# VMIAC Policy Position Paper #7: Adherence to Mental Health Laws

## Purpose

To ensure that government, stakeholders and mental health services adhere to their responsibilities under mental health and human rights law.

## The Issue

VMIAC welcomes the Royal Commission's recommendation to repeal the *Mental Health Act 2014* (Vic) ('the Act').[1] While this represents a positive step, equally important to mental health law is the implementation and enforcement of those laws. This is critical in ensuring mental health services and other organisations meet their obligations to respect consumer rights. We highlight the following issues in relation to the Act:

- **Inadequate protection of human rights –** the Act has failed its objective of protecting the human rights of consumers and is noncompliant with international and domestic human rights law. While consumers' rights are predominantly set out in the principles of the Act, obligations on services are unclear[2] and the Act contains no consequences for services that fail to uphold the rights of consumers. As acknowledged by the Final Report of the Royal Commission, the principles of the Act are not "widely embedded in treatment, care and support."[3]
- **Inconsistent adherence to mental health or human rights legislation –** Consumers report experiencing coercion from services, failures of services to obtain informed consent for treatment, deprivation of liberty by refusing voluntary patients leave and failing to ensure that least restrictive treatment is provided.[4] The Final Report of the Royal Commission supports these concerns, stating that that consumers often feel like they have taken a backseat in their care, and in many cases, there have been outright breaches of both the Act and human rights legislation by services.[5] In spite of the Act clearly stating that consumers must be treated in the least restrictive way possible, over half of inpatient admissions are compulsory. The Act has failed its goal to reduce the use of compulsory treatment – rates have not significantly changed since its introduction in 2014.[6]
- **There is a lack of accountability and oversight under the Act –** currently, system oversight is predominantly reactive and relies on consumers knowing and being able to identify that their rights have been breached; and knowing which oversight body to complain to. This places a huge burden on already vulnerable consumers and is a burden we should not have to bear. Consumers should not be expected to make a complaint about harm *after* it has occurred.[7] Service accountability is limited by a lack of public reporting and vague requirements in terms of what data should be captured and how it is analysed. Neither the Office of the Chief Psychiatrist ('OCP') nor the Mental Health Complaints Commission ('MHCC') have a clear function to *protect* the rights of consumers, and in any event, they have inadequate powers to either protect consumer rights or manage service nonadherence. However, these agencies *do* have powers that remain underutilised. In spite of the MHCC's acknowledgement of widespread human rights breaches and breaches of the current Act, there have been no known instances of it using its existing power to issue compliance orders to services.[8]
- **The Act fails to ensure procedural fairness –** where decisions are made to limit someone's rights, the basic principles of procedural fairness[9] must be followed. Decisions made under the Act limit consumers' most basic rights, and yet procedural fairness is not ensured. On a service level, the authorised psychiatrist may decide, with minimal oversight, to restrict a person's right to liberty by placing them on a temporary treatment order and administer treatment without their consent.[10] The Mental Health Tribunal is bound by the rules of procedural fairness,[11] but in practice the Act allows for the limitation of procedural fairness. The treatment criteria are poorly defined, which risks decision-makers injecting their own bias into decisions.[12] Low levels of legal representation at hearings is a serious concern, with approximately

[1] State of Victoria, Royal Commission into Victoria's Mental Health System, *Final Report* (2021) Volume 4, 11.
[2] *Mental Health Act 2014* (Vic), s 11(3).
[3] State of Victoria, above n 1, Volume 4, 41.
[4] State of Victoria, above n 1, 245; Simon Katterl, 'Regulatory Oversight, Mental Health & Human Rights' (2021) *Alternative Law Journal* (forthcoming) 1.
[5] State of Victoria, above n 1, Volume 4, 244.
[6] Department of Health and Human Services, 'Victoria's Mental Health Services Annual Report 2019 – 2020' (*State of Victoria*, 2000) 72; Department of Health and Human Services, 'Victoria's Mental Health Services Annual Report 2015 – 2016' (*State of Victoria*, 2016) 80.
[7] Simon Katterl, above n 4, 8.
[8] Simon Katterl, above n 4, 4.
[9] 'Procedural Fairness' is a legal principle that requires decision-makers (such as courts or tribunals) to follow certain steps or rules when making decisions to ensure that the decision-making process is fair.
[10] *Mental Health Act 2014* (Vic) ss 30 & 46.
[11] *Mental Health Act 2014* (Vic) s 181(1)(b).
[12] Christopher Maylea, Witness Statement to the Royal Commission into Victoria's Mental Health System, *Royal Commission into Victoria's Mental Health System*, 30 April 2020, 6.

13% of people who appear before the Tribunal having legal representation.[13] This is in spite of the fact that people who *do* have legal representation are subjected to shorter periods of compulsory treatment and are significantly less likely to be compulsorily subjected to electroconvulsive therapy (ECT).[14] As well as this, the setting of the Tribunal can be overwhelming and stressful for consumers who are already in incredibly vulnerable positions.

**Our Position**

- **Mental health laws *must* ensure services are accountable for upholding human rights –** good mental health law must ensure that there are consequences for services that breach their legal obligations; and must also include transparent and stringent accountability mechanisms and clearly defined, robust regulation. Penalising services is not a novel idea, with many other states and territories in Australia having penalties ranging from fines to imprisonment.[15] While regulation and penalties can help to hold services accountable, we ultimately need an oversight system that aims to prevent harm from ever occurring in the first place. The Commission's recommendation that compulsory treatment remain a feature of the new Act (albeit in a more limited and regulated manner)[16] does not represent any real improvement on the current Act and is inconsistent with an Act that is based on human rights. It is also critical that mental health laws clearly define coercion as unlawful and ensure that it is not used as a means to 'reduce' or replace compulsory treatment.
- **Services must be supported to adhere to mental health and human rights law** – services have highlighted the challenges of working in an under resourced, underfunded system that is driven by risk management.[17] Supporting services to identify the barriers to adhering to the law and educating clinical staff on human rights and legal obligations will help to build their capacity to comply with legislative requirements, but on their own, these measures are not sufficient to ensure service compliance.
- **We urgently need a culture change within services in order to increase adherence to mental health law –** the culture within mental health services is paternalistic, risk averse and accepting of restrictive practices and compulsory treatment despite their inherent violence.[18] Services justify their use of restrictive practices based on the idea that they have a 'moral obligation' to act in the 'best interests' of consumers, which likely contributes to service failures to adhere to the law by allowing them to justify the use of forced treatment on the basis that it is in the consumer's 'best interests'.[19] We urgently need a culture change in terms of what is normalized or morally justified by services and this must be reflected in mental health laws. Services must see treatment as something that is done *with* us, as equals, rather than something that is done to us.
- **Oversight, regulatory and accountability mechanisms must be strengthened –** the oversight, regulatory and accountability mechanisms that we currently have are insufficient to ensure service compliance with the law. Strengthening oversight and accountability mechanisms will require services to have the understanding of and capability to implement mandatory minimum standards and KPIs. This should involve mandatory public reporting of service level data, including implementation and compliance with KPIs and legislative principles,[20] together with the establishment of oversight and regulatory bodies that not only have robust powers to compel change and enforce the law; but are willing to utilise these powers to ensure accountability and service quality.
- **Maintaining procedural fairness is critical to upholding the rights of consumers –** legislation that permits limiting the rights of any group of people requires that the rules of procedural fairness are followed. If compulsory treatment is to remain under the new Act, the rules of procedural fairness must apply to all decisions that affect consumers' rights – from decisions made by clinicians through to decisions made by the Mental Health Tribunal itself. We support the implementation of an opt-out system for IMHA for all consumers, in order to ensure that people do not fall through the cracks' in circumstances where they are not compulsory but are also not truly voluntary.

**Our Recommendations:**

VMIAC calls upon the Victorian Government to:

[13] Mental Health Tribunal 2021, *Quarterly Activity Report*, https://www.mht.vic.gov.au/quarterly-reports
[14] Productivity Commission, *Mental Health Inquiry Report*, (2020) vol 1, 47.
[15] See for example SA MHA, QLD MHA, WA MHA…. etc
[16] State of Victoria, above n 1, Volume 4, 361.
[17] Ibid, 240.
[18] Cath Roper, 'Ethical Peril, Violence, and "Dirty Hands": Ethical Consequences of Mental Health Laws' (2019) 10 *Journal of Ethics in Mental Health* 1, 8 – 9.
[19] Ibid 4 – 10.
[20] State of Victoria, above n 1, Volume 4, 42.

1. **Ensure mental health legislation provides for substantive protection of human rights and sets mandatory minimum standards for services.** This will include the co-design of KPIs, mandatory minimum standards and new mental health principles with consumers. In order to ensure compliance, mental health laws must clearly require service compliance and include consequences for services that fail to comply. The rights to nominated persons, advance statements and second psychiatric opinions must be strengthened so that services cannot choose to override them. If compulsory treatment is to remain, the types of treatment that are permitted must be limited to the least invasive type of treatments and should not permit, for example, electroconvulsive therapy, to be performed on a compulsory patient unless consent is specifically set out in an advance statement.
2. **Provide funding for an education program for services and clinicians that is co-designed, co-produced and co-delivered with consumers.** This program should be delivered through the Collaborative Centre for Mental Health and Wellbeing and include ongoing and responsive education for services and clinicians on the new Act, human rights law, reflective practice and quality improvement.[21] Modules delivered by people with lived experience of the system should be included in order to educate clinicians and services on the limitations of and harms caused by overreliance on the medical model. This training would also aim to address the power imbalance that exists between clinicians and consumers, challenge the normalisation of restrictive interventions and highlight the harm that is caused by the use of compulsory treatment and restrictive practices.
3. **Legislate penalties for breaching mental health legislation.** Many other states in Australia include penalties for breaches of mental health legislation, ranging from thousands of dollars in fines up to years of imprisonment.[22] If compulsory treatment is to remain, services and clinicians alike must be held to a higher standard that reflects the gravity of treating someone against their will. Services must be penalised by the responsible regulators for serious breaches of minimum standards. Additionally, funding decisions should take service compliance with mental health laws into account when allocating funding to services.
4. **Ensure that the Mental Health and Wellbeing Commission is granted clear and robust powers.** These powers must be specific, enforceable and the Commission must be committed to using them when required. The powers should include the ability to refer services for prosecution for serious breaches of the law, the power to adequately address the harms that have been caused to consumers during the course of receiving 'treatment,' and powers that allow the Commission to respond proactively to concerns about breaches of consumer rights prior to the harm occurring.
5. **Ensure that the principles of procedural fairness are included in mental health laws.** Provisions relating to procedural fairness must be specific so that they are able to be practically upheld and enforced. There must be avenues for appeal where consumers believe that they were not afforded procedural fairness. Legal representation must be funded for all consumers who are required to appear before the Mental Health Tribunal, in addition to the increased funding that is being provided for an opt-out system for IMHA. Procedural fairness should also be considered on a service level, to ensure sufficient oversight of any decisions made by clinicians that negatively affect a consumer's rights.

**Background**

- On 2 March 2021, the Royal Commission into Victoria's Mental Health System handed down its final report, containing 65 recommendations. Chief amongst these was the recommendation that the *Mental Health Act 2014* (Vic) be repealed, and that a new Mental Health and Wellbeing Act be enacted in its place. The Commission emphasised that the new Act would be founded on human rights, including the *Victorian Charter of Human Rights and Responsibilities 2006* (Vic), the Covenant on the Rights of People with Disabilities, and the Optional Protocol to the Covenant against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment – which would establish a system of regular inspections of places of detention (including inpatient psychiatric units) in order to ensure that people who are deprived of their liberty are not subjected to torture or other cruel, inhuman or degrading treatment.[23]
- The final report recommended a target of 10 years to eradicate the use of restrictive practices and a reduction in the use of compulsory treatment (including more specific. legal provisions relating to its use) in order to ensure that it is no longer the defining feature of mental health legislation.[24]

[21] Christopher Maylea, above n 12, 8.
[22] For example, many states impose penalties for using restrictive practices without proper authority or performing ECT without fully informed consent: *Mental Health Act 2015* (ACT) s 152; *Mental Health Act 2007* (NSW) s 88; *Mental Health and Related Services Act 1998* (NT) s 66; *Mental Health Act 2016* (Qld) s 235; *Mental Health Act 2009* (SA) s 42(8); *Mental Health Act 2014* (WA) s 193.
[23] State of Victoria, above n 1 Volume 4, 16.
[24] Ibid 11.

- The Final Report also recommended that a new Mental Health and Wellbeing Commission be established to monitor the implementation of the recommendations by government and as oversee services to ensure accountability. This new Commission will absorb the Mental Health Complaints Commission; and will be granted additional powers relating to regulation, oversight, quality and safety and service accountability.[25]
- The Royal Commission acknowledged significant issues with service adherence to mental health and human rights laws[26] and recommended an improved monitoring and accountability framework for services that places the views and preferences of consumers and their families at the forefront.[27] Ultimately, the Final Report recognises the need for a system that is focused on outcomes and has recommended that service outcomes be a central part of measuring and reporting on performance.[28]

[25] Ibid 59.
[26] Ibid 236 – 238.
[27] Ibid 144.
[28] Ibid 92.