“Although health is truly holistic, our health system responds with an apartheid-like division between mind and body, in which people with mental ill health are treated like second-class citizens” ¹

1. Introduction

Since the early 1990s, studies such as the Burdekin Report (1993) found that a significant number of people with mental illness experienced discrimination, social exclusion and violations of human rights. The rapid move toward deinstitutionalisation and reform of institutional care and frameworks means that the rights of those with mental illness are better protected, however in light of the Victorian Charter of Human Rights and Responsibilities (the Charter), public authorities and government can make further changes to comply with their human rights obligations.

The ‘Briefing paper on key issues on the right to health in Australia’ conducted by the United Nations Special Rapporteur on the right to health noted that mental illness causes 13% of the burden of disease in the health system in Australia, yet receives only 7% of funding². It found that people with mental illness are vastly overrepresented in statistics relating to unemployment, homelessness, poverty and substance abuse. They are also overrepresented throughout the criminal justice system including the prison population³.

The ability of those with a mental illness to properly exercise their human rights is limited by the lack of available community based services which would enable

³ Ibid.
them to live, work and participate fully in the community, and the operation of involuntary treatment regimes.

Accordingly, it is fundamental that treatment and care options and reform of mental health frameworks adopt a rights-based approach which adopts a holistic view to mental health.

**The disparity between care and treatment for physical illness and mental illness**

The disparity between the care options available to those suffering physical illness compared to mental illness is highlighted by statistics which show that 90% of people with physical illness gain ready access to quality care, whereas only 35% of those with mental illness obtain access, often with variable quality of care. These figures drop as low as 15% gaining access to mental health treatment for young men, people in rural and regional areas and indigenous people.

**Relevant human rights issues for people with a mental illness include**: *

- The right to privacy and equality before the law.
- Mental illness and intellectual disability within the court system
- Overcoming discrimination in mental health law
- Involuntary detention of those unfit to stand trial
- Disability and fitness to plead
- Guardianship and administration

* Please see Appendix 2 for detailed analyses of these rights vis-a-vis the Charter.

In July 2006, the Coalition of Australian Governments (COAG) released a National Action Plan on Mental Health, focussing on early identification and treatment of mental illnesses. The plan represented a commitment by the Cth, State and Territory govts to address mental health issues, “however, on the ground, more remains to be done”

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5 Ibid.
6 Ibid.
Furthermore, mental health issues were identified by the UN Special Rapporteur on the Right to Health in a ‘Briefing paper on key issues on the right to health in Australia. The report stated that involuntary treatment regimes compromise the right to adequate healthcare, and this may be improved by the use of Advance Directives (which are prepared by people when they are well and allow the person to articulate their treatment preferences and decisions).

Accordingly, community based initiatives and policy and legislative reform to better protect and promote the right of people with a mental illness is a fundamental step to address the inequalities faced by this part of the population.

2. The Victorian Charter of Human Rights & Responsibilities

In January 2008, the Victorian Charter of Human Rights and Responsibilities (‘the Charter’) came into effect as a new mechanism designed to protect the fundamental rights and freedoms of all Victorians.

It aims to protect human rights by requiring that government and other public authorities observe the Charter when making decisions, creating laws, setting policies and providing services.


The report highlighted many situations in which the Charter has been invoked to bring positive change for individuals and communities, however also noted that there is more work to do to ensure it effectively protects the rights of all Victorians.

3. VCOSS and Human Rights

VCOSS and Human Rights in Victoria Forum – 7 September 2010
It has been four years since the Victorian Charter of Human Rights and Responsibilities (the Charter) was introduced, and it is due for review in 2011. The Charter includes many universal rights contained in international human rights treaties ratified by Australia and requires Government and public authorities to observe human rights when making laws and providing services.

VCOSS has been actively involved in the development and implementation of the Charter, from conducting consultations around its introduction to advocacy, training of community sector workers and advocates, education and publications and a report on the ways in which community sector organisations are using the Charter in policy and practice.

In order to ensure that the experiences of community sector organisations are included in the review, VCOSS is documenting community sector views and experiences of the Charter and human rights through four human rights forums and a survey. The findings from the survey and forums will be compiled in a final report to the Department of Justice in late 2010.

4. The Forum

On 7 September 2010, VCOSS in partnership with the Mental Health Legal Clinic (Vic) and the VicServ held a forum- “Mental Health & Human Rights in Victoria: Creative Ways Forward to Promote the Rights of People with a Mental Illness” at CQ at Karstens in Melbourne.

Approximately 60 people attended the forum, including consumers and community sector organisations which provide services, support and advocacy to people with a mental illness.

The objectives of the forum were to:

1. Promote understanding and engagement with human rights in community sector organisations involved in providing services, support and advocacy for people with a mental illness;
2. Explore the experiences of consumers and mental health organisations in light of the introduction of the Victorian Charter of Human Rights and Responsibilities (‘the Charter’); and

3. Support practice change in order to imbed a human rights culture in policy and practice within community sector organisations involved in providing services, support and advocacy for people with a mental illness.

5. Agenda

Welcome and Welcome to Country, Carolyn Atkins

Deputy Director of VCOSS, Carolyn Atkins welcomed participants, acknowledged Country and thanked the Wurunjeri people for their ongoing contribution to Victoria. She then introduced the Chair, Phil Lynch, who is currently the Director of the Human Rights Law Resource Centre.

Introduction of Keynote Speaker and Panel Members

Phil Lynch introduced the keynote speaker, Mary O’Hagan, and the four panel members. Please see their biographies below.

Keynote speaker

Mary O’Hagan

Mary O’Hagan experienced severe mental health problems and used mental health services for several years as a young woman. She slowly realised that, like her, many people were not helped or understood in the mental health system and some were deeply harmed by it. Society, in collusion with the mental health system, had also failed to uphold the rights and participation of some of its most marginalised citizens. In response to this, Mary initiated the user/survivor movement in New Zealand in the mid 1980s.

From 1991 to 1995 she was the first chair of the World Network of Users and Survivors of Psychiatry. Mary was a mental health commissioner in New Zealand between 2000 and 2007. She is now an international consultant in mental health. Over the last two decades she has occupied many roles in many types of agencies, always with
an overriding commitment to promote service user expectations of services as well as their full participation in society.

Chair
Phil Lynch, Executive Director, Human Rights Law Resource Centre

Phil Lynch has been Executive Director and Principal Solicitor of the Human Rights Law Resource Centre since 2006. The HRLRC is a leading national community legal centre dedicated to promoting and protecting human rights in Australia. Phil was previously the founding Coordinator of the PILCH Homeless Persons’ Legal Clinic which, in 2005, was conferred with the Australian Human Rights Law Award. Phil has also worked with Allens Arthur Robinson. Phil is on the Editorial Board of the Alternative Law Journal, an appointee to the Federal Government’s Human Rights Grants Scheme Expert Panel, and a member of the Victorian Attorney-General’s Human Rights Leadership Forum.

Panellists

Sophie Delaney- Lawyer, Civil Law Services, Victorian Legal Aid: Sophie has worked at the Centre for 12 years as a policy worker, legal caseworker and co-ordinator. She has published major articles in relation to Victoria’s Mental Health Act and the United Nations Principles for the Protection of Persons with Mental Illness and Improvement of Mental Health Care, and on an optimally rights recognising mental health review tribunal. She was on the Disability Discrimination Legal Service Committee of Management for many years, is the Federation of Community Legal Centres representative on the Human Rights Law Resource Centre Advisory Committee and is a member of the Law Institute of Victoria’s Disability Law Committee.

Vrinda Edan- Director, Consumer and Carer Relations, Southern Health: Vrinda has been employed in the mental health consumer movement for over 10 years and been involved in local, state and national committees and projects. Vrinda is passionate about helping Mental Health Workers to understand the impact that service use has on the person, particularly in providing opportunities for the clinician to hear directly from consumers about their experiences and how it can influence change in practice.

Professor Jayashri Kulkarni- Professor of Psychiatry, The Alfred and Monash University: Professor Kulkarni became a Fellow of the Royal Australian and New Zealand College of Psychiatrists in 1989. She was appointed as the first Associate Professor/Director of Psychiatry to Dandenong Hospital, Department of Psychiatry in 1994. She founded and directed the Dandenong Psychiatry Research Centre (DPRC) and the Monash University Research Centre for Women’s Mental Health. She
commenced her appointment as Professor of Psychiatry, The Alfred and Monash University in 2002.

She directs a large psychiatric research group, the Monash Alfred Psychiatry Research Centre (MAPrc), which has a team of over 100 staff and post-graduate students from medicine, nursing, psychology, allied health, science, and health information services. Funding for this group comes from a number of national and international project grants plus industry collaboration.

Judy Hamann- General Manager, Victorian Operations MIND Australia

6. Keynote address, Mary O’Hagan

For a copy of Mary’s slide presentation, please click here.

Mary began by highlighting the importance of the concept of ‘choice not force’. This concept should be adopted when considering policy, legislative reform and treatment options to assist people with a mental illness.

Mary began her address by noting that although social, cultural and economic rights are fundamental aspects of any examination of human rights, given the Charter focuses on civil and political rights, she would focus on these in the context of mental health.

Currently, the most central issue in mental health is compulsory treatment. Mary noted a high level of reluctance for government and policy-makers to address this issue.

➢ Compulsory Treatment and Coercion

Mary stated that compulsory treatment is:

- Discriminatory: the criteria of ‘competence’ is discriminatory as many people who do not suffer a mental illness could not be judged ‘competent’.
- A deprivation of liberty: no crime has been committed.
- Based on contested views on diagnosis and treatment

It:

- Undermines human rights;
- Has questionable harmful outcomes (eg- stigmatisation/trauma);
- Undermines Recovery Policy and the following aspects of service delivery and rights:
  - Self determination and personal resourcefulness
  - Collaborative relationships
  - Choice of services
  - Equal participation in society
The outcomes can be harmful, life depleting and life shortening in that it:

- Retraumatises and corrupts therapeutic trust
- Compulsion gets conflated with ‘premier’ service.
- There are perverse incentives to use it for clinicians and consumers.

Furthermore, the Cochrane Review showed that compulsion treatment doesn’t result in any significant difference in service user outcomes than normal treatment.

- **The Victorian Charter of Human Rights and Responsibilities (the Charter)**

  Relevant Charter rights to consider in the context of mental health are:

  - Recognition and equality before the law (ADD SECTION?)
    - Lack of natural justice in Mental Health Act processes;
    - ‘non compliance’ and ‘lack of insight’ justify restraint (but not in the legislation).
  - Protection from torture, cruel, inhuman and degrading treatment;
    - Seclusion, restraints, forced injections- these are surely cruel and inhumane?
  - Freedom of movement
    - Locked wards and choice of residence under Mental Health Act.
  - Inpatient and CTOs- are rising
    - Definitions of mental disorder getting narrower;
    - CTOs are ‘coercion’;
    - NZ and Australia have a higher rate of CTOs than USA and Canada (Simon Lawton-Smith, ‘A Question of Numbers’, 2005).

- **United Nations Disability Convention (2006)**

  This is the seminal document from which to assess human rights issues in the field of mental health.

  Quote from recent report by UN Special Rapporteur on Torture: ‘the acceptance of involuntary treatment and confinement runs counter to the provisions of the Convention’.

- **Justifications for Denying Freedom to People with a Mental Illness**

  Western culture justifies removing freedoms when citizens:

  1. Transgress social order (eg- crime)
  2. Judged not fully human (eg- slaves, women, mad)

  Justifications include:
- People are better off without their freedom;
- Prefer loss of freedom;
- Necessary for social order and public safety;
- People may misuse freedom.

These assumptions have been removed for women and slaves—how long will it take for people with a mental illness?

➢ Outcomes of improved status seen in the examples of women and slaves:

- raised status, self esteem and opportunities;
- resulted in more just and open society;
- social order changed but not destroyed.

➢ Alternatives to compulsion

- stop colluding with discriminatory community consensus
- recovery focus
- talk, ask questions—not ‘sighting’
- more and better crisis options
- better individual advocacy
- ‘compulsory responsiveness order’
- Separate healing function from control function

➢ An end to mental health laws

- Treatment and detention rare and brief
- Emergency interventions comparable threshold to physical medicine
- Rethink assumption about human responsibility for crimes.
- Humane recovery oriented CJS.

➢ Moving Forward - Mechanisms to promote human rights

- Strengthen ‘mad people’s advocacy’;
- Community support (opinion leaders, politicians);
- Built coalitions;
- Get media interest with stories;
- Use legal and policy levers (int, nat, state);
- Develop a vision for ‘liberatory’ services;
- Advocate for rights based anti-discrimination campaigns;
- Advocate for monitoring of Mental Health Act;
- Start with eliminating seclusion.

Panel Discussion

Participants were asked to respond to the following questions and provided answers integrating the following two questions.
1. To what extent do you believe a human rights framework is currently utilised by community sector organisations who provide services, support and advocacy for people with a mental illness?

2. Do you believe that the experiences of consumers and services provided by community sector organisations have improved in light of the Victorian Charter of Human Rights and Responsibilities. Do you have any specific examples of changes or improvements?

Vrinda Edan
- We need to adopt a therapeutic approach, rather than compulsion. It is impossible to have both working together.
- She hasn’t seen much change since the implementation of the Charter. Rather, the rate and use of CTOs has increased.
- It is still a very paternalistic system.

Sophie Delaney
- Sophie has represented people on Community Treatment Orders (CTOs) yet believes that although there hasn’t been a noticeable change, perhaps it is too early in the life of the Charter and practitioners (and lawyers) are still working out what the Charter means for them.
- The principles of respect and acting on the client’s best interests already underlie practice in her area.

Judy Hamann
- The PDRSS service is defined by the idea of choices- choice is a fundamental part of the system.
- A framework of choice and provision of information is essential.
- Involuntary treatment is the fundamental problem and issue in light of the concept of choice.

Professor Jayashri
- The current systems are ‘primitive’ in the way they treat mental health- in this day and age we should be in a more advanced state.
- She does not agree with coercion and seclusion.
- The idea of a ‘health retreat’ to treat mental illness is central to her philosophy- a more holistic approach.
- She has experienced and seen conflict between her own role (as a psychiatrist) and other roles in care- this does not lead to better outcomes for consumers.
- Home-based services are very effective- this puts the consumer in control in their own ‘territory’ rather than the reverse.
- As a public authority under the Charter (hospital and university), she has seen little or no change since its implementation, nor significant education regarding how it is to be applied.
- The Charter underpins the reform of the Mental Health Act, however it is questionable whether the new Act will make a difference.

Mary O’Hagan

- Phil Lynch asked whether the New Zealand experience of a Bill of Rights improved the rights of people with a mental illness. Could this provide a comparison for Australia?
  - The Bill of Rights has had no impact.
  - The Bill is not entrenched and by its nature can be thrown out by an Act of Parliament.
  - The law isn’t the only problem- the use of the Mental Health Act is discriminatory.
  - Relying on the law alone is not useful- it can provide a framework for service delivery, but is not useful (ie- as a ‘sword’ or ‘shield’) on its own.

Sophie Delaney

- The Victorian case of Kracke and the resultant declaration received by the Plaintiff did not change anything for him- there was no compensation and it was a purely symbolic victory.
- We need to include economic, social and cultural rights in the Charter, and have funding in the clinical sector which reflects the extreme needs of mental health issues.
- Anti-discrimination laws can also be used to bring actions.
- We need to change the culture of service delivery, rather than simply rely on laws etc.

3. What changes are required for organisations to more effectively imbed a human rights framework in policy and practice?

4. Are there any recommendations you would make regarding the operation of the Charter in the context of mental health for the upcoming review in October 2011?

Mary O’Hagan

- If you build things to limit people’s freedom, they will be used- the actual structures and attitudes must be changed.

Vrinda Edan

- Peer support and controlled services and budget allowances to enable this.
- Peer advocates- opportunity for consensus or choice to have one.

Sophie Delaney
- Inclusion of economic, social and cultural rights in the Charter the first step.
- Need legal and cultural change- the law can play a central role (ie- if one could bring actions regarding informed consent and treatment in its own right).
- Separate right of action re: informed consent.
- Mechanisms for compensation.

Judy Hamann

- Social participation.
- Access to housing is fundamental- the right to affordable housing should be a human right.
- Affordable housing underpins mental health- a fundamental aspect.

Mary O’Hagan

- Need to create social change and new responses to mental illness- being labelled is damaging, but being given a legitimate, positive and respected status is significant.

Professor Kulkarni

- Remove involuntary treatment in its entirety.

Mary O’Hagan

- The people of Victoria should have a say on the limitations on human rights evident in Mental Health Act. There is reluctance for government to adequately engage with the sector about this issue.
- CSOs have responsibilities regarding the Charter too.

Question from the floor (Catherine Leslie) regarding Mary’s views of advance directives

- Advance Directives are included in the New Zealand Code of Health and Disability Rights; however the Mental Health Act overrides these Codes.
- Difficulties as some psychiatrists are not using/believing in the effectiveness of Advance Directives in Australia.
- There should be more use of Advance Directives both in Australia and New Zealand.
- Noted polarised attitudes towards the Directives in the sector.

Close.
APPENDIX 1

CURRENT REVIEW OF MENTAL HEALTH FRAMEWORKS IN VICTORIA


The Law Reform Commission (Victoria) is currently reviewing Guardianship and Administration laws under the Guardianship and Administration Act 1986. The purpose of the review is “to ensure that guardianship and administration law in Victoria is responsive to the needs of people with an impaired decision making capacity, and advances, promotes and protects the rights of people with an impaired decision making capacity”\(^8\).

The review will examine:

i. the principle of respect for the inherent dignity, individual autonomy including the freedom to make one’s own choices, and independence of persons, and the other General Principles and provisions of the United Nations Convention on the Rights of Persons with Disabilities (the United Nations Conventions);

ii. the introduction of the Victorian Charter of Human Rights and Responsibilities;

iii. developments in policy and practice in respect of persons with impaired decision making capacity since the Act commenced;

iv. The increase in Victoria’s ageing population and the changing demographic nature of the clients of the Office of the Public Advocate.

The review will also examine the relationship between this Act and other Victorian and Commonwealth legislation, including the Disability Act 2006, the Children, Youth and Families Act 2005 and the Crimes (Mental Impairment and Unfitness to be Tried) Act 1997.

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2) Review of Mental Health Act 1986 (Vic)

In Many 2008, the Government announced a review of the Mental Health Act 1986 (the Act) to examine whether it provides an effective framework for the treatment and care of Victorians with a mental illness. The Act is the oldest mental health law in Australia and therefore must be adapted to incorporate developments in mental health policy, practice and legislation. The review aims to ‘promote a more participatory, rights-oriented and recovery focussed approach’. ‘Because Mental Health Matters: Victorian mental health reform strategy 2009-19’ represents the structure of the review and implementation of policy and legislative change.

The review aims to ensure that the Act provides an effective legislative and policy framework based on an assessment of:

- The principles and reform outcomes of the Mental Health Strategy “Because Mental Health Matters”
- The evidentiary bases for reform.
- The Victorian legal framework.
- Australian and international models including those in the ‘Victorian Guide to Regulation’.
- The impacts of proposed reforms and associated implementation issues.

This may involve explicit recognition of human rights and a more holistic, rights-based approach to treatment options and frameworks. The Commission is due to report in June 2011.

* See Appendix for a summary of the submission made by the Mental Health Legal Centre (Vic) regarding the review.

(3) Implementation of Mental Health List (Assessment and Referral Court- ‘ARC’) in the Magistrates Court

In March 2010, the Government announced the introduction of a specialist mental health list known as the ‘Assessment and Referral Court’ (ARC) in the Magistrates Court of Victoria9. The ARC list allows the court to take a more holistic and

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9 See the Magistrates’ Court Amendment (Mental Health List) Bill.
specialised approach to accused with mental illness and cognitive impairment. This will ensure that the basic individual rights of those with a mental illness are taken into account in line with the Charter, providing a more equal and fair criminal justice process.\textsuperscript{10}

\textsuperscript{10} Also see Attorney-General Rob Hulls’ Media Release, ‘New Court List to address mental health and impairment’ at www.premier.vic.gov.au/newsroom/9880.
APPENDIX 2

A. Charter rights relevant to those with a mental illness

Many rights contained in the Charter are particularly relevant for people living with a mental illness and those working in mental health services and treatment.

Information below extracted from Mental Health Legal Centre website at: www.communitylaw.org.au/clc/mentalhealth

Section 8: Discrimination and Equality

The right to equality before the law means that people must not be discriminated against based on a number of attributes, including ‘impairment’. The definition of impairment includes both physical and mental impairments, including mental illness. It is unlawful to treat someone less favourably than someone else in the same situation on the basis of the person having or having had a mental illness.

Section 13: Privacy

The right to privacy in the Charter is broader that other privacy legislation in Victoria and relates not only to personal information, but other areas such as bodily privacy and privacy of the home. The right prohibits arbitrary and unlawful interferences with privacy. Accordingly, any interference with privacy must be authorised by law and reasonable, necessary and proportionate in the particular circumstances.

Unlawful disclosure of personal information about someone, such information about their mental illness, is a breach of privacy. Another way in which the right to privacy is relevant is a person’s right to bodily privacy where a person is in care or receiving treatment. People who are in hospital or receiving other care, treatment or support due to their mental illness must have their privacy respected. This includes respecting their modesty, their personal relationships, and their right to communicate with or correspond with other persons privately.

Section 21: Liberty and security

The right to liberty and security means that people must not be detained except in accordance with law. A person’s right to liberty may be limited if
they are lawfully detained under the Mental Health Act because of their mental illness (for example, if they are under an involuntary treatment order). If someone is detained, they must be told the reasons why and any process they can use to challenge the lawfulness of their detention. People detained under the Mental Health Act must be advised on their right to appeal to the Mental Health Review Board to seek discharge of their treatment order. If an appeal is lodged, the Review Board must hear the appeal without delay. The Charter provides also provides that all people detained have the right to challenge the lawfulness of their detention in court.

Section 22: Humane treatment when deprived of liberty

The right to humane treatment when deprived of liberty means that people who are detained must be treated with humanity and with respect for their dignity. The right is concerned with ensuring that where people are detained, the conditions of their detention must comply with commonly accepted standards. For example, the use of seclusion – keeping and supervising a patient alone in a room that may be locked – must be done in a manner that respects the person’s humanity and dignity. For example, staff must provide the person with appropriate bedding, clothing, food and drink.

Section 10: Freedom from torture, cruel inhuman or degrading treatment

It is never permissible to torture someone or subject them to cruel, inhuman or degrading treatment. The ban on inhuman or degrading treatment can be very relevant to mental health. Inhuman treatment means treatment or neglect causing severe mental or physical harm and degrading treatment means treatment that is grossly humiliating and undignified. Whether treatment is serious enough to be inhuman or degrading will always depend on the particular circumstances of the person’s case, taking into account factors such as the person’s age, gender, state of health, and the length of time they were subjected to the treatment. Unlike torture, the definition of cruel, inhumane or degrading treatment does not require that treatment or neglect to be deliberate – it is the impact it has on the person that matters. For example, in some instances, the use of physical restraint of a patient may amount to inhuman or degrading treatment. However, restraint is not necessarily in itself a breach of human rights. Another example of degrading treatment is if the person being restrained does not have adequate toilet arrangements, including the opportunity to wash.
Section 10: Freedom from medical treatment without consent

If a person with a mental illness has the capacity to make decisions for her or himself, they cannot be treated against their wishes. However, if a person is lawfully detained as an involuntary, security or forensic patient or subject to a restricted involuntary treatment order under the Mental Health Act, they can be given medical treatment without consent as long as it is appropriate treatment for the mental disorder that the person is suffering. Therefore, it is important that proper procedures are in place to define what is medically necessary. The procedure followed to decide whether to treat a person without their consent must be fair and comply with the requirements of the Mental Health Act. These patients may also seek review of their status by the Mental Health Review Board.

When may these rights be limited?

The Charter permits limiting people’s rights, but only where these limits are lawful, necessary and proportionate. An example of where it is permissible to limit a right is where a person with a mental illness is behaving in such a manner as to place their safety at risk. In such a situation, it may not be a breach of human rights to restrain someone in order to prevent them from injuring themselves.

B. Review of Mental Health Act

Extracted from Executive Summary – Mental Health Legal Centre review of the Mental Health Act 1986 (Feb 2009, Mental Health Legal Centre)

1. Govt should adopt a holistic approach and review interaction between Instruments Act, Guardianship and Administration Act, Disability Act, Medical Treatment Act and the Mental Health Act.

2. Govt to consider whether guardianship is a more appropriate mechanism than involuntary detention in the event that the person is unable to consent and where there is no advance directive.

3. The review of the Act is transferred to the Law Reform Commission as part of a review to examine:
   a. Justification for limitations to the human rights of those with a mental illness under the Charter (s.7)
   b. Whether there is a need for stand alone mental health legislation
   c. Whether an involuntary scheme should be maintained
d. Protection of the right to autonomous decision making and bodily integrity consistent with those in the general health sector

e. Right to protection against discrimination

f. Respect for advance directives articulated in accordance with Advance Directive legislation to include a statement of purpose consistent with the Medical Treatment Act.

g. Ongoing review of mental health legislation every 3 years to ensure compatibility with human rights.

h. Explore options for Medicare funded counselling and support services.

i. Alterations to the definition of mental illness in Act

j. Those who are voluntarily detained have the right to review their file, treatment plan and obtain a second opinion, right to appeal and legal advice

k. Advance Directives—recognition of advance directives as a less restrictive alternative and in the best interest of the person consistent with principles of self determination and respect for human dignity without discrimination.

l. Explore options for supported decision making where person cannot consent (in accordance with Disabilities Convention).

m. Less restrictive options to involuntary treatment explored.

n. Legal representation to be available to all that need it, especially in the case of involuntary detention.

o. Second opinions available, especially where an Involuntary Treatment Order is extended twice.


q. Statements of reasons to be provided to consumers at the end of hearings.

r. Treatment plans to include broader options and information.

s. Abolition of seclusion and regulation of both chemical and mechanical restraint.

t. Extension of review and appeal mechanism.

u. Establishment of a monitoring, accountability and complaints system (ie- as an independent commission or division of the Ombudsman’s office).
v. Confidential information not to be disclosed without consent