health Commissioner, the Chief Psychiatrist and Child Psychiatrist, and the Mental Health Tribunal would all be public authorities under section 4 of the Charter. Indeed, the Explanatory Guide to the Exposure Draft acknowledges that the Tribunal will be a public authority within the meaning of the Charter following the decision in *Kracke v Mental Health Review Board* [2009] VCAT 646.

34. The Bill should explicitly acknowledge the Mental Health Commissioner, the Chief Psychiatrist, the Child Psychiatrist and the Mental Health Tribunal as being "public authorities" under the Charter and therefore bound by the obligations contained in the Charter. An explicit reference to the status of these bodies would avoid any uncertainty and provide guidance for people who engage with these bodies, including the bodies themselves.

Recommendation 9:

That the Bill explicitly provide that the Mental Health Commissioner, the Chief Psychiatrist, the Child Psychiatrist and the Mental Health Tribunal are "public authorities" under the Charter.

6.2 Division 2 – Mental Health Commissioner

35. The HRLRC welcomes the establishment of the Mental Health Commissioner. In addition to the complaints handling role, we recommend that the Commissioner's powers be extended to be able to conduct own motion investigations and that appropriate powers be vested in the Commissioner to undertake this function.

Recommendation 10:

That the powers of the Mental Health Commissioner be extended to include conducting own motion investigations.

6.3 Division 4 – Mental Health Tribunal

36. Article 12(4) of the CRPD provides that the obligation to provide equal recognition before the law requires state parties to ensure that:

> all measures that relate to the exercise of legal capacity provide for appropriate and effective safeguards to prevent abuse in accordance with international human rights law. Such safeguards shall ensure that measures relating to the exercise of legal capacity respect the rights, will and preferences of the person, are free of conflict of interest and undue influence, are proportional and tailored to the person's circumstances, apply for the shortest time possible and are subject to regular review by a competent, independent and impartial authority or judicial body. The safeguards shall be proportional to the degree to which such measures affect the person's rights and interests.

37. The HRLRC welcomes the provisions in the Bill which seek to ensure that the Mental Health Tribunal is a "competent, independent and impartial authority", including the following provisions:

(a) the Tribunal must act independently and impartially and is not subject to the direction or control of any person or body, including the minister (clause 27);

(b) the Tribunal is bound by the rules of natural justice (clause 4 of Schedule 2);

(c) the Tribunal can review on its own motion an Inpatient Treatment Order and Community Treatment order (clause 25(c)); and

(d) the Tribunal is obliged to ensure proceedings are conducted in a way that recognises and is responsive to the needs of a person involved in a proceeding or a witness in the proceeding having regard to their age, any disability and their gender, sexuality, religion, culture (including Aboriginal culture), language and other communication needs (clauses 5(b) and (c) of Schedule 2).

38. However, the HRLRC remains concerned that these safeguards do not satisfy all of the obligations required under the Charter and the CRPD, particularly as they relate the right to a fair hearing and freedom from arbitrary detention.

(a) Delays in Proceedings

39. In *Kracke v Mental Health Review Board* [2009] VCAT 646, Justice Bell determined that the Mental Health Review Board was a public authority bound by the Victorian Charter and was obliged to conduct matters before it in accordance with the fundamental rights contained in the Victorian Charter. Justice Bell held that the Board had breached Mr Kracke's human right to a fair hearing. As part of the human right to a fair hearing, hearings must be conducted within a reasonable time. What is reasonable will depend on such factors as the complexity of the

case, the importance of the case to the applicant, any delay caused by the applicant and the explanation for the delay.

40. On the evidence, Mr Kracke's case was not unusually complex and was very important to the protection of his human rights. While Mr Kracke had requested adjournments, the primary reason for the delay was administrative oversight and consequently the failure to review was a breach of Mr Kracke's right to a fair hearing.

41. Clauses 79(2), 80(2) and 117(2) of the Bill provide that if a mental health service applies to the Tribunal to consider an application to make an Extended Inpatient Order, Extended Community Treatment Order or Extended Secure Treatment Order (**Extended Order**), the tribunal must hear and determine the application before expiry of the existing Order.

42. However, clauses 79(4), 80(4) 117(4) of the Bill give the Tribunal an opportunity to extend this timeframe for up to 10 days if the Tribunal determines that it cannot hear and determine the application before the expiry of the existing order. No guidance is given as to what constitutes a reasonable justification for the extension of time.

43. The HRLRC submits that an additional sub-clause be inserted into clauses 79, 80 and 117 to provide that:

    (a) an extension of time must be reasonable, necessary, proportionate and justifiable in the circumstances of the case (inadequate resourcing or administrative oversight does not justify an extension of time); and

    (b) if the Tribunal decides to extend the operation of the existing Order while it determines the application for an Extended Order, the application must be heard and determined *as soon as reasonably practicable* within the 10 day period. This ensures that the Tribunal is discouraged from unnecessarily extending the time frame for review to the full 10 day period.

44. The HRLRC makes further submissions in *Part 5 - Compulsory Patients* about the specified timeframes for review of Treatment Orders by the Tribunal and whether they comply with international human rights obligations.

Recommendation 11:

That adequate resources be provided to the Mental Health Tribunal to ensure that hearings are expeditious and are not unduly delayed or extended.

Recommendation 12:

An additional sub-clause be inserted into clauses 79, 80 and 117 to provide that:

(a) an extension of time must be justifiable in the circumstances of the case and inadequate resourcing or administrative oversight does not justify an extension of time; and

(b) if the Mental Health Tribunal decides to extend the operation of the existing Order while it determines the application for an Extended Order, the application must be heard and determined *as soon as reasonably practicable* within the 10 day period.

(b) Legal Representation

45. Justice Bell in the Kracke decision highlighted the fact that inpatient treatment orders necessarily involve serious human rights breaches because they involve administering treatment involuntarily and, as a result, "the medical authorities and others involved in making orders and giving treatment are therefore in an extremely powerful position. The patients are in a very vulnerable position".[16]

46. Of the 5,447 hearings conducted under the Act in 2006–07, only 5.6 per cent involved legal representation.[17] This extremely low rate of representation is of even greater concern given those individuals who appear before the MHRB and who have legal representation are two to three times more likely to successfully challenge their order.[18]

47. In certain circumstances, the right to a fair hearing requires that individuals be provided with legal advice and/or representation. Particularly given the potentially grave consequences of matters coming before the Mental Health Tribunal, the HRLRC strongly recommends that the Bill be amended to provide that individuals appearing before the Tribunal be provided with legal representation. Failure to do so would, in certain circumstances, raise concerns with the right to a fair hearing enshrined in section 24 of the Victorian Charter.

48. Indeed, the Joint Committee on Human Rights of the UK Parliament has said, relying on the judgment of the European Court of Human Rights in *Storck v Germany*,[19] that in cases involving compulsory medical treatment the UK Government has a positive obligation "to

[16] *Kracke v Mental Health Review Board* [2009] VCAT 646, [704].

[17] Consultation Paper, 59.

[18] Information taken from the Mental Health Legal Centre (Victoria) Annual Report 2006-07.

[19] *Storck v Germany*, application no 61603/00 (16 June 2005) at [103], [150] (ECtHR).

provide effective supervision and review of treatment without consent".[20] To be "effective", those safeguards must account for the vulnerability of mentally-ill persons,[21] their inability (in some cases) to complain about how they were being affected by the treatment and their position of powerlessness and inferiority.[22]

Recommendation 13:

That the Bill be amended to include a provision that all individuals appearing before the Mental Health Tribunal have access to adequate legal advice and/or representation, where appropriate.

(c) Rules of Natural Justice

49. While clause 4(1)(a) of Schedule 2 states that the Mental Health Tribunal is bound by the rules of natural justice, clause 4(4) provides that it does not apply to the extent that the Act authorises, whether expressly or by implication, a departure from the rules of natural justice. This provision appears to be in direct contravention of section 24 of the Charter which protects the right to a fair hearing. The HRLRC notes that right to a fair hearing is an absolute right, which means that there are no circumstances in which it is justifiable to limit its protections.

Recommendation 14:

That clause 4(1)(a) of Schedule 2 of the Bill be amended to provide that the Mental Health Tribunal is bound by the rules of natural justice and the right to a fair hearing and that clause 4(4) of Schedule 2 be deleted.

6.4 Division 6 – Review Officers

50. Review Officers have been introduced into the Bill as a form of "rights protection". The role of Review Officers is to meet with patients subject to compulsory orders to "ensure that the processes and procedures relating to the making of the order have been followed, and to provide the person with rights advice" (Information Sheet 2 summarising clause 42).

[20] See review of the Mental Health Bill: United Kingdom House of Lords and House of Commons Joint Committee on Human Rights, *Legislative Scrutiny: Seventh Progress Report – Fourth Report of Session 2006-07* (4 February 2007) at [66], [97].

[21] *Renolde v France*, application no 5608/05 (18 October 2008) at [114] (ECtHR).

[22] *Herczegfalvy v Austria*, application no 10533/83 (24 September 1992) at [82] (ECtHR).

51. Review Officers are appointed to assess whether Orders are made "in compliance with this Act" (clause 44). Clause 88 provides that a Review Officer may apply to the Mental Health Tribunal if "there is a mistake or error in the process for the making of the Assessment Order or Compulsory Order". Review Officers are authorised to provide "rights advice" but are not intended to act as public advocates (Information Sheet 5).

52. The HRLRC considers that there are a number of significant shortcomings in the breadth and depth of the role of review officers and their ability to properly safeguard against abuse of process and abuse of human rights. Instead, the HRLRC recommends that the role of review officers be removed and that this role should be replaced by adequate means for legal advice and/or representation to be provided to individuals.

Recommendation 15:

That the role of review officers be removed from the Bill and that this role should be replaced by adequate means for legal advice and/or representation to be provided to persons subject to the Mental Health Act.

7. Part 5 – Compulsory Patients

53. Making a Treatment Order engages and may limit the following rights under the Victorian Charter and CRPD:

(a) right to respect for dignity and individual autonomy (preamble and Article 3 of the CRPD)

(b) right to non-discrimination (Article 5 of the CRPD, Section 8 of the Charter);

(c) right to protection of physical and mental integrity (Article 17 of the CRPD; Section 13 of the Charter);

(d) freedom of movement (Section 12 of the Charter);

(e) right to equal standards of health care, including on a free and informed basis (Article 25 of the CRPD)

(f) right to life (Article 10 of the CRPD, Section 9 of the Charter)

(g) right to equal recognition before the law (Article 12 of the CRPD, Section 8 of the Charter);

(h) right to liberty and security of person (Article 14 of the CRPD, Section 21 of the Charter);

(i) freedom from torture or cruel, inhuman and degrading treatment or punishment (Article 15 of the CRPD, Section 10 of the Charter);

(j) freedom from medical experimentation (Article 15 of the CRPD) or treatment (Section 10 of the Charter) without consent;

(k) freedom from exploitation, violence and abuse (Article 16 of the CRPD);

(l) right to liberty of movement and nationality (Article 18 of the CRPD, Section 12 of the Charter);

(m) right to live in the community with choices equal to others (Article 19 of the CRPD);

(n) right to respect for privacy (Article 22 of the CRPD, Section 13 of the Charter);

(o) right to participate with others in cultural life on an equal basis (Article 30 of the CRPD, Section 19 of the Charter);

(p) freedom of expression (Section 15 of the Charter); and

(q) freedom of thought, conscience, religion and belief (Section 14 of the Charter).

7.1 Principle of Last Resort

54. The Government's Response to the Consultation Report acknowledged that under a supported decision-making model "involuntary orders should only be used as a last resort."[23] The HRLRC is concerned that the principle of last resort has not been expressly incorporated into Part 5 of the Bill. The only explicit reference to the principle of last resort as a guiding principle for the administration of the legislation is found in clause 136 in relation to Restrictive Interventions (Part 8).

> ***Recommendation 16:***
>
> That an additional clause be inserted at the commencement of Part 5 explicitly providing that the principle of last resort applies to Orders made under this Part.

[23] See Government's Response to the Community Consultation Report segment 'Minimising use of orders and restrictive interventions'.

7.2 Assessment Orders

55. The HRLRC welcomes the introduction of the staged assessment process in clause 63 of the Bill. However, the HRLRC remains concerned at the length of time that a person can be subject to an Assessment Order without sufficient oversight and review of the making of the Order.

(a) Timing

56. Clause 63 states that an Assessment Order permits a person:

> [t]o be detained for a period not exceeding 72 hours for examination by an authorised psychiatrist to determine whether the person should be made subject to a Treatment Order.

57. Clause 65(7) sets out how an Assessment Order is to be made and provides that:

> If an Assessment Order is made under this section, the person to whom the Order applies must be taken to an approved mental health service as soon as practicable but not later than 72 hours after the Order is made.

58. Upon receipt of the person at the approved mental health service, clauses 67(1)-(3) authorise the detention of the person for up to 72 hours (being 24 hours plus two renewable periods of 24 hours each) to permit the Authorised Psychiatrist to examine the person to assess the need for a Treatment Order. The combined effect of clauses 65(7) and 67(1)-(3) is that a person who *appears to have a mental illness* may be subject to an Assessment Order for a total of six days.

59. The HRLRC remains extremely concerned at this excessive time frame, particularly given:

(a) these provisions apply to people who “appear” to have a mental illness; and

(b) the potentially serious violation of a person's human rights whilst subject to an Assessment Order.

60. The HRLRC recommends that clause 65(7) be amended to include a maximum time frame of 24 hours for a person to be taken to an approved mental health service after an Assessment Order is made.

61. The HRLRC recommends that clauses 67(2) and(3) be deleted, such that clause 67 only permit the detention of the person for a maximum of 24 hours to permit the Authorised Psychiatrist to examine the person to assess the need for a Treatment Order.

Recommendation 17:

That clause 65(7) be amended to provide that:

> "If an Assessment Order is made under this section, the person to whom the Order applies must be taken to an approved mental health service as soon as practicable but not later than 24 hours after the Order is made."

Recommendation 18:

That clauses 67(2) and(3) be deleted, such that clause 67 only permit the detention of the person for a maximum of 24 hours to permit the Authorised Psychiatrist to examine the person to assess the need for a Treatment Order.

(b) Criteria for an Assessment Order

62. Clause 68(2) provides that treatment may be administered without a person's consent if the registered medical practitioner employed or engaged at the approved mental health service or the authorised psychiatrist:

> believe on reasonable grounds that the treatment is necessary
>
> ....
>
> (b) to prevent suffering or relieve pain or distress.

63. The HRLRC considers that clause 68(2) creates an impermissibly low threshold for the administration of treatment without consent.

64. The lower threshold introduced at clause 68(2) potentially represents an unjustified restriction on a person's rights, especially in light of the fact that treatment is administered without immediate recourse to review by an independent authority and before a person has even been assessed by an Authorised Psychiatrist.

65. The HRLRC submits that clause 68(2) should be amended to heighten the threshold required before an Assessment Order can be made by including the word "significant".

Recommendation 19:

That clause 68(2) be amended to provide:

> "believe on reasonable grounds that the treatment is necessary
>
> ....
>
> (b) to prevent significant suffering or relieve significant pain or distress."

7.3 Treatment Orders

66. Clauses 70 and 71 of the Bill outline the criteria for a person to be made subject to an Inpatient Treatment Order and Community Treatment Order respectively.

67. The HRLRC considers that both clauses 70(b) and 71(b) should be strengthened by including a requirement to consider whether the positive effects of the treatment would outweigh any adverse effects of the treatment, as well as the effects of not providing the treatment.

Recommendation 20:

That clauses 70(b) and 71(b) be amended to include a requirement to consider whether the positive effects of the treatment would outweigh any adverse effects of the treatment, as well as the effects of not providing the treatment.

7.4 Review by the Mental Health Tribunal

68. The HRLRC acknowledges the Bill's commitment to reduce the time for external review of Inpatient Treatment Orders from 8 weeks under the current Mental Health Act to 28 days under clause 73(5) of the Bill. While this improvement is welcomed, a period of 28 days is still unacceptable by reference to international standards.

69. Under the current proposed arrangement it is possible patients will be subject to an Assessment Order for a period of up to 6 days, an Inpatient Treatment Order for the full 28 day period, and then subjected to a Community Treatment Order for three months before the Mental Health Tribunal is called upon to assess whether an extended Treatment Order is warranted.

70. These timeframes present an unacceptable infringement of fundamental human rights. As identified in our previous submission, the World Health Organization (WHO) has indicated that involuntary orders should be automatically externally reviewed within **three days** after they are

made and every six months thereafter.[24] Indeed, international law standards indicate that there is a trend towards a *stricter view* regarding this limit.[25]

71. Delays in tribunal hearings may result in the unjustified detention of patients, particularly in situations where patients are ultimately discharged,[26] and raise concerns in relation to the right to a fair hearing and the right to liberty.

> ***Recommendation 21:***
>
> That clauses 70(b) and 71(b) be amended to include a requirement to consider whether the positive effects of the treatment would outweigh any adverse effects of the treatment, as well as the effects of not providing the treatment.

7.5 Applications to the Mental Health Tribunal

(a) Timeframe for review

72. Clause 87 provides that a person subject to an Order may make an application to the Mental Health Tribunal at any time to have the Order revoked. Clause 87(4) provides that the Mental Health Tribunal "must hear and determine an application under this section within 10 business days of the application being lodged with the Mental Health Tribunal".

73. The HRLRC submits that the timeframe contained in clause 87(4) be amended to provide that the Mental Health Tribunal must hear and determine an application under this section *as soon as reasonably practicable* and within *no later than* 10 business days of the application being lodged with the Mental Health Tribunal.

[24] Consultation Paper, 51, citing World Health Organization, *Mental health care law: ten basic principles* (1996).

[25] Joseph, Schultz and Castan, The International Covenant on Civil and Political Rights: Cases, Materials and Commentary (2004, 2nd ed), 325, citing *Van der Houwen v The Netherlands*, HRC, Communication No 583/1994, UN Doc CCPR/C/54/D/583/1994 (24 July 1995), *Jijon v Ecuador*, HRC, Communication No 277/1988, UN Doc CCPR/C/44/D/277/1988 (26 March 1992), *Borisenko v Hungary* (852/99), *Freemantle v Jamaica* (625/95), and HRC, Consideration of Reports Submitted by States Parties under Article 40 of the Covenant: *Concluding Observations on Gabon*, UN Doc. CCPR/CO/70/GAB; *Concluding Observations of the Human Rights Committee: Zimbabwe*, UN Doc CCPR/C/79/Add.89 (1998) [17].

[26] See, eg, *R (KB) v Mental Health Review Tribunal* [2002] EWHC 639 (Admin) at [8].

(b) Matters to which the Tribunal must have regard

74. Clause 90 provides that the Tribunal may have regard to a list of factors when considering an application under Part 5. The list appears to be an exclusive list. The factors are:

> (a) the person's current mental condition;
>
> (b) the person's medical and psychiatric history;
>
> (c) the availability of care and support for the person;
>
> (d) the person's wishes and preferences, whether expressed in an advance statement or otherwise;
>
> (e) the views of the nominated person if a nominated person has been appointed unless after taking reasonable steps to do so, the nominated person cannot be identified or found;
>
> (f) with the consent of the person being examined, the views of any family member, guardian or carer.

75. The HRLRC considers that clause 90 should explicitly require the Tribunal to have regard to the Mental Health Principles contained in Part 2 of the Bill. While clause 6(2) provides that the Mental Health Principles contained in Part 2 are to be given effect "wherever possible" in the administration of the Act, the HRLRC considers that it is important to reiterate their application to ensure the Act genuinely provides a "rights based model" and that explicit guidance is provided to the Tribunal by the criteria contained in clause 90.

Recommendation 22:

That clauses are introduced into the Bill to provide that:

(a) All Inpatient Treatment Orders must automatically be reviewed by the Mental Health Tribunal within 48 hours.

(b) All Community Treatment must be reviewed by the Mental Health Tribunal within 7 days.

Recommendation 23:

That clause 87(4) is amended to read:

"The Mental Health Tribunal must hear and determine an application under this section as soon as reasonably practicable and no later than within 10 business days…".

Recommendation 24:

That clause 90 is amended to require the Mental Health Tribunal to have regard to the Mental Health Principles contained in Part 2 of the Act.

8. Part 7 – Treatment

8.1 Treatment without Consent

(a) Patients with Capacity

76. Clause 125(1) enables treatment to be authorised without consent if a patient:

> (a) has the capacity to consent to the administration of treatment for mental illness and does not give consent; or
>
> (b) does not have the capacity to consent to the administration of treatment for mental illness.

77. The HRLRC understands that clause 125 is intended to introduce a "two-stage" approach to compulsory treatment. However, clause 125(1)(a) is a significant departure from the principle that a patient *with capacity* not be treated against his or her will. Involuntary treatment must not occur where a person is deemed to have capacity and has refused treatment. The right to freedom from medical treatment provided for in section 10(c) is an absolute right under international law, which means that it is never permissible for the right to be limited in any way. This is relevant to the consideration of the "nature" of the right as envisaged by section 7(2)(a) of the Victorian Charter regarding permissible limitations.

78. Clause 125(1)(a) is therefore in direct conflict with section 10(c) of the Victorian Charter and must be repealed.

Recommendation 25:

That clause 125(1)(a) be removed.

(b) Principle of Last Resort

79. Clause 125(3) lists the factors that the authorised psychiatrist must have regard to when determining whether to administer treatment without consent. The HRLRC considers that clause 125 should be strengthened to ensure that treatment without consent is only provided as a measure of last resort. This would ensure consistency with section 7(2)(e) of the Victorian Charter, which provides that any limitations on human rights must consider whether any less restrictive means are reasonably available to achieve the purpose that the limitation seeks to achieve.

80. This approach would also be consistent with the United Nations *Principles for the protection of persons with mental illness and the improvement of mental health care*.[27] The principle of "least restrictive " intervention contained in Principle 9(1) provides that every individual

> shall have the right to be treated in the least restrictive environment and with the least restrictive or intrusive treatment appropriate to the patient's health needs and the need to protect the physical safety of others.

81. The right to treatment in the least restrictive environment is also reinforced by Principle 9(4), which requires that:

> [t]he treatment of every patient shall be directed towards preserving and enhancing personal autonomy.

82. The HRLRC notes that this principle should be applied consistently throughout the Bill. An example of appropriate drafting to reflect the principle of "least restrictive" intervention is found at clause 139(1)(b) providing that bodily restraint may only be applied if "all reasonable less restrictive options have been considered or tried and are not suitable".

Recommendation 26:

That clause 125 be strengthened to ensure that treatment without a patient's consent is only provided as a measure of last resort.

[27] UN General Assembly, *Principles for the Protection of Persons With Mental Illness and the Improvement of Mental Health Care*, 17 December 1991, A/RES/46/119, available at: http://www.unhcr.org/refworld/docid/3ae6b3920.html.

9. Part 8 – Restrictive Interventions

9.1 Restraint

83. The HRLRC's previous submission highlights the inadequate protection of human rights for patients subject to restraint or seclusion. The submission notes the difference between the written protections contained in the Victoria Charter, international conventions and the Mental Health Act and how those rights are protected in practice in mental health services.

84. The use of restraint and seclusion engages a number of rights, including:

(a) protection from against cruel, inhuman or degrading treatment;

(b) the right to liberty and security of person;

(c) the right to humane treatment when deprived of liberty;

(d) freedom of movement; and

(e) principles of dignity, autonomy and physical and mental integrity.

85. The HRLRC welcomes the introduction of the principles in clause 136 that restrictive interventions may only be used only as a last resort for safety reasons and that restrictive interventions must be the least restrictive and maintain the safety and dignity of the person. This amendment complies with the World Health Organization's view that any limitation of a person's right to be free from detention must be "strictly necessary" to achieve a legitimate public objective – such as public safety.[28] The HRLRC also welcomes the requirement for notification after the use of a restrictive intervention in clause 138.

86. However, the HRLRC considers that the provisions relating to restrictive interventions could be strengthened by amending clause 139(1)(a) to require "that restraint is strictly necessary, reasonable and proportionate", rather than just "necessary". For the same reasons stated above in paragraph 79, this would ensure consistency with section 7 of the Victorian Charter regarding justifiable and permissible limitations on rights.

87. The HRLRC notes that the Bill fails to deal with the use of medication as a form of restraint and considers that this should be regulated by the legislation. Many patients consider that medication in psychiatric hospitals is commonly used to keep people quiet or to control them – that is, as chemical restraints – rather than for sound therapeutic reasons.[29]

[28] World Health Organization, "Resource Book on Mental Health, Human Rights and Legislation – Stop exclusion, dare to care" (2005), 37.

[29] See, eg, *Report of the National Inquiry into Human Rights of People with Mental Illness*, Human Rights and Equal Opportunity Commission, 1993.

88. The HRLRC considers that a new clause should be inserted into Part 8 providing that the use of medication, or chemical restraint, is prohibited except as part of a treatment plan approved in accordance with the Act.

Recommendation 27:

That clause 139(1)(a) be amended to require that any restraint be "strictly necessary, reasonable and proportionate".

Recommendation 28:

That a clause be inserted providing that the use of chemical restraint is prohibited except as part of a treatment plan approved in accordance with the Act.

9.2 Seclusion

89. Clause 141 introduces a number of valuable safeguards against the misuse of seclusion and minimisation of abuse of human rights whilst a patient is in seclusion. In line with comments provided above, the HRLRC considers that the provisions relating to seclusion could be strengthened by amending clause 141(1)(a) to require "that seclusion is strictly necessary, reasonable and proportionate", rather than just "necessary". For the same reasons stated above in paragraph 79, this would ensure consistency with section 7 of the Victorian Charter regarding justifiable and permissible limitations on rights.

Recommendation 29:

That clause 141(1)(a) be amended to require that any restraint be "strictly necessary, reasonable and proportionate".

10. Part 9 – Regulated Psychiatric Treatments

10.1 Electroconvulsive Therapy

90. Clause 145 permits the use of electroconvulsive therapy (**ECT**) as emergency treatment if the person is over 18 years of age and:

> The authorised psychiatrist is satisfied that the administration of electroconvulsive therapy is necessary to save the person's life.

91. Clause 145(c) is intended to provide a level of protection against abuse of the use of ECT as an emergency treatment by requiring the Authorised Psychiatrist to obtain:

> a certificate in writing from a registered medical practitioner and a registered psychiatrist which states that the administration of electroconvulsive therapy is necessary to save the person's life.

92. The HRLRC considers that clause 145 should be strengthened by the inclusion of an additional sub-clause which provides that no other treatment is reasonably available. Wording along similar lines to that in clause 139(1)(b), which provides for "all reasonable less restrictive options have been considered or tried and are not suitable", is suggested.

Recommendation 30:

That clause 145 should be strengthened by the inclusion of an additional sub-clause which provides that no other treatment is reasonably available.

11. Part 10 – Further Protection of Rights

11.1 Advance Statements

93. The provision for advance statements is a welcome introduction to the Bill. Advance statements represent an important aspect of an Act that is intended to reflect a supported decision-making model, rather than the existing substituted decision-making model.

94. Under clause 151(1), a person may make an advance statement specifying their wishes and preferences in the event that their capacity to make decisions is significantly impaired by a mental illness which requires treatment. Under clause 151(2), this may include the ways in which the person does or does not wish to be treated for the mental illness. Clause 152 sets out specific requirements that must be complied with in order for an advance statement to be effective.

95. However, clause 154(4) provides that if the Mental Health Tribunal, or indeed any other body making a decision in relation to a patient, makes a decision that is inconsistent with the patient's wishes in their advance statement, the mental health service provider must make a record of this and give written reasons to the patient, Mental Health Commissioner and authorised psychiatrist (if the decision is not made by them). In other words, despite a person's ability to make an informed decision prior to their mental health deteriorating as to the nature of the treatment they wish to be subjected to, the wishes of the mentally ill person may be overridden so long as a record of the decision is provided to the patient.

96. The HRLRC advocates for a stronger model of advance directives to be included that provides more adequate protection of patients' wishes and instructions. The rights of persons with mental illness would be better protected through the availability of legally binding advance directives.

Recommendation 31:

That legally binding advance directives be provided in place of the current formulation of advance statements.

11.2 Nominated Persons

97. The HRLRC welcomes the introduction of the nominated persons scheme. We consider that the role of nominated persons will assist to improve individual autonomy and participation in decision-making, as well as provide an additional important safeguard for ensuring that the rights of patients are respected.

11.3 Information about Rights

98. Clause 165 of the Bill lists the matters which are to be contained in the 'Statement of rights for patients'. It includes the mental health principles and rights and entitlements of a patient under the Act.

99. The HRLRC recommends that additional information be included in the statement of rights about the right to access legal advice and representation. In addition, the statement should also provide information and contact details for relevant legal service providers, including Victoria Legal Aid and the Mental Health Legal Centre.

> ***Recommendation 32:***
>
> That clause 165 be amended to provide that the Statement of Rights include information about the right to access legal advice and representation, as well as information and contact details for relevant legal service providers.

12. Parts 11 to 13 – Accountability and Oversight Mechanisms

100. The HRLRC remains generally concerned about the inadequacy of the incident reporting requirements contained in the Bill. An independent, effective and efficient oversight and complaints system is essential to ensure that vulnerable patients are protected against potential violations of their rights.

12.1 Part 11 – Complaints

101. Clause 179 provides for a patient, or someone on their behalf, to complain to the mental health service provider about their treatment. Pursuant to this, the mental health service is required to institute and operate an internal complaints handling system under clause 180, with penalties to apply where they fail to do so. The service is also required to report annually to the Mental Health Commissioner under clause 181. The HRLRC welcomes these

provisions, as well as clause 185 which empowers a person receiving mental health services to make a complaint to the Mental Health Commissioner.

102. The HRLRC notes that a complaints-based system is a reactive and often ineffective accountability mechanism, particularly in situations where (as in the mental health context) individuals often have to make complaints to the persons about whom they are complaining. As a result, additional monitoring and accountability mechanisms are often required to ensure that human rights issues are *prevented* from taking place. The HRLRC therefore welcomes the powers granted to the Mental Health Commissioner, including the appointment of investigators (clause 203) and the power to enter premises at any time (clause 206).

103. We note that the effective monitoring and investigation mechanisms are also enhanced by the role of community visitors in Part 10 Division 6 of the Bill. The HRLRC particularly welcomes:

(a) clause 174(1), which provides a community visitor may visit a designated mental health service with or without previous notice at any time they think fit;

(b) powers of inspection granted under clause 175(1), together with clauses 175(2) and (3) which oblige the centre and its staff to provide such reasonable assistance as the visitor requires to exercise their powers effectively; and

(c) clause 176, which allows a patient or someone acting on their behalf to request to see a community visitor.

12.2 Part 13 – Public Enquiries and Death Reviews

104. Clause 237(1) of the Bill provides that the Secretary may conduct a public inquiry to investigate any matter which the Secretary considers connected with the provision of care, treatment or any other service for any person who has a mental illness. The Secretary is given the power to appoint a person or panel of persons to carry out this enquiry under clause 237(3).

105. Additionally, under clause 243(1), the Chief Psychiatrist must conduct a review in relation to the death of any person receiving treatment from a mental health service provider for a mental illness if the death is a reportable death.

106. The HRLRC considers that oversight and accountability mechanisms would be enhanced by requiring the Chief Psychiatrist to also conduct reviews in relation to incidents that result in serious injury. Such a mechanism would be an important aspect of ensuring compliance with sections 10 and 22 of the Victorian Charter regarding the treatment of people deprived of their liberty. Both of the rights contain positive elements which require the state to take appropriate steps to investigate circumstances where concerns are raised about violations of these rights. Effective reporting and review procedures are important to ensure, on a systemic level, that similar issues do not continue to be raised.

107. While the community visitor and public inquiry provisions do offer some protection for vulnerable patients unable to instigate their own complaint (or without anyone to do so on their behalf), the level of protection for people receiving mental health services would be significantly improved by such a requirement. This mechanism should be supplemented by also requiring a mental health service provider to report a serious injury immediately upon becoming aware of it, rather than relying on a patient or their representative to be the key instigator of a review.

Recommendation 33:

That provisions be inserted into the Bill which require mental health services to automatically report any serious injuries sustained by patients in their care and which require the Chief Psychiatrist to conduct reviews into such incidents.