5 March 2014

The Hon Richard Dalla-Riva MLC
Chairperson
Scrutiny of Acts and Regulations Committee
Parliament House
MELBOURNE VIC 3002

Dear Mr Dalla-Riva

Submission on the Mental Health Bill 2014

The Victorian Equal Opportunity and Human Rights Commission has prepared the attached submission to contribute to the Scrutiny of Acts and Regulations Committee’s consideration of the Mental Health Bill 2014. The Bill was introduced into the Legislative Assembly on 18 February 2014.

The Commission welcomes the development and introduction of new mental health laws for Victoria and we acknowledge the significant step forward the new Act will be in protecting the rights of Victorians with psycho-social disabilities. However, a number of concerns remain from a human rights perspective. In this submission, the Commission outlines key issues that should be addressed in the Bill. This is not a comprehensive list of human rights issues that may arise in the application of the legislation.

These issues include (addressed in the order they appear in the Bill):

- gender identity should be explicitly excluded from the definition of ‘mental illness’
- the promotion of mental health should be one of the objectives of the Act
- information, including information about people’s rights, must be provided in forms that people can understand – this will require the use of interpreters (including Auslan), the use of Easy English formats, and Augmentative and Assistive Communication
- communication must be supported in other ways as well, including seeking and imparting information at times when people are best able to participate
- the capacity of people to consent to and refuse treatment must be respected
• second psychiatric opinions must be timely

• electroconvulsive therapy should only be provided with informed consent, and the Commission has grave concerns about the use of such treatment on children – the best interests of the child must be given primary consideration for any young person under 18 years

• restraint or seclusion must be necessary, reasonable and proportionate to be consistent with human rights in the circumstances used and method chosen, not simply ‘necessary’

• there should be better protections around the use of chemical restraints

• the Mental Health Tribunal should have the power to review treatment plans and should be able to more quickly review compulsory assessment and treatment

• the full range of measures available in the current Act to help community visitors carry out their roles effectively should be clearly retained

• all children subject to searches should be entitled to have an adult present (not just those under 16)

• there should be a requirement to consider the rights of parents and children to reside together and have adequate access to one another when making orders under the Act.

I invite the Committee to make this submission available on its website.

If you would like further information, please feel free to contact me on 9032 3404 or kate.jenkins@veohrc.vic.gov.au.

Yours sincerely

[Signature]

Kate Jenkins
Commissioner
Mental Health Bill 2014
> Submission to the Scrutiny of Acts and Regulations Committee

5 March 2014
Introduction

1. The review of the *Mental Health Act 1986* has been one of the most significant law reform endeavours in Victoria in recent times. The old Act is out of date and in need of an overhaul. The consultation over the past six years has also provided an important opportunity for government, service providers and the community to consider the serious human rights issues in mental health treatment and care.

2. The Commission welcomes the introduction of the *Mental Health Bill 2014* (Bill) and acknowledges the work of the Minister, the Department, service providers and members of the community in developing the Bill and contributing productively to consultation about these important issues over the last six years.

3. The Commission welcomes the placement of human rights at the heart of the new principles outlined in the Bill. This is fundamental in a legislative regime that can give service providers extensive control over the most basic rights of individuals.

4. The Commission notes that many of the issues we raised in relation to the 2010 Exposure Draft Bill have been addressed\(^1\). However, some critical issues remain, and in this submission the Commission highlights areas in need of further attention to ensure that the new Act can best promote and protect the human rights of Victorians.

5. The Commission also recognises that beyond the legislative framework of the Bill, there are people in the community who find it difficult to access mental health services. This is relevant to the availability of services, timeframes to access care in both the public and private health systems, and the funding models used. For example a member of the Commission’s Disability Reference Group commented on experiences of long waiting times for a suicidal young person to receive treatment and also noted that federal funding for services was insufficient to address some serious conditions or not available at all for others.

6. The Commission also recognises that there are ongoing issues about access to *appropriate* services for people with particular needs, including people from culturally and linguistically diverse backgrounds, Aboriginal and Torres Strait Islanders, women, young people, older people, Gay, Lesbian, Bisexual, Transgender and Intersex people, people with multiple disabilities, people in rural and regional Victoria, and people in prisons and other closed environments.

7. While access issues are not the subject of this submission, they are significant human rights issues that need to be addressed in practice and will influence: (a) mental health outcomes; (b) the need for compulsory treatment or treatment that involves a deprivation of liberty; and (c) the way people move in and out of the system that is covered by the Act.

8. The Commission also recognises that there are different views in the community about how mental health laws should operate. It is important in such a complex policy area for Parliament to consider different perspectives.

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\(^1\) VEOHRC, Comments on the Department of Health’s Mental Health Bill 2010 Exposure Draft, 24 March 2011.
9. As final overarching point, the Commission notes the importance of regular reviews of Victoria’s mental health laws so that their operation can be considered and so that they do not become so out of date again in the future. We welcome the Minister’s commitment in her Second Reading Speech to review the legislation five years after its commencement. This should be built into the Bill as a statutory review period.

The Commission’s role and the laws we work with


11. The Commission would like to acknowledge the input of members of its Disability Reference Group in discussing issues arising in this submission. The Commission’s Disability Reference Group meets quarterly with the Commission and its aims include helping the Commission to identify human rights priorities affecting people with disabilities and providing advice to the Commission on the development of policies and procedures. The views expressed in the submission are those of the Commission and not necessarily those of members of the Disability Reference Group, but our views have been usefully informed by discussions with them.

The Charter of Human Rights and Responsibilities Act

12. The Charter sets out 20 fundamental human rights that are protected under state law.

13. Section 28 of the Charter requires the Parliament, when enacting legislation, to consider the consistency of proposed legislation with human rights protected under the Charter.

14. Under section 39 of the Charter, public authorities must act in a way that is compatible with human rights, and give proper consideration to relevant Charter rights when making decisions.

15. The Bill potentially engages a broad range of human rights, including the:

- right to equality (section 8)
- right to life (section 9)
- right to protection from torture and cruel, inhuman or degrading treatment (section 10)
- freedom of movement (section 12)
- right to privacy and reputation (including personal autonomy and family (section 13)
- freedom of thought, conscience, religion and belief (section 14)
- freedom of expression (section 15)
- right to protection of families and children (section 17)
- right to take part in public life (section 18)
- cultural rights (section 19)
- right to liberty and security of person (section 21)
• humane treatment when deprived of liberty (section 22), and
• fair hearing rights (section 24).

16. The operation of the mental health laws can at times support these rights, and in many cases will limit these rights.

17. In recognising that human rights protections are vital in the mental health context, the Commission notes under the Charter, human rights can be subject to limitations that are reasonable and can be demonstrably justified in a free and democratic society based on human dignity, equality and freedom, depending on the nature of the right and the importance of the limitation.

18. Section 7(2) of the Charter provides that:

   A human right may be subject under law only 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.

**International human rights law**

19. The Commission also notes that relevant human rights protections exist in international law, including the:

   • International Covenant on Civil and Political Rights
   • International Covenant on Economic, Social and Cultural Rights
   • International Convention on the Rights of Persons with Disabilities
   • Convention on the Rights of the Child
   • Convention on the Elimination of All Forms of Discrimination Against Women, and
   • Convention Against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment.

20. States and Territories have a role in ensuring that Australia can meet its legal obligations under international human rights law.
The Equal Opportunity Act


22. Mental illness falls within the definition of ‘disability’ in section 4 of the Equal Opportunity Act. Disability is a protected attribute under section 6.

23. Under section 15 of the Equal Opportunity Act, all duty holders have a positive duty to take reasonable and proportionate measures to eliminate discrimination and victimisation as far as possible.

24. Under section 44, discrimination in the provision of services is unlawful. Section 45 requires service providers to make reasonable adjustments for a person with a disability.

25. Section 103 prohibits victimisation of a person. This includes victimisation of a person because they brought a complaint about discrimination.

26. Each of these duties is relevant to the way mental health services are delivered and complaints are addressed.

The definition of mental illness

27. In this submission, the Commission generally uses the term ‘mental illness’ because that is the terminology of the Bill. However, we note that the use of terminology is contested and is important to people. The use of terminology can have an impact on people accessing the right to equality and their experiences of discrimination. It is important for the Commission to acknowledge that some people object to the use of the term ‘mental illness’, as it can reinforce labels of a person being ‘deficient’ or ‘abnormal’. Some people prefer the term psycho-social disabilities.

28. In clause 4 of the Bill which sets out the meaning of ‘mental illness’, the Commission welcomes the express inclusion of matters which do not of themselves indicate that a person has a mental illness. This list includes sexual orientation and intellectual disability.

29. To be consistent with the Equal Opportunity Act, Parliament should also include gender identity in this list. This has important implications for protection from discrimination. People with a particular gender identity may experience mental health issues, as any other member of the community may, but they should not be classed as having a mental illness merely by reference to their gender identity.

Objectives of the Act

30. The Commission generally welcomes the objectives of the Act set out in clause 10 of the Bill. We particularly welcome of the inclusion of an objective for persons to receive assessment and treatment in the least restrictive way possible with the least possible restrictions on human rights and human dignity, and to ensure that persons who are assessed and treated under the Act are informed of their rights (clause 10).
31. There are a number of places where these rights should be more strongly reflected in the rest of the Bill to ensure these objectives can be achieved. For example, an authorised psychiatrist must consider a number of factors to the extent that it is reasonable in the circumstances when making a Temporary Treatment Order (clause 46) and whether is it a Community Temporary Treatment Order or an Inpatient Temporary Treatment Order (clause 48). What is the least rights restrictive option should also be a consideration here. Another example is when reviewing treatment, the chief psychiatrist should be required to consider whether treatment is the least rights restrictive option, in addition to the factors listed in clause 88(3)). This may not be the determinative factor, but it should be a factor to ensure decision making is consistent with human rights.

32. It is also important that a Mental Health Act include an objective to promote, support and protect people’s mental health. While the legislation is dealing specifically with the legal basis needed for the more serious end of interventions, it should not displace the overall goals of a mental health system, which is to support mental health and wellbeing. Addressing this appropriately will influence whether people need the interventions contemplated under the Bill, the goals of treatment, and how people move in and out of the system. We therefore suggest an additional objective be added to clause 10 of the Bill ‘to promote and support people’s mental health’.

The mental health principles

33. The Commission welcomes the creation of the mental health principles and recognises that they are firmly grounded in human rights. The principles also draw people’s attention to the particular needs of different groups. This is extremely positive. However, there are some elements that could be improved from a human rights perspective.

34. Clause 11(1)(g) says that ‘persons receiving mental health services should have their individual needs (whether as to culture, language, communication, age, disability, religion, gender, sexuality or other matters) recognised and responded to’. This list should specifically recognise the needs of people because of their gender identity as well.

35. The Bill should also recognise that people have the right to have their individual needs recognised and responded to in accordance with the Equal Opportunity Act and the Charter.

36. Clause 11(1)(h) is positive in recognising that ‘Aboriginal persons receiving mental health services should have their distinct culture and identity recognised and responded to’. The Commission would like to see specific recognition of culture as a right and the stronger obligation to protect and promote these rights (as recognised in section 19 of the Charter).

37. Clauses 11(i) and (j) relating to children and young people are also positive. The Commission would like to see protection and promotion of their ‘rights’ articulated, in addition to their needs, wellbeing and safety.

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38. In a number of places in the Bill, the drafting refers to the ‘promotion’ of relevant rights. To be effective from a human rights perspective, rights must be promoted and protected. This more active language of protecting rights is sometimes missing from the Bill. One example is in clause 11(i) where ‘children and young persons receiving mental health services should have their best interests recognised and promoted as a primary consideration’. In this case, the protection of the right is also an important part of the human rights obligation and should not be lost in the drafting. Similarly in clause 120, the role of the chief psychiatrist includes ‘to promote the rights of persons receiving mental health services’. This should also include the protection of rights.

**Statement of rights**

39. The Commission welcomes provision for a statement of rights to be developed in a form approved by the Secretary (clause 12). We note that these rights will need to be consistent with rights under the Charter as well as mental health legislation. The Commission would be happy to provide input to the Department during the development of the statement of rights.

40. We also note that the statement of rights will be a standard form and therefore should be translated into community languages, audio, Auslan video format, and provided in an Easy English form to ensure that it is accessible. People’s ability to understand information may also change over time, so different approaches to communicating these rights may need to be considered at different points in time.

41. The statement of rights must also outline the procedural and review rights that people have, for example, the right to apply to the chief psychiatrist for review of treatment provided for in clause 87 of the Bill. People must be informed that they have this right in a way they can understand. They must also be informed of their rights at the earliest and at all subsequent relevant points.

42. While we welcome the provision in clause 13 for the statement of rights to be explained, elsewhere the Bill simply refers to the requirement to give a person ‘a copy of the relevant statement of rights’ (for example, clause 32(1)(b)(ii) in relation to Assessment Orders). This will rarely be sufficient and a duty to make reasonable endeavours to inform people about their rights in a way that they can understand should be a requirement at all relevant points in the Bill.

**Right to communicate**

43. The Commission welcomes explicit recognition of the right to communicate in clause 15 of the Bill.

44. The right to communicate supports the right to freedom of expression in section 15 of the Charter and can be used to support access to a range of other human rights, including the right to equality in section 8 and the right to protection from being subject to medical treatment without full, free and informed consent in section 10.

45. People must be provided with interpreters, including Auslan, as well as languages other than English, to facilitate communication, as required.
46. Service providers will have obligations under sections 44 and 45 of the Equal Opportunity Act not to discriminate against people on the basis of race, which can include language, and to make reasonable adjustments for people with disabilities. They also have a positive duty to take reasonable steps to prevent discrimination. This will require service providers to take reasonable steps to provide an interpreter, including in languages other than English, and Auslan, where needed.

47. While the Commission welcomes provision made in clause 185 of the Bill that a person may use an interpreter at the Tribunal, this is not sufficient protection for people who can be subject to extreme deprivations of their rights under the Act. Given the rights involved, at a minimum, an interpreter must be provided when it is needed and the person will be subject to compulsory treatment.

48. Communication aids must also be used to support people with communication disabilities so that they can access their right to communicate.

Right to information and communication issues more generally

49. This raises issues about communication more generally in the Bill. The Commission welcomes the recognition in a number of places in the Bill that communication with a patient should be in a language and mode of communication that they are most likely to understand. An example of this is in clause 8. It would be useful to include a drafting note and guidance material that applies across the Bill to specify that this may include the need for interpreters including Auslan, as well as languages other than English, and that Augmentative and Alternative Communication, and Easy English tools may be required. The Commission has been told about situations where service providers and courts have refused to allow the use of devices that would assist people with disabilities to communicate. Accessible communication is fundamental to people accessing their right to equality and many other rights that can be influenced by the operation of mental health laws.

50. At a number of points the Bill also sets out that notification must be given to patients in writing, for example, of the outcome of a review of the chief psychiatrist in clause 88(6) or notice of a hearing at the Tribunal in clause 189. Other places where this is relevant include clause 20 for the making of advance statements and clause 24 for nomination of a nominated person that must be in writing. While the protection offered by this formality is important, for clarity, it should be clearly accompanied by a requirement to also communicate the information to the patient in a way that they can understand and for them to express their intent in a way that they can. This may not always be in writing and the Bill should be clear that it does not prohibit a person with disabilities from providing for a nominated person, for example, because they can not sign their name.

51. Best efforts must also be made to communicate with a person at a time when they are best able to receive and impart information. This is recognised for the communication of the statement of rights at clause 13(3), but is relevant at other times as well. People’s capacity to take in complex information may vary over time, including during the course of the day or with the range of drugs or treatment they are given.
52. A member of the Commission’s Disability Reference Group raised concerns with us about a situation they observed in which a person asked what the drug they were being given was for. They said that the service provider refused to answer. They also described another situation where a person was heavily sedated and unable to receive or impart information because of the drugs they were on, rather than their mental health condition. The protections from these kinds of abuses need to be clearer in the Bill.

**Advance statements**

53. The provision for advance statements in clause 20 of the Bill is welcome. Advance statements are intended to assist the authorised psychiatrist to understand the patient’s treatment preferences and, if the person is unable to make decisions, enable the authorised psychiatrist to make treatment decisions that better align with the patient’s preferences.

54. These statements are not binding and cannot anticipate every scenario or treatment option. However, Parliament may want to consider that people without mental illness disabilities can make similar directives to refuse treatment, and these are generally respected by medical professionals. The failure to make provision for a binding directive to refuse treatment may therefore be discriminatory on the basis of disability.

55. The Commission notes that the categories of person who can witness an advance statement may not be appropriate. The witness of an advance statement has an important role in making an assessment that the person making the statement understands it and the consequences of it (clause 20(d)(i)). This protects the rights of the person as much as the interests of health professionals who may later take it into account.

56. Under clause 3 of the Bill, an authorised witness means a registered medical practitioner, a mental health practitioner, or a person who may witness the signing of a statutory declaration under section 107A of the Evidence (Miscellaneous Provisions) Act 1958. This includes a veterinary practitioner and the secretary of a building society. The Commission queries the replication of this list from the statutory declaration context. This list of professions may also not be most accessible people to someone subject to compulsory treatment.

**Capacity**

57. The determination of whether a person has capacity, and the related determination of whether a person gives informed consent to treatment, is central to the treatment provisions of the Bill. The assessment of capacity is therefore critical to ensuring the rights of people with psych-social disabilities are protected.

58. The following Charter rights may be engaged by a determination that a person does not have capacity to make decisions about their treatment:

- the right to not be subject to medical treatment without full, free and informed consent (section 10(a))
the right to equality and non-discrimination (section 8)

the right to protection from cruel, inhuman or degrading treatment or punishment (section 10(b))

the right to freedom from unlawful or arbitrary interference with privacy (section 13), and

in some circumstances, rights relating to detention and the right to liberty and security of person (section 21).

59. These Charter rights may be subject to reasonable limits that can be demonstrably justified in a free and democratic society (section 7(2)).

60. The Convention on the Rights of Persons with Disabilities (CRPD) also enshrines a number of rights relevant to any assessment of capacity under the Bill. The CRPD protects the right to respect for physical and mental integrity on an equal basis with others (Article 17) and the right to equal recognition before the law (Article 12). In particular, Article 12 of the CRPD requires states to recognise that persons with disabilities enjoy legal capacity on an equal basis with others, and that appropriate and effective safeguards are provided for the exercise of legal capacity. Relevantly:

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.  

61. The Commission strongly supports the presumption of capacity in clause 70(2) of the Bill. The Commission also welcomes the inclusion of principles to guide an assessment of a person’s capacity, set out in clause 68(2) of the Bill. These measures are important to protect the autonomy of people to make and participate in decisions about their health.

62. The Bill should explicitly recognise that people may require support to exercise their legal capacity. The CPRD requires that ‘appropriate measures’ are provided to persons with disability to support them in exercising their capacity. Such a requirement would also be consistent with the obligation of service providers to take reasonable and proportionate measures to eliminate discrimination under the Equal Opportunity Act.

63. The Commission is concerned that clause 70(3) provides that a person does not have to seek informed consent if they form the opinion that the other person does not have capacity to give informed consent at that time. An individual opinion on this issue can have a significant limitation on the rights of persons with mental illness and the Bill does not provide a clear standard for this assessment. It is contrary to the objectives of the Bill outlined in clause 10(d) to fail to support people with a mental

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2 CRPD, Article 12(4).
illness to participate in decisions that affect them, and it also runs contrary to the principles of the Bill in clause 11.

64. The Commission recommends that the Bill is clarified to require practitioners to have a *reasonable* basis for their opinion that a person does not have capacity to give informed consent at a particular time. Practitioners should also be expressly directed to have regard to the principles in section 68(2) of the Bill when making such a determination. Clause 76(3) regarding medical treatment requires an authorised psychiatrist to consider if the person may have capacity to give informed consent in a reasonable amount of time. These safeguards should also apply to treatment decisions under clause 70(3).

65. There should be provision in the Bill to ensure that people are given the best opportunity to participate and make decisions. For example, a member of the Commission’s Disability Reference Group has cautioned about people being unable to participate in decision making or hearings because of the drug regime they have been put on. People may also have varying capacity over time, even over the course of a day, and this should be something service providers and oversight bodies have to take into account.

66. The Bill should also protect the right of a person with limited capacity to make decisions about aspects of treatment when they retain capacity to make those decisions, that is, capacity is not ‘all or nothing’ and can change over time and vary depending on the complexity of the issue.

**Informed consent**

67. The Commission welcomes the explicit recognition of the right of people to make informed decisions about their health care.

68. However, we note the practical challenges to ensure that the person has given informed consent in accordance with the meaning in clause 69. Clause 69 provides that a person gives informed consent if the person:

(a) *has the capacity to give informed consent to the treatment or medical treatment proposed; and*

(b) *has been given adequate information to enable the person to make an informed decision; and*

(c) *has been given a reasonable opportunity to make the decision; and*

(d) *has given consent freely without undue pressure or coercion by any other person; and*

(e) *has not withdrawn consent or indicated any intention to withdraw consent.*

69. A number of consumers have expressed concern to the Commission that they have felt pressure to consent to particular forms of treatment and their concerns that if they withhold consent, a decision may be made that they do not have capacity to make the decision.

70. The Tribunal must have effective oversight of these issues.
Compulsory treatment where consent to treatment is refused

71. The Commission is concerned that clause 71 of the Bill permits treatment when a person has exercised their capacity to not consent to treatment. Such a clause limits a person’s right to not be subjected to medical treatment without full, free and informed consent.4

72. Clause 71(1)(ii) permits an authorised psychiatrist to make a treatment decision for a person where the person has the capacity to give informed consent, but does not give consent to that treatment. This broad provision directly contradicts the principles outlined in section 11 of the Bill, that:

(e) persons receiving mental health services should be allowed to make decisions about their assessment, treatment and recovery that involve a degree of risk; and

(f) persons receiving mental health services should have their rights, dignity and autonomy respected and promoted.

73. The Bill provides the following criteria for overriding a person’s wishes to refuse treatment:

- the person has mental illness (clause 5)
- the person needs immediate treatment to prevent either serious deterioration in the person’s mental or physical health or serious harm to the person or to another person (clause 5), and
- the authorised psychiatrist is satisfied that there is no less restrictive way for the patient to be treated (Clause 71(3)).

74. The effect of these provisions is to provide for a different approach for people who have capacity to consent to treatment but refuse to do so, dependent on whether a person has a mental illness or not. Victorian law otherwise protects the right of people with capacity to refuse medical treatment, and provides for substituted decision-making in circumstances where there is impaired capacity.5

75. The Commission acknowledges there are different views in the community about the role of substitute decision-making. The Commission considers there may be extremely limited, rare, circumstances where a risk of immediate harm to others warrants intervention. The Commission notes that the power to arrest or detain a person in order to prevent harm may be a reasonable limitation on a person’s rights.6 Such limitations are provided generally in the community and are not limited to particular people because of any disability they may have.

76. However, the Bill provides that a person’s decision to refuse treatment may be overridden where there is serious deterioration in that person’s health. This means a

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4 Charter of Human Rights and Responsibilities Act 2006, section 10(c).
person with a mental illness who has capacity may receive treatment they have refused. By contrast, a person who does not have a mental illness who has capacity can refuse treatment – even in instances where their life depends on that treatment.\footnote{For example, a Jehovah’s witness could refuse a blood transfusion, even if the transfusion was life-saving treatment.}

77. Where an adult has capacity to make the decision, their right to do so must be respected, even though other people may disagree with their choice or the reason for it. The law should support a person’s autonomy, bodily integrity and beliefs.

78. The Minister’s Statement of Compatibility for the Bill states that:

\begin{quote}
If a patient has the capacity to make a decision but refuses treatment, compulsory treatment is reasonable in circumstances where the person has mental illness and, because of the mental illness, immediate treatment is necessary to prevent serious harm to the person or another person or serious deterioration in the person’s health.\footnote{\textit{Hansard} 20 February 2014, p 21.}
\end{quote}

79. Clause 71 of the Bill is in direct conflict with sections 10(c) and 8 of the Charter, and may also conflict with the right to protection from cruel, inhuman or degrading treatment in paragraph 10(b). The justification for this unequal treatment is not sufficient. The Statement does not explain why discriminatory treatment, and a breach of Charter rights, is demonstrably justified.

80. This is an issue that should be subject to further examination during Parliament’s consideration of the Bill.

**Compulsory treatment where there is no capacity**

81. While compulsory treatment for mental illness may support the right to security of person in subsection 21(1) of the Charter, it is also a significant limitation on the rights of people with a mental illness to equal protection of the law set out in subsection 8(3).

82. The Commission notes that there are different views in the community on the question of compulsory treatment (also referred to as forced, non-consensual or involuntary treatment). Some view this as a breach of the right to consent to medical treatment, and some would view it as torture, or cruel, inhuman or degrading treatment.

83. The Commission notes comments by the United Nations Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment that:

\begin{quote}
Free and informed consent should be safeguarded on an equal basis for all individuals without any exception ... Any legal provisions to the contrary, such as provisions allowing confinement or compulsory treatment in mental health settings, including through guardianship and other substituted decision-making, must be repealed.\footnote{Statement by Mr Juan E Mendoza, Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, 22nd Session of the Human Rights Council, Geneva, 4 March 2013, p 2.} 
\end{quote}
84. The starting point from a human rights perspective is that there must be a presumption of capacity and that capacity must be respected, including the capacity to consent to and to refuse treatment.

85. There must be safeguards to ensure that consent or the withholding of consent is free and informed, and that all reasonable efforts are made to obtain consent at a time when the person is able to exercise their own judgement.

86. In 2012, civil society groups themselves noted that there are diverse views on the role of substitute decision-making, which would allow involuntary treatment in restricted circumstances when a person does not have capacity.¹⁰

87. The Commission acknowledges that there may be limited circumstances where involuntary treatment is appropriate where a person does not have capacity. This must be a measure of last resort, used in rare circumstances and be subject to stringent safeguards.

88. The Commission welcomes the safeguards included in the Bill that will restrict the circumstances in which compulsory treatment may be administered, including that:

- Part 4 of the Bill provides a person may only be subject to compulsory treatment where a Treatment Order or Temporary Treatment Order is in place

- the high threshold criteria for compulsory treatment which require that a person needs immediate treatment to prevent serious deterioration in their mental or physical health or to prevent serious harm to the person or to another person (clause 5)

- a person may only be subject to compulsory treatment if there is no less restrictive means reasonably available to enable the person to receive the immediate treatment (clause 5).

89. The Commission supports the requirement that compulsory treatment be a last resort, and acknowledges that the process for establishing a Part 4 order includes requirements to have regard to the views and preferences of the person to be treated and to provide the person with a statement of their rights.

**Second psychiatric opinions**

90. The Commission welcomes the right for certain compulsory patients to seek a second psychiatric opinion. In particular, the Commission supports:

- the ability for a patient to seek a second psychiatric opinion at any time (clause 79) and from any psychiatrist (people should be informed of this choice in the statement of rights) (clause 80)

- the requirement for a psychiatrist giving a second opinion to have regard to the patient’s views and preferences about their treatment (clause 82(d)(i))

• the ability for a patient to apply to the Tribunal at any time to have a Temporary Treatment Order or a Treatment Order revoked (clause 60(1)), and

• the requirement for the chief psychiatrist to have regard to the patient’s views and preferences about their treatment in conducting a review (clause 88(3)(a)).

91. The Bill provides compulsory patients with the right to apply to the chief psychiatrist for review of their treatment if there is a conflict between the views of the authorised psychiatrist and the second opinion psychiatrist (clause 87). The Bill should provide that all reasonable efforts must be made to inform a patient of this right in a way that they can understand.

92. The Bill could also be strengthened by requiring the process for seeking a second psychiatric opinion and any subsequent review to be undertaken as a matter of urgency. This will help to ensure that any limit on a compulsory patient’s rights is reasonable and proportionate in accordance with section 7(2) of the Charter.

93. Principle 17 of the United Nations Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care states that review:

    of a decision to admit or retain a person as an involuntary patient shall take place as soon as possible after that decision and shall be conducted in accordance with simple and expeditious procedures as specified by domestic law.

94. While these principles are not binding, they provide useful guidance on how to meet Victoria’s obligations under human rights law (including the right to liberty under section 21 of the Charter). The right to liberty is engaged where a person is detained involuntarily in a mental health facility and seeks review of their detention.

95. Depending on the nature of a person’s treatment (which could include, for example, electroconvulsive treatment), the need to establish clearly defined and expeditious time limits for the review of a person’s involuntary detention and/or treatment is particularly important. It is also consistent with findings that medical opinion on the nature of a psychiatric illness and the necessity of administering medical treatment is not always accurate.

96. Therefore, the Bill should include clearly defined or maximum time limits for:

• a psychiatrist who gives a second opinion to prepare a written report (and to provide a copy of that report to the patient, the authorised psychiatrist, and other relevant persons) (clause 84)

• an authorised psychiatrist to examine a patient or review their treatment after receiving a second opinion report (rather than simply ‘as soon as practicable’) (clauses 85(1) and 86(1)), and

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• the chief psychiatrist to notify the relevant parties of the outcome of a review (rather than simply ‘as soon as practicable’) (clause 88(6)).

97. The Commission considers that all of these activities must be undertaken ‘as soon as practicable’, but should also include a maximum time limit (for example, the Bill could require an authorised psychiatrist to examine a patient ‘as soon as practicable, but not later than two business days after receiving a second opinion report’). 13

98. In light of the above, the Commission also considers that the chief psychiatrist should be required to review a patient’s treatment within a shorter time period than 10 business days (for example, ‘as soon as practicable, but not later than five business days after receiving an application for review’). 14

99. Finally, while the Commission welcomes the inclusion of the right to seek a second psychiatric opinion, the Commission is concerned about access to safeguards in the Bill for compulsory patients in rural and regional parts of Victoria. In particular, in implementing the Bill, authorities will need to consider the practical difficulties of obtaining a second psychiatric opinion in a timely manner and ensuring the rights of people in rural and regional areas are protected in practice.

Electroconvulsive treatment

100. The Commission has concerns with provision in Division 5 of the Bill for the use of electroconvulsive treatment (ECT). If ECT continues to be used, it should only be with informed consent.

101. The Commission is deeply troubled by the use of ECT on children. The human rights set out in subsection 17(2) of the Charter make the protection of the best interests of the child a primary consideration in all matters relating to young people under 18 years.

102. The World Health Organization (WHO) has recommended that ECT should be prohibited in patients aged less than 18 years given the lack of evidentiary data to support the safety and need for this form of treatment on children. In its resource book on mental health, human rights and legislation, the WHO notes the controversy surrounding ECT as a treatment option for persons of any age and reiterates that it remains a treatment that should only be administered where there is informed consent. 15

103. We also note that the Exposure Draft Bill released in 2010 proposed a prohibition on the use of ECT on children under the age of 13. No such restriction appears in the current Bill before Parliament.

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13 This approach is consistent with other parts of the Mental Health Bill 2014 which include a maximum time limit for activities that must be conducted ‘as soon as practicable’. See for example, clause 33 which addresses Inpatient Assessment Orders and the person being required to be taken to a designated mental health service, but not later than 72 hours and clause 95 of the Bill relating to the listing of an electroconvulsive treatment application by the Tribunal as soon as practicable and within five days after receiving the application.

14 Clause 88(1).

104. The Commission also notes that provision has been made for young people who are 16 years and older, to consent to ECT. The administration of ECT in relation to a young person under 18 must also be approved by the Tribunal.

105. The Commission acknowledges that while consent to treatment is generally more appropriately considered with reference to a person’s capacity rather than their age, this is a particularly vexed issue given the reports of uncertain outcomes of ECT and the possible impact of the treatment on a young person’s developing brain. Young people are at a critical point in their biological and mental development.

106. The Commission is concerned that the Tribunal is directed in clause 94 to grant an application for ECT where they are satisfied that the young person has provided informed consent. While it is important that young people are able to exercise autonomy in decisions affecting their health, there is a risk that the treatment will in some instances be contrary to the best interests of the child protected in section 17(2) of the Charter and the Convention on the Rights of the Child. These protections apply to all persons under the age of 18 years.

107. Given these issues, the Commission continues to have serious concerns about the use of ECT on minors contained in the Bill.

108. If ECT is to be permitted for use on young people, the relevant principles outlined in clause 11 of the Bill should be expressly inserted into the decision making framework in this part of the Bill. In particular, the Tribunal should be required to consider whether the use of ECT is in the best interests of, and is the least restrictive treatment option for any young person subject to an application for ECT. This is irrespective of whether the young person has the capacity to provide informed consent.

Neurosurgery for mental illness

109. The Commission welcomes the framework in the Bill that specifies that neurosurgery for mental illness may only be performed on a person who has given informed consent and where the Mental Health Tribunal has approved the performance of the treatment.

110. The Tribunal’s role is described in the Second Reading Speech as ‘the Tribunal must be satisfied that the neurosurgery for mental illness is likely to remedy the person’s mental illness or lessen the symptoms and improve the person’s quality of life’. This is reflected in the Bill as the Tribunal being satisfied that the neurosurgery will ‘benefit’ the person. Given the nature of the procedure and potential risks (considered at clause 102(3)(d)), a higher test such as ‘significant benefit’ may be more appropriate.

111. We note that no substitute decision maker will have the authority to consent to neurosurgery for mental illness.

112. We also note the challenges in practice of ensuring that there is informed consent, without undue, influence. The Tribunal’s oversight of this will be critical to protecting human rights in practice.
Restrictive interventions including restraint and seclusion

113. The use of restrictive interventions such as restraint and seclusion, engages a number of rights under the Charter, including:

- protection against cruel, inhuman or degrading treatment (section 10)
- the right to liberty and security of person (section 21)
- the right to humane treatment when deprived of liberty (section 22)
- freedom of movement (section 12), and
- principles of dignity, autonomy and physical and mental integrity (part of the rights to privacy in section 13 and equality in section 8).

114. The Commission welcomes the introduction of the principles in Part 6 of the Bill, that restrictive interventions (defined in clause 3 as bodily restraint and seclusion) may only be used after all reasonable and less restrictive options have been tried or considered and have been found to be unsuitable. In addition, the Commission welcomes the requirement in Part 6 that a person authorising a restrictive intervention must ensure that the person subject to the intervention has their needs met and their dignity is protected.

115. Restrictive interventions must be strictly regulated and imposed only as a last resort after less restrictive options reasonably available have been considered and are unsuitable in the circumstances. Interventions must be subject to rigorous oversight and review.

116. On balance, the Commission considers that both of these primary concerns have been addressed in the new Bill.

Suggestions for other alternatives

117. The Commission is pleased that the Bill includes safeguards which ensure that bodily restraint and seclusion are only used if it is 'necessary to prevent serious or imminent harm to the person or to another person'. However, the Commission notes that the safeguards would benefit from the addition of the requirement that bodily restraint or seclusion is 'necessary, reasonable and proportionate', rather than simply 'necessary'. This would help to ensure that the Bill in consistent with s 7(2) of the Charter, requiring justifiable limitations on rights.

118. The Commission also notes that Part 6 of the Bill does not expressly deal with the use of medication as a form of restrictive intervention. The definition of restrictive intervention in clause 3 expressly includes 'bodily restraint' only and does not extend to chemical restraint. Moreover, the Statement of Compatibility refers only to mechanical and physical restraint and makes no mention of chemical restraint, except in the context of transporting a person to a designated mental health service (see Part 15, Division 3 of the Bill).
119. The Commission notes that some consumers consider that medication in mental health facilities is commonly used to keep people quiet or to control them – that is, as chemical restraints – rather than for sound therapeutic reasons. This has also been noted by a member of the Commission’s Disability Reference Group who recalls seeing someone sedated with drugs for laughing at people and calling them names.

120. The Bill would be further strengthened by the inclusion of the use of medication or chemical restraint as a restrictive intervention so that its use attracts the same safeguards that currently regulate the use of bodily restraint and seclusion. However, the Commission notes that the administration of medication is elsewhere covered in the Bill, particularly in respect of the regulation of ‘treatment’ in Part 1. We note that there are thresholds for its use, but not the full range of safeguards that are provided for restrictive interventions.

Mental Health Tribunal

121. The Commission welcomes the creation of the Mental Health Tribunal and notes that the Tribunal will play an important role in oversight and accountability under the new Act.

122. The Commission particularly welcomes:

- the application to the Tribunal of the rules of procedural fairness in clause 181
- provision for representation in clause 184 (and the Government’s commitment in the Minister’s Second Reading Speech to fund advocacy and support services for patients), and
- provision for interpreters in clause 185 (but also notes that the use of Augmentative and Alternative Communication aides should also be explicitly provided for to ensure the right to equality for people with communication disabilities).

123. The Commission is concerned by what appears to be the removal of a power held by the Mental Health Review Board under the current Act to review treatment plans. This has been an important provision where amendments have been made to existing treatment plans, such as changes to the medication a person must take.

124. A variation to a Temporary Treatment Order or a Treatment Order can be made by an authorised psychiatrist (clause 58), and unless this variation changes a person’s status from being subject to a Community Treatment Order to an Inpatient Treatment Order, the variation does not appear to be subject to review by the Tribunal.

125. The timeliness of reviews and appeals under the Bill are also an ongoing issue of concern. A person can undergo assessment and then a temporary treatment order which can together operate for about a month. During this time, a person can be subject to interventions without scrutiny by the Tribunal. This is a significant limitation

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on human rights and may not be, in all the circumstances, a reasonable and
demonstrably justified limitation.

126. The Commission is concerned that these obligations are not met with the current provisions for the time it may take for review and appeal.

127. Finally, the Commission notes that the Tribunal will have to list a matter for hearing and give written notice of that hearing 'as soon as practicable' (clause 189) and that clause 192 will allow the Tribunal to adjourn hearings to a date after the relevant Order expires where the Tribunal is 'satisfied that exceptional circumstances exist'. It would be more protective of human rights to also require that the delay is reasonable and justifiable in the circumstances so that any limitations on human rights are consistent with section 7(2) of the Charter.

Community visitors

128. Community visitors carry out an essential role in providing independent oversight of mental health facilities and assistance to persons receiving mental health services. This independent role is crucial to protecting people’s rights in contexts where authorities have significant powers over the lives of individuals. It is essential that community visitors are properly empowered under the law to continue to carry out their role effectively.

129. The Commission is concerned that some of the provisions contained in the Bill may weaken the powers of community visitors to carry out their functions.

130. For example in the current Act, community visitors are provided with the explicit power to enquire into the adequacy of the assessment and treatment of people with a mental disorder. This is no longer clearly stated in the Bill, although we note that there is provision for a community visitor to enquire into whether services are being provided in accordance with the objects and principles of the Act. This includes the objective to provide for assessment and treatment of persons who may have a mental illness.

131. It may be useful for this function to be explicitly stated to avoid uncertainty.

132. Under the current Act, it is an offence for any member of staff or management at a mental health service to fail to provide assistance or commit another form of prohibited conduct to or against a community visitor. This provision has been removed from the Bill and staff at mental health facilities will now be required to provide reasonable assistance to a community visitor only as far as is ‘practicable’. This may also be seen as a weakening of a community visitor’s ability to compel a service to cooperate and facilitate the proper carrying out of their functions.

133. The Commission supports the use of stronger language to strengthen the power of community visitors to compel this assistance where it is reasonably required. Clear requirements are useful and often prevent the need for enforcement action to be taken.
134. There is an additional change to the Bill in terms of community visitor’s ability to access particular categories of patient records. Under the current Act, a community visitor is able to access any document other than a medical record. This will be amended to allow access to any document other than a clinical record under the Bill.

135. This change may decrease the number of documents that a community visitor will be empowered to inspect in the absence of consent on the part of the person to whom the information relates. This is problematic in circumstances where the patient has been discharged from the service prior to them being able to meet with the community visitor and may ultimately hinder the community visitor’s ability to provide effective independent oversight of the services being provided where people cycle in and out relatively quickly.

136. The Commission would like to see a return to the language of the current Act, which provides for inspection of all documents other than medical records. An individual’s right to privacy in this context (protected in section 13 of the Charter) will be protected under the secrecy provisions, which apply to community visitors. These provisions provide that any information obtained by a community visitor in the course of their role must not be disclosed without the consent of the person to whom the information relates or where necessary to the performance of a function or duty or the exercise of a power under the Bill.

**Mental Health Complaints Commissioner**

137. The Commission welcomes the creation of a Mental Health Complaints Commissioner. The Commissioner will provide an important avenue to help people resolve complaints and will provide a useful source of independent expertise for consumers and service providers.

138. The Commission welcomes the function of the Mental Health Complaints Commissioner set out in clause 228(f) ‘to make the procedure for making complaints in relation to mental health service providers available and accessible’.

139. We note that when dealing with complaints, the new Commissioner will have legal responsibilities as a service provider under the Equal Opportunity Act. This includes:

   (a) a positive duty in section 15 to take reasonable and proportionate measures to eliminate discrimination and victimisation, as far as possible

   (b) an obligation in section 44 to refrain from discrimination on the basis of disability when providing services, and

   (c) an obligation in section 45 to make reasonable adjustments for persons with disabilities.

140. The Commissioner will also be a public authority under section 4 of the Charter. This means that the Commissioner must act compatibly with human rights, and give proper consideration to relevant human rights when making a decision (subsection 38(1)).
141. The Commissioner will need to ensure that people with disabilities can effectively use the Commissioner’s services, participate in the complaints process, and that there is informed consent to any conciliation agreements reached under clause 248.

142. Service providers whose actions are under consideration by the Commissioner will also have obligations under the Equal Opportunity Act, and in many cases, under the Charter as well. Considering the lawful of actions under these laws will be particularly relevant when the Commissioner is considering the content of a proposed resolution, recommendations from investigations, compliance notices, and undertakings from a mental health service provider. These must be consistent with the obligations service providers have under the Equal Opportunity Act and the Charter.

Rights of children subject to searches

143. We welcome the respect of privacy and dignity of people subject to searches set out in clause 355. We note that the Charter will apply when people are carrying out searches.

144. The additional protection for young people under the age of 16 in the Bill is that the search will be conducted in the presence of a parent of the person or, if it is not reasonably practicable for a parent to be present, another adult. All young people under 18 years have the right under section 17(2) of the Charter to protection in their best interests. We are not clear on the policy distinction here between people under 16 and people under 18. As a protective measure, all young people should entitled to have an adult present during searches, although we note that this may not need to be a parent for young people over 16.

Rights of children of parents receiving mental health services

145. The Commission also welcomes the principle in clause 11(1)(j) that ‘children, young persons and other dependents of persons receiving mental health services should have their needs, wellbeing and safety recognised and protected’. However, more needs to be done to ensure that this principle is taken into account when decisions are made under the new mental health laws that impact on the rights of children whose parents have a mental illness.

146. Consideration of the rights of children and families is required under section 17 of the Charter. The protection of the right to privacy, reputation and family in section 13 and cultural rights in section 19 of the Charter may also be relevant to particular cases.

147. This issue is particularly critical when parents are subject to compulsory treatment. There must be consideration of:

- the rights of parents and children to reside together or have adequate access to one another

- the rights and ability of parents to participate in decision making concerning a child’s wellbeing, and
the provision of adequate support services to children in the care of parents with disabilities.

148. These considerations should be built into provisions dealing with treatment, and practical steps must be provided to support families with mental illness disabilities in the community.