



**VMIAC Submission to the Independent Review
into the compulsory treatment criteria and
alignment with decision-making laws**

30th May 2023

Acknowledgement: VMIAC proudly acknowledge Aboriginal people as Australia's First Peoples and the Traditional Owners and custodians of the land and water on which we live and work. We acknowledge Victoria's Aboriginal communities and culture and pay respect to Aboriginal Elders past and present.

We recognise that sovereignty was never ceded and acknowledge the significant and negative consequences of colonisation and dispossession on Aboriginal communities.

Despite the far-reaching and long-lasting impacts of colonisation on Aboriginal communities, Aboriginal people remain resilient and continue to retain a strong connection to culture. We acknowledge the strong connection of Aboriginal people and communities to Country, culture and community, and the centrality of this to positive mental health and wellbeing.

About VMIAC

The Victorian Mental Illness Awareness Council (VMIAC) is the peak body run by and for Victorian mental health consumers. By 'mental health consumers' VMIAC mean people with lived experience of mental health challenges, trauma, or emotional distress, and/or who have accessed mental health or related services to support their wellbeing.

Our vision is a world where all consumers stand proud, live a life with their choices honoured and their rights upheld, and where these principles are embedded in all aspects of society.

VMIAC support extends across State-wide across metro, rural and regional communities. We provide individual and systemic advocacy to consumers with psychosocial disabilities, using a rights-based approach, to ensure their rights and freedoms are exercised.

VMIAC's program of work includes leading:

- systemic policy advocacy and campaigning
- consumer-led individual advocacy support
- consumer-led NDIS-related information and support
- training and consumer capacity development
- a Lived and Living Experience Workforce (LLEW) program.
- operations of the Victoria-wide consumer register
- consumer community engagement events and opportunities
- consumer-led research and research project support
- consumer secondary consultations
- operation of a State-wide consumer register

This submission

This submission has been informed by a survey of 55 respondents, which focused on decision-making under the Act; and a consultation focus group that focused on the compulsory assessment and treatment criteria and the purpose of compulsory assessment and treatment. VMIAC would like to thank all those who participated in this process. We acknowledge the power of people's Lived Experiences of mental health and that it is only through the determination of those willing to share their stories that we can truly learn how to improve systems and processes to be supportive rather than harmful.

Overview

Compulsory assessment and treatment are a breach of people's fundamental human rights, and as such must be considered with utmost scrutiny. VMIAC does not condone treating people against their will, we argue for system reforms based the following four foundations upon which we believe the new system must be built. These must be fostered and worked towards in tandem – as each relies on the other to succeed.

1) Supported decision-making.

Supported decision-making should be the foundational goal of reform as the means to ensure people's human rights are upheld in a mental health system that permits compulsory treatment. This requires a whole of system shift from being risk focused and paternalistic, to being person-centred and supportive. It requires clinicians and other decision-makers to treat consumers as equals and is built upon the human right to legal capacity. The obligation should be on services

to support people when they face trouble making decisions including when they are assessed as lacking decision-making capacity.

Supported decision-making must be the default, including when consumers are on a compulsory treatment order. Just because a decision-maker has been given legal authority to make a substitute decision, it doesn't mean they have to use it. And equally, just because a consumer has been placed on a compulsory treatment order, it doesn't always mean they cannot understand or contribute to decisions about their treatment.

Shared decision-making is not supported decision-making. Supported decision-making will require the system to slow down and prioritise the human rights of consumers, and, that any compulsory treatment used is driven by the consumer's will and preferences.

2) Human rights

Compulsory assessment and treatment violate the human rights to liberty, autonomy, equality before the law, bodily and mental integrity, and at times, the right to protection from torture and other cruel, inhumane, or degrading treatment¹. These fundamental rights should only be limited in the most exceptional of circumstances and for the shortest possible time.

Compulsory assessment and treatment rates in Victoria are some of the highest in the country, with data from 2020-2021 reporting that 59.1% of the time consumers spent in acute inpatient services was spent as a compulsory patient, compared to the 55.8% national average.² VMIAC believes any changes to assessment and treatment criteria should reduce the use of compulsory treatment and be more closely aligned with other decision-making laws, with less focus on risk. These criteria must reflect obligations under the Victorian Charter of Human Rights and Responsibilities 2006 (Vic) ('the Charter'), which require any limitation to human rights is reasonable, necessary, justifiable, and proportionate.³

This means that capacity must be included as one of the treatment criteria, and that the presumption of capacity should remain. We also believe that amending the test for capacity in line with the Justice Bell's interpretation in *PBU & NJE v Mental Health Tribunal*⁴ will ensure that consumers are only assessed as lacking capacity in exceptional circumstances. This interpretation of the test only requires that consumers have the *ability* to understand, remember, use, weigh and communicate their decision; not that they *actually* do these things when making their decision. This sets a much lower bar for assessing capacity than is usually understood, meaning that it is more likely that consumers will be assessed as having capacity rather than lacking capacity. In situations where it is decided rights need to be limited, there must be safeguards and consequences for unreasonable limitations on rights.

3) Valuing the voice of lived experience

System reform must be driven by those most affected by the changes, including changes to compulsory assessment and treatment laws. This should include lived experience co-design and co-production of changes to assessment and treatment criteria. Consumers have noted how orienting the criteria towards holistic assessment and treatment would feel more hopeful

¹ Victorian Charter of Human Rights and Responsibilities 2006 (Vic) ss 21, 8 & 10; Convention on the Rights of Persons with Disabilities, opened for signature 13 December 2006, A/RES/61/106 (entered into force 3 May 2008) arts 12, 14, 15, 17 & 18.

² Australian Institute of Health and Welfare, 'Key Performance Indicators for Public Mental Health Services 2020-2021', *Mental Health Performance Indicators* (Table, 28 March 2023) Table KPI 17.1.

³ Victorian Charter of Human Rights and Responsibilities 2006 (Vic) s 7.

⁴ *PBU & NJE v Mental Health Tribunal* [2018] VSC 564, 182.

and be more responsive. We believe including lived experience voices in all reform will help create a system that consumers don't feel they have to fight against or run from.

4) Holistic, safe, and person-centred assessment and treatment

VMIAC have heard from some consumers that often treatments they received while on an order caused further harms. Treatment should be safe in the broadest sense, including psychological and emotional safety, not just physical. Our system is currently premised on risk aversion and concern about the 'harm' that consumers might do, either to themselves or another. This leads to treatments often singularly focused on preventing risks of harm, rather than seeing whole complex and unique people with varied needs and values.

Assessment should focus on more than whether someone meets the criteria for compulsory treatment. Ideally assessment and treatment should address social drivers of distress and needs to include psychological and emotional support, and other supports such as housing, domestic violence, trauma, or financial security.

Recommendations

1. Limit compulsory treatment to the most exceptional circumstances and ensure compulsory treatment is never imposed upon someone who has capacity.
2. Ensure services are properly funded to provide voluntary treatment to consumers who need/want it for as long as the consumer feels it is necessary.
3. Embed supported decision-making practices in clinical practice so supported decision-making is the default.
4. Ensure clinicians receive training and skills in supported decision-making practices as an alternative to substitute decision-making.
5. Set targets to reduce the use of compulsory treatment immediately and ensure these targets are decreased over time.
6. Require clinicians to keep records of their attempts at supported decision-making to demonstrate they have made real and significant attempts at alternatives to putting a consumer on a treatment order.
7. Co-design the purpose of compulsory treatment with consumers and people with lived experience, ensuring that the harm being prevented is both *immediate* and *serious*, and that treatment is provided in line with the consumer's will and preferences.
8. Redefine 'treatment' to include broader, less medicalised therapies that include psychological or emotional support.
9. If compulsory treatment is permitted in emergencies, codesign the criteria with consumers to ensure they are strict, narrow and leave no room for interpretation to ensure is only used in genuine emergencies.
10. Ensure emergency treatment is only provided for the shortest possible time until the emergency is addressed, and the criteria no longer apply.
11. Require regular assessments of the criteria by an independent entity as a safeguard.
12. Amend the purpose of assessment orders so that it is no longer to determine whether the treatment criteria apply, but instead requires holistic assessment of a person's needs, identifies their will and preferences, and differentiates between 'distress' and 'mental illness'.
13. Use assessment orders as an opportunity to make referrals to other services or to provide advice about treatment options where relevant depending on what the consumer's circumstances at that point.
14. Ensure assessment orders are not used to: coerce people, compel them to make treatment decisions on the spot, or to accept treatment they do not want. Allow consumers time to think over options, outside of hospital if that is their preference.
15. Supported decision-making should be embedded in mental health practice.
16. Clinicians must discuss treatment options clearly with consumers, including about how different treatments would fit with the consumer's wants, needs and personal recovery goals.
17. Clinicians must ensure conversations occur in circumstances where the consumer is most comfortable and permit them to have support persons present.
18. An independent body of supporters for decision-making should be established for situations where a person doesn't have anyone in their life who they want to support them or where assistance with supported decision-making is needed.
19. Clinicians must be required to keep detailed documentation of their attempts at supported decision-making if it fails, and they seek to put the consumer on a compulsory treatment order.
20. Clinicians should make every effort to collaborate with consumers, including when writing clinical records, and allow consumers to provide input or correct their records when necessary.
21. Create a right for consumers to appoint a decision-maker who can make decisions for them if they are unable to make treatment decisions for themselves.
22. Implement safeguards to ensure the appointment process protects vulnerable consumers from being coerced or pressured into appointing someone who cannot properly perform the role in a way that benefits them, or who uses their role to take advantage of or abuse the consumer.
23. Codesign and coproduce training for decision-makers that includes supported decision-making, the obligations that decision-makers have to consumers and other considerations such as how to determine the consumer's will and preferences if substitute decision-making is required.
24. Ensure consumers remain active participants in the decision-making process, even if they are assessed as lacking capacity and have a substitute decision-maker appointed. This includes utilising supported decision-making wherever possible, including when substitute decision-making is permitted.

25. Require that appointed decision-makers are held to the same standards as guardians and administrators, as set out in the *Guardianship and Administration Act 2019* (Vic).
26. Amend the Act so authorised psychiatrists do not have decision-making power unless the consumer has expressly requested and consented to this.
27. Require decision-makers are only appointed on behalf of consumers in the most exceptional circumstances.
28. Ensure there is a process established for consumers to appoint decision-makers even if they are assessed as lacking capacity for treatment decisions.
29. Require the use of supported decision-making to assist consumers to make their own choice about appointing a decision-maker, rather than having one assigned for them.
30. Give the Tribunal the power to hear disputes about decision-makers and to make orders to uphold the consumer's decision in line with their will and preferences, so long as these can be established.
31. Adopt the process for appointing decision-makers on behalf of consumers as set out in the *Medical Treatment Planning and Decisions Act* but amend the process so that consumers have veto power in relation to appointing next of kin or family; and so, an independent decision-maker can only be appointed in the most exceptional circumstances (e.g., when multiple attempts at supported decision-making have failed).
32. Make advance statements in mental health binding.
33. Amend the law around advance care directives so preferences for mental health treatment and values statements can be included.
34. Empower advocates, nominated decision-makers or independent decision-making supporters to assist voluntary inpatients to draft advance statements if they do not already have one as soon as possible after they are admitted.
35. Require services to provide information about advance statements to voluntary consumers as they are admitted.
36. Allow consumers to override consent to treatment in advance statements if they no longer consent (even if they lack capacity)
37. Ensure consumers cannot override advance refusal of treatment unless they currently have decision-making capacity and make a competent decision to make a new advance statement.
38. Revoke the current assessment criteria.
39. Codesign new assessment criteria with consumers and people with lived experience that are:
 - a. less focused on risk, and
 - b. ensure the purpose of assessment is to conduct a holistic assessment of the consumer's needs, will and preferences, rather than simply assessing whether the treatment criteria apply.
40. Revoke the current treatment criteria.
41. Use codesign to develop new treatment criteria with people who have lived experience, ensuring:
 - a. *There is a presumption that compulsory treatment criteria do not apply, even when a person lacks capacity, and voluntary treatment is always preferred.*
 - b. *Capacity is included in the treatment criteria and there is a presumption the person has capacity.*
 - c. *The criteria include the test for capacity, amending it to ensure it is not overused and noting in the criteria that capacity can fluctuate or return.*
 - d. *There is a requirement of sufficient attempts at supported decision-making have been made and failed, and that this is able to be demonstrated.*
42. Compulsory treatment is limited to the most exceptional circumstances and is only used as a last resort, or to prevent serious and *imminent* harm to another person.
43. Compulsory treatment is only used to give effect to the consumer's will and preferences.
44. Use codesign with consumers and people with lived experience to define emergency treatment, ensuring that it is sufficiently narrow not to be overused.
45. Include decision-making capacity as one of the treatment criteria, clearly stating that capacity can fluctuate or be regained, and is decision specific.
46. Maintain the presumption of capacity, so the treatment criteria can only be assessed when the decision-maker has reason to believe a person lacks capacity and assesses them as lacking capacity.

47. Include in the criteria an amended test for capacity in line with Justice Bell's interpretation in *PBU & NJE v Mental Health Tribunal*.
48. Implement safeguards for the assessment of capacity, such as requiring that the assessment be made on more than one occasion and requiring that two independent decision-makers conduct the assessment.
49. Exclude situations where the consumer is seriously threatening immediate harm to another from capacity assessments.
50. Continue the current practice of allowing medical practitioners and mental health practitioners make assessment orders.
51. Implement a safeguard that requires an assessment order to be signed off by two independent clinicians.
52. Implement a requirement that two independent decision-makers with experience in capacity must sign off on the capacity criterion before a compulsory treatment order can be made.
53. If the presence of 'mental illnesses and a subsequent need for treatment are retained as criteria, require that the assessment of these criteria is conducted by a psychiatrist.
54. Implement a review process for compulsory treatment orders that is triggered within a few days, but no longer than a week after an order has been made.
55. Review the functions of the Mental Health Tribunal and revoke its power to make treatment orders.
56. Limit the use of community treatment orders to circumstances where consumers have provided advance consent via a binding advance statement.
57. Ensure consumers are permitted to provide advance consent to community treatment orders via their advance statement.
58. Require the test for limiting human rights as set out under the Charter is incorporated into the legislation and be met in any circumstances where a decision-maker is permitted to make decisions that affect a consumer's rights.
59. Create additional rights for consumers, including:
 - a. The right to appeal their order at the Tribunal before treatment commences; and the right to have the appeal heard within 7 days.
 - b. The right to have a legal representative at all hearings before the Tribunal.
 - c. The right to a second opinion on a treatment order prior to treatment starting, and for this opinion to be provided within a reasonable timeframe.
 - d. The creation of offences for failing to obtain fully informed consent to treatment where the treatment is given on a voluntary basis (including where the consumer is coerced into accepting treatment).
60. Limit the duration of treatment orders to seven days, after which time they must be subject to review.
61. Change the role of the Mental Health Tribunal so it is no longer responsible for making treatment orders, but rather plays a role in system oversight including:
 - a. *Hearing appeals*
 - b. *Hearing matters where the consumer's decision (after using supported decision-making) is in question and ensuring that any decision is made in line with their will and preferences (whether or not the consumer's decision is affirmed)*
 - c. *Hearing and determining matters where there are allegations an assessment or treatment order has been improperly used.*
 - d. *Ensuring clinicians and other decision-makers are accountable, including ensuring they followed proper process to make a decision, and the decision was the correct one under the circumstances.*
62. Require that consumers are reviewed within seven days of a treatment order being made.
63. The time limits that currently exist for assessment orders are appropriate and should remain a feature of the reformed system.
64. Require that the emergency treatment criteria are reassessed every few hours until the emergency is addressed, and treatment is no longer required.
65. A person's nominated decision-maker should make treatment decisions for a person who is being treated compulsorily in line with that person's will and preferences. The decision-maker may rely on relevant opinions and advice from mental health or other professionals, including social support services, when making their decision, in line with the expanded definition of 'treatment' under question 1.
66. The purpose of treatment must be to prevent more harm than the treatment causes.

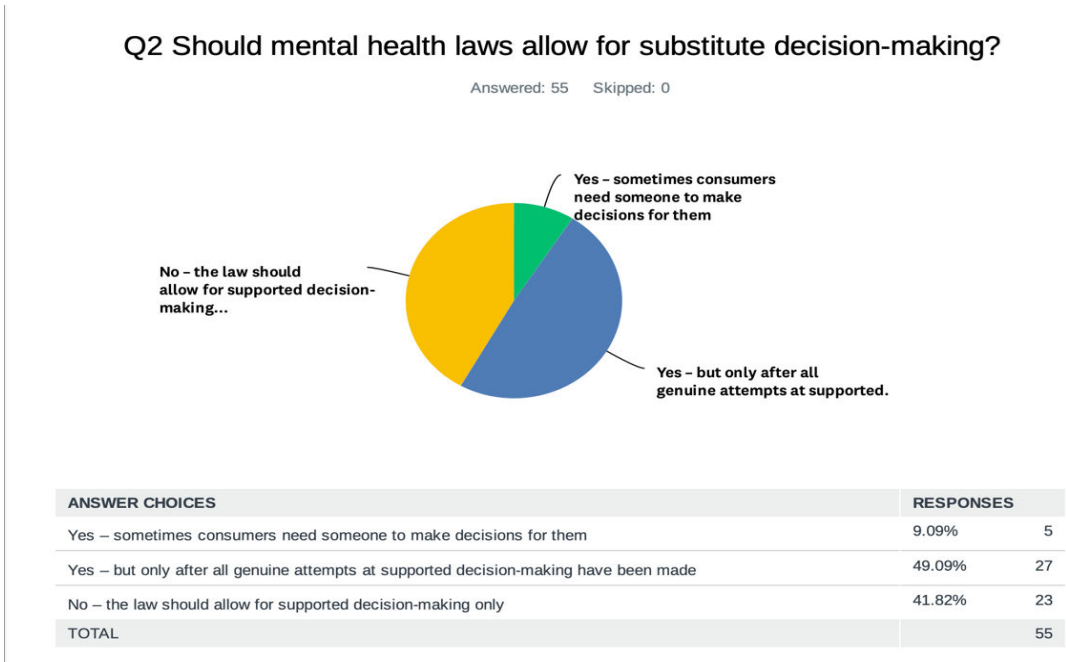
Part A: Introductory Questions

Question 1: There are many different perspectives on compulsory treatment. One of these is that compulsory treatment should be abolished/eliminated entirely. Do you agree with this?

VMIAC believes within the context of a trauma-informed, supportive, and human rights focused mental health system there is no place for compulsory treatment other than where compulsory treatment is consented to by the person prior via an advance care directive or a nominated decision-maker.

We note the Royal Commission did not recommend eliminating compulsory treatment, therefore our responses to the consultation paper questions are shaped by the assumption compulsory treatment will remain a feature of the post reform landscape, albeit in a limited way. The Royal Commission did recommend however that Government ‘act immediately’ to reduce compulsory treatment rates.

In our survey, we asked whether mental health laws should ever allow for substitute decision-making. Most consumers conceded there are times when substitute decision-making might need to be used but stated this should only occur after all efforts at supported decision-making were exhausted. 41.82% of consumers believed substitute decision-making should never be used, and that the system should rely on supported decision-making only.



Many consumers told us their experience was that supported decision-making is rarely used by clinicians, and that substitute decision-making is the default, an observation which is backed up by research.⁵ VMIAC would like to see clinicians play a key role shifting this dynamic by engaging in supported decision-making with all consumers, to foster trusting, safe and positive therapeutic relationships.⁶ This is backed by evidence indicating supported decision-making, advance statements, nominated persons, second opinions, and advocacy can lead to ‘clinically

⁵ Chris Maylea et al, ‘Consumers’ experiences of rights-based mental health laws: Lessons from Victoria, Australia’ (2021) 78 *International Journal of Law and Psychiatry* 101737, 3 – 5.

⁶ Renata Kokanovic et al, ‘Options for Supported Decision-Making to Enhance the Recovery of People Experiencing Severe Mental Health Problems’ (Research Report, Melbourne Social Equity Institute, University of Melbourne, August 2017) 13.

significant reductions in compulsory treatment admissions⁷. Using supported decision-making over substitute decision-making would also ensure mental health services comply with human rights obligations under the Convention on the Rights of Persons with Disabilities (the 'CRPD')⁸ and the Charter.

There were mixed and nuanced views among survey respondents and focus group members about the contexts in which compulsory treatment is used, even when consented to in advance. For example, one participant in the consultation focus group noted compulsory treatment may be necessary when a person is unable to provide consent. They identified a time when they were in a dissociated state and this person believed, with hindsight, that compulsory treatment may have been beneficial because they were not able to know what they needed at the time. However, others in the group still wondered whether, with the right support to make decisions, compulsory treatment would still be needed for this person.

Survey respondents and consultation group members also raised the iatrogenic harms that mental health treatments can cause. They said 'treatment' must be defined more broadly to properly support mental health in ways that are beneficial to consumers. This broader understanding of treatment is also essential to ensure advance care directives work properly and do not lead to situations where a consumer has provided advance consent to compulsory treatment, and that treatment ends up being traumatic or harmful to them.

VMIAC share the concerns about compulsory treatment of many consumers and consumer activists. In an often-over-stretched system, resorting to coercion may seem the easier option than collaborating with someone experiencing a mental health crisis. Having the option of compulsory treatment means clinicians don't have to take the time to build the necessary skills to get to know people, understand what they want or need, discuss available treatment options with them or use alternatives to coercion, such as supported decision-making.

As compulsory treatment is likely to remain a feature of the post system reform landscape, this firms our belief that while compulsory treatment needs to remain technically possible, there should be significant barriers to ensure imposed treatment is not misused and that it is the least likely or straightforward option. Also, where a person requests compulsory treatment in an advance statement, this should only occur after supported decision making is attempted. We believe the setting of targets for reduction and a phasing out of how compulsory treatment is currently used and applied is required. We note the development of the Strategy to Reduce Seclusion and Restraint and the targets being set against these practices and suggest this could guide the approach to compulsory treatment.

There have been some unintended risks of limiting compulsory treatment identified by people we consulted with and fears that without cultural change, the system will simply find other ways to treat people against their will. For example, an increase in the use of the Guardianship and Administration Act 2019 (Vic), or an increase in the criminalisation of mental health issues.

The accountability of psychiatrists to not only the *Mental Health Act 2014* (Vic) ('the Act'), but also other entities such as the Coroner's Court, and the family and loved ones of consumers contributes to fears held by clinicians of the consequences of failing to use restrictive treatment. When there is a high level of risk, there is a reluctance to move away from substitute decision-making.

Another unintended consequence as identified in our consultations was consumers may not be able to access acute inpatient care when they need it. VMIAC has heard from consumers that

⁷ Renata Kokanovic et al, 'Options for Supported Decision-Making to Enhance the Recovery of People Experiencing Severe Mental Health Problems' (Research Report, Melbourne Social Equity Institute, University of Melbourne, August 2017) 15.

⁸ *Convention on the Rights of Persons with Disabilities*, opened for signature 13 December 2006, A/RES/61/106 (entered into force 3 May 2008) art 5.

they are often told to leave inpatient units before they are ready, and that compulsory treatment orders are used at times to ensure a person is able to access treatment⁹. In practice the criteria for making compulsory treatment orders effectively allows for this. To mitigate the use of compulsory treatment orders for this purpose we need a system sufficiently resourced to provide voluntary treatment to people for as long as they need it.

People who want and need treatment but who are incapable of consenting should still be able for to get their preferred treatment. Advance statements can be helpful in this regard, however currently they have a very low uptake¹⁰. Therefore, VMIAC believe supported decision-making and, if necessary, substitute decision-making, must focus on giving effect to a person's will and preferences, rather than their 'best interests.' Additionally, there must be a focus on human rights, including better using the test for limiting rights as set out in the Charter¹¹. Supported decision-making and ensuring rights are limited in line with the test under the Charter should result in compulsory treatment being used only in exceptional circumstances and for short periods of time.

Supported decision-making can also address negative implications that result from limiting compulsory treatment. The rationale for substitute decision-making is that consumers must be treated compulsorily lest they refuse treatment they need and pose a risk to themselves or someone else. This thinking fails to account for the reality most people experiencing mental or emotional distress want help. Consumers tell us they believe supported decision-making will better identify the support people want and need, rather than relying only on assessments made by the authorised psychiatrist.

Question 2: Are there any exceptional circumstances where compulsory treatment might be appropriate? If so, what are they?

As stated VMIAC's position is that consumers should only be treated compulsorily if they consent to it in advance and record their consent in a binding advance statement or with a nominated decision-maker. Furthermore, supported decision-making practices should assist the decision-maker to identify the consumer's will and preferences, and ultimately lead to a situation where coercion is considered unnecessary.

In exceptional circumstances, where consumers are incapable of providing consent to treatment, e.g., if they are in an extremely altered state or unconscious, then this may increase a need for short term compulsory treatment if the risk is serious and immediate. However even in exceptional circumstances treatment provided should be done in the least restrictive way possible and in a way that upholds the consumers rights to the greatest extent possible. We heard from consumers that even in exceptional circumstances, they want treating teams to make every effort to collaborate with them and communicate why they are receiving the treatment despite their purported inability to consent. This view was reflected by our survey results where 40% of respondents preferred using **only** supported decision-making over appointing decision-maker for a consumer who did not have one appointed.

Finally, the only other 'exceptional' circumstance that was identified where compulsory treatment could be permitted is where a consumer was threatening immediate harm to another person. In these circumstances, the aim of compulsory treatment would be to ensure the safety of both the consumer *and* others and to ensure the consumer did not end up in the criminal justice system. In this circumstance, we suggest that capacity is irrelevant. However, the threat of harm must be serious and immediate, which requires amending the criteria definitions to

⁹ Chris Maylea, Witness statement to the Royal Commission into Victoria's Mental Health System, Royal Commission into Victoria's Mental Health System (30 April 2020) paras 10 & 15.

¹⁰ Royal Commission into Victoria's Mental Health System (Final Report, January 2021) vol. 4, 23.

¹¹ Victorian Charter of Human Rights and Responsibilities 2006 (Vic) s 7.

ensure this exception is not overused. For example, consumers should not be compulsorily treated for angry comments or frustration but with no actual intention or plans to harm anyone.

Recommendations

1. Limit compulsory treatment to the most exceptional circumstances and ensure compulsory treatment is never imposed upon someone who has capacity.
2. Ensure services are properly funded to provide voluntary treatment to consumers who need/want it for as long as the consumer feels it is necessary.
3. Embed supported decision-making practices in clinical practice so supported decision-making is the default.
4. Ensure clinicians receive training and skills in supported decision-making practices as an alternative to substitute decision-making.
5. Set targets to reduce the use of compulsory treatment immediately and ensure these targets are decreased over time.
6. Require clinicians to keep records of their attempts at supported decision-making to demonstrate they have made real and significant attempts at alternatives to putting a consumer on a treatment order.

Purpose of compulsory treatment

Question 3: What do you think the purpose of compulsory treatment should be?

VMIAC recommend the current purpose of ‘preventing serious deterioration or risk of harm to the [consumer] or another person’ be revised and a new purpose be co-designed with consumers. We believe the current purpose perpetuates risk averse culture and prevents more supportive or caring approaches being used. We also recommend ‘treatment’ be redefined to include broader, less medicalised modalities with less potential to cause harm, such as psychological or emotional support - so when compulsory treatment must be used, it is less likely to adversely impact or retraumatise people.

The purpose of compulsory treatment should include two different aims – giving effect to the will and preferences of someone who is unable to consent despite attempts at supported decision-making, and treatment that is given in a true emergency.

In circumstances where supported decision-making fails, compulsory treatment should aim to provide treatment that the consumer would want (their will and preferences), if they were able to decide about treatment. It should also ensure that the consumer’s rights are upheld to the highest standard. VMIAC believe the ‘best interests’ paradigm is outdated and should never be used when deciding about compulsory mental health treatment.

VMIAC believes substitute decision-making does not have to be the default, even if a person is on a compulsory treatment order. Supported decision-making practices must still be attempted, with substitute decisions only being made as a last resort. Supported decision-making can help decision-makers identify the consumer’s will and preferences along with any advance statement or other documents. Consumers must always be afforded the dignity of risk, even when their will and preferences are being relied upon to make a substitute decision.

There must be steps taken to ensure ‘emergency’ treatment is not overused or misused. The overuse and misuse of the compulsory assessment and treatment criteria is not new – we know that psychiatrists already take a very liberal approach to applying the assessment and treatment

criteria, and often don't even follow it.¹² We must ensure that the same situation does not occur for emergency treatment.

Consumers in our consultations did identify emergencies could be a legitimate purpose for compulsory treatment and that this should be reflected in the criteria by qualifying the goal of preventing 'serious deterioration or harm to the consumer or another person', but by stating it must be 'immediate and serious deterioration or harm'.

Additionally, in line with the nature of 'emergency' treatment, our participants suggested there would need to be a requirement that the treatment lasted for the shortest possible period and that it was ceased as soon as the emergency was addressed. We recommend co-designing separate criteria for compulsory treatment and for emergency treatment with consumers to ensure that compulsory treatment is only used in true emergencies and that the criteria are sufficiently narrow to avoid misuse.

Recommendations

7. Co-design the purpose of compulsory treatment with consumers and people with lived experience, ensuring that the harm being prevented is both *immediate* and *serious*, and that treatment is provided in line with the consumer's will and preferences.
8. Redefine 'treatment' to include broader, less medicalised therapies that include psychological or emotional support.
9. If compulsory treatment is permitted in emergencies, codesign the criteria with consumers to ensure they are strict, narrow and leave no room for interpretation to ensure is only used in genuine emergencies.
10. Ensure emergency treatment is only provided for the shortest possible time until the emergency is addressed, and the criteria no longer apply.
11. Require regular assessments of the criteria by an independent entity as a safeguard.

Purpose of compulsory assessment

Question 4: What do you think the purpose of compulsory assessment should be?

The role of assessment orders currently is to assess the consumer to determine whether the treatment criteria apply. This in part leads to a system is focused on compulsory treatment. The purpose could be changed so assessments are more holistic and include a broader assessment of the drivers of a person's distress and what their will and preferences or needs are. This may not be 'treatment' under the Act, but the provision of social support services such as family violence, homelessness, trauma-related, physical, or general health services, to name a few, and could also include social prescribing.

This idea received strong support from consumers during consultations, with many noting such a change would make the process of being put on an assessment order less frightening and more hopeful because they would feel like they might have a real chance of getting help that is beneficial to them.

The distinction between 'distress' and 'mental illness' is important and requires an assessment of the drivers of distress. When deciding in relation to compulsory treatment, clinicians must be able to rule out other possible drivers of distress, which, if addressed, may alleviate symptoms

¹² Chris Maylea et al, 'Consumers' experiences of rights-based mental health laws: Lessons from Victoria, Australia' (2021) 78 International Journal of Law and Psychiatry 101737, 3 – 5.

and do away with the perceived need for ‘treatment’ under the Act. The Mental Health and Wellbeing Act 2022 (Vic) (‘the new Act’) refers to the concept of ‘distress’ in many parts, but as it currently stands, ‘mental illness’ is the only condition that can be treated compulsorily (or that is defined). VMIAC believes the purpose of assessment orders should differentiate ‘distress’ from ‘mental illness’ and clarify the circumstances under which a person may be treated against their will.

Similarly, even if a consumer has a ‘mental illness,’ clinicians must be certain that their mental health is what is driving the current crisis. Treatment should not be the only option for supporting someone identified as having ‘mental illness’ when there are other significant determining influences impacting their wellbeing.

Using assessment orders more holistically is in line with the objectives and principles of the new Act, including the diversity of care principle, the supported decision-making principle, the health needs principle, and the balancing of harm principle.¹³ Consumers suggested during consultation that while this approach may seem like a more expensive process, over the longer term, it would address more of the consumer’s issues. Particularly at the assessment stage. Our participants believed focusing only on containment and responding to the crisis was a band-aid fix at best.

Assessment orders could also be used to identify treatment options, when appropriate, for consumers to consider without an obligation to stay in hospital or decide on the spot. The risk focused nature of compulsory assessment and treatment leaves no room for consumers to decline treatment or take the time to talk it through with supporters, consider whether they want treatment or what treatment they might want, which is something that is encouraged in every other area of health.

Consumers spoke about being locked up when they hadn’t done anything wrong, and how it only made things worse for them. If assessment orders have any chance of achieving a beneficial purpose (and consumers were hopeful they could), they must also allow people the freedom to leave hospital if they do not want to be there, and to take the time to decide for themselves whether they agree with the treatment that has been proposed. We would encourage efforts to support consumers with their decision at this stage rather than holding them against their will.

Recommendations

12. Amend the purpose of assessment orders so that it is no longer to determine whether the treatment criteria apply, but instead requires holistic assessment of a person’s needs, identifies their will and preferences, and differentiates between ‘distress’ and ‘mental illness’.
13. Use assessment orders as an opportunity to make referrals to other services or to provide advice about treatment options where relevant depending on what the consumer’s circumstances at that point.
14. Ensure assessment orders are not used to: coerce people, compel them to make treatment decisions on the spot, or to accept treatment they do not want. Allow consumers time to think over options, outside of hospital if that is their preference.

¹³ Mental Health and Wellbeing Act 2022 (Vic) ss 17, 19, 22 & 82

Part B: Decision-making

Question 5: What should supported decision-making in mental health treatment look like?

Most people with mental health issues can be supported to make a decision, even if they are assessed as lacking mental capacity for some decisions.¹⁴ This is the foundation of the human right to legal capacity and the basis for relying on supported decision-making. Services have an obligation to support people to exercise their legal capacity, and as far as is possible, to make their own decisions about assessment and treatment. This is the only way they can ensure they have treated people in the least restrictive and CRPD-compliant way.

Treatment options should be discussed in detail with the consumer, including a discussion of how different treatment options may benefit or harm their longer-term goals. Supported decision-making requires slowing down the process and giving people time to think things through or express themselves. This also provides greater time for the clinician to understand the person's circumstances, will and preferences.

These conversations need to occur in safe and comfortable environments which allow the consumer time to arrange any support people that they need to be with them. Consumers we consulted strongly supported the right for people to have a support person present when meeting with psychiatrists. It was thought the presence of a support person could make the difference between a consumer being assessed as having or lacking capacity.

Not everyone might want a personal contact to act as a support person, and so there should be an option for having an independent supporter – someone who is well trained in supported decision-making practices and who can help them throughout the process. This could be an advocate, or there could be a new entity established that offers independent support for decision-making.¹⁵

Supported decision-making should be used at all stages of the treatment process, including where a consumer is being treated compulsorily. Being on an order doesn't mean that consumers should automatically be cut out of the decision-making process. Supported decision-making must be the foundation of all decisions, including substitute decisions. Additionally, supported decision-making should be used where a consumer has consented to treatment via an advance statement. Clinicians must be required to clearly document their attempts at supported decision-making, including an explanation of how and why it failed if they seek to use substitute decision-making and compulsory treatment.

Some examples given by consumers were:

- Clinicians should explain everything that they are doing and every decision that they make, including the reasons for those decisions.
- Clinicians collaborate with them when writing clinical records, so people can contribute and correct any inaccuracies before information becomes permanent – there was significant concern among consumers that clinical records become 'truth' – whether they are or not.

¹⁴ George Szmukler, "Capacity", "best interests", "will and preferences" and the UN Convention on the Rights of Persons with Disabilities' (2019) 18(1) World Psychiatry 34, 37.

¹⁵ Office of the Public Advocate, Decision Time: Activating the Rights of Adults with Cognitive Disability (February 2021) 11 & 23.

Recommendations

15. Supported decision-making should be embedded in mental health practice.
16. Clinicians must discuss treatment options clearly with consumers, including about how different treatments would fit with the consumer's wants, needs and personal recovery goals.
17. Clinicians must ensure conversations occur in circumstances where the consumer is most comfortable and permit them to have support persons present.
18. An independent body of supporters for decision-making should be established for situations where a person doesn't have anyone in their life who they want to support them or where assistance with supported decision-making is needed.
19. Clinicians must be required to keep detailed documentation of their attempts at supported decision-making if it fails, and they seek to put the consumer on a compulsory treatment order.
20. Clinicians should make every effort to collaborate with consumers, including when writing clinical records, and allow consumers to provide input or correct their records when necessary.

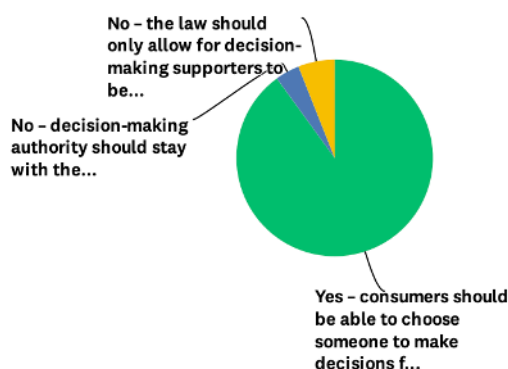
Substitute decision-makers for mental health

Question 8: If people had the right to choose a substitute decision-maker for compulsory mental health treatment, what would need to be considered?

During our consultation and amongst survey respondents there was strong support for people have the right to choose a substitute decision-maker if they wished, and for this power being taken away from the authorised psychiatrist.

Q4 Should mental health law be changed to allow people to appoint a binding decision-maker in case they lose decision-making capacity?

Answered: 50 Skipped: 5



ANSWER CHOICES	RESPONSES	
Yes – consumers should be able to choose someone to make decisions for them in case they lose capacity	90.00%	45
No – decision-making authority should stay with the authorised psychiatrist	4.00%	2
No – the law should only allow for decision-making supporters to be appointed	6.00%	3
TOTAL		50

However, there are several issues that would need to be considered, that were the focus of our survey. Firstly, at what point would a consumer be permitted to nominate someone as their substitute decision-maker? Should there be a process for appointing a decision-maker when the

consumer does not already have one and have been assessed as lacking decision-making capacity?

The process for appointing decision-makers should be codesigned with consumers and be capable of protecting vulnerable people who may be pushed or coerced into appointing a person who is unable to fulfil their position in a way that benefits them or exploits them. The process would need safeguards to ensure that whoever is appointed understands the obligations of their role and acts properly, by making decisions based on the consumer's will and preferences and are guided by what the consumer would have decided if they had the capacity to make the decision.

We recommend that decision-makers be held to the same standards as guardians and administrators are under the *Guardianship and Administration Act 2019* (Vic). We also recommend that training for decision-makers and clinicians be developed, and include supported decision-making as well as considerations related to making substitute decisions.

It would be vital to ensure consumers are not cut out of the decision-making process on the basis they have a decision-maker appointed. As far as is possible, the decision-maker should still be required to utilise supported decision-making, explain any options or decisions being made and give people opportunities to ask questions and participate in those decisions. Both our survey and consumer focus group strongly supported this idea, noting that decisions, reasoning, and treatment should always be explained to the consumer no matter what.

Recommendations

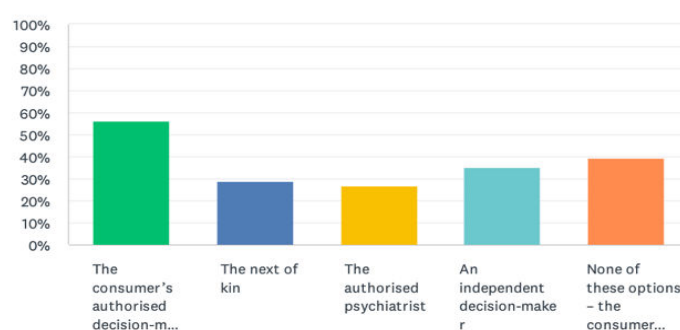
21. Create a right for consumers to appoint a decision-maker who can make decisions for them if they are unable to make treatment decisions for themselves.
22. Implement safeguards to ensure the appointment process protects vulnerable consumers from being coerced or pressured into appointing someone who cannot properly perform the role in a way that benefits them, or who uses their role to take advantage of or abuse the consumer.
23. Codesign and coproduce training for decision-makers that includes supported decision-making, the obligations that decision-makers have to consumers and other considerations such as how to determine the consumer's will and preferences if substitute decision-making is required.
24. Ensure consumers remain active participants in the decision-making process, even if they are assessed as lacking capacity and have a substitute decision-maker appointed. This includes utilising supported decision-making wherever possible, including when substitute decision-making is permitted.
25. Require that appointed decision-makers are held to the same standards as guardians and administrators, as set out in the *Guardianship and Administration Act 2019* (Vic).

Question 9: If a compulsory treatment patient has not chosen a substitute decision-maker, should it be possible to assign a substitute decision-maker other than the authorised psychiatrist?

In circumstances where the consumer has not appointed a decision-maker, decision-making authority should never fall to the authorised psychiatrist without consumer consent, as this would result in a conflict of interest. The role of psychiatrists must be limited to that of other specialist health practitioners. Only 27% of consumers surveyed supported the notion of decision-making power remaining with the authorised psychiatrist.

Q8 Who should be allowed to authorise assessment or treatment orders for consumers when they do not have an appointed decision-maker? (Please tick all that apply).

Answered: 48 Skipped: 7

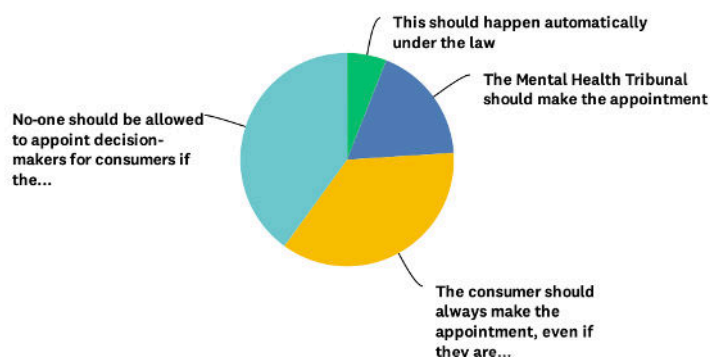


ANSWER CHOICES	RESPONSES	
The consumer's authorised decision-maker	56.25%	27
The next of kin	29.17%	14
The authorised psychiatrist	27.08%	13
An independent decision-maker	35.42%	17
None of these options – the consumer should always be allowed to make decisions about whether they are placed on an order	39.58%	19
Total Respondents: 48		

However, it should still be possible to appoint a decision-maker when a consumer has not previously done so, even if they are assessed as lacking decision-making capacity. Survey respondents were clear that decision-makers should never be appointed for consumers. There should also be a process to apply to the Tribunal if their appointment was challenged. 36% of survey respondents agreed that consumers should always be able to make the appointment, even if they are assessed as lacking decision-making capacity. 40% agreed consumers should be allowed to refuse decision-makers, and that in such circumstances, supported decision-making only should be relied upon.

Q5 Who should be allowed to appoint a decision-maker for a consumer who does not have one appointed?

Answered: 50 Skipped: 5



ANSWER CHOICES	RESPONSES
This should happen automatically under the law	6.00% 3
The Mental Health Tribunal should make the appointment	18.00% 9
The consumer should always make the appointment, even if they are assessed as lacking decision-making capacity	36.00% 18
No-one should be allowed to appoint decision-makers for consumers if they do not want one. The process should rely on supported decision-making only.	40.00% 20
TOTAL	50

When asked whether the Tribunal should be permitted to appoint a decision-maker for consumers, 62% of survey respondents agreed consumers who lack capacity should be able to apply to the Tribunal to appoint a decision-maker of their choice and the Tribunal should make the appointment based on its understanding of the consumer's will and preferences. Only 18% of respondents surveyed thought the Tribunal should make the appointment on behalf of consumers. Wherever possible, consumers who lack capacity should be supported to make an appointment. Appointments should only be made on behalf of consumers in the most exceptional circumstances and after significant attempts at supported decision-making have failed.

Recommendations

26. Amend the Act so authorised psychiatrists do not have decision-making power unless the consumer has expressly requested and consented to this.
27. Require decision-makers are only appointed on behalf of consumers in the most exceptional circumstances.

Question 10: What would be the best process to identify and assign a substitute decision-maker for a compulsory patient who has not identified a specific person?

The Act acknowledges consumers may lack capacity for some decisions but still retain capacity for others. Therefore, it is possible a consumer could lack capacity for treatment decisions but retain capacity to appoint a decision-maker. There are different requirements involved in each of these decisions, and so it is reasonable to retain the presumption that a consumer is competent to appoint a decision-maker, even when they lack competency for treatment decisions.

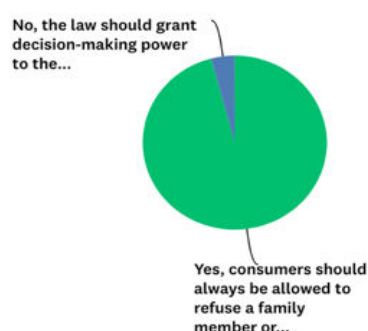
Consumers should be supported to appoint a decision-maker even when they lack capacity. If their decision is disputed, the Tribunal should have the power to direct that the consumer's decision is upheld, based on their will and preferences (we note the Tribunal would have to undergo significant cultural and functional changes for this process to be viable). This is

consistent with upholding the consumer's right to legal capacity. Even if they lack decision-making capacity, the CRPD requires that consumers are supported to make their own decision (in this case, about appointing a decision-maker).

In this case, VMIAC suggest using the process set out in the *Medical Treatment Planning and Decisions Act 2016* (Vic) ('the MTPD Act'), with some modifications. Consumers should be allowed veto power with respect to appointing a family member or next of kin, even when they lack capacity. 95.83% of our survey respondents agreed consumers should have veto power for family or next of kin.

Should consumers be able to refuse their next of kin being granted decision-making power?

Answered: 48 Skipped: 7



ANSWER CHOICES	RESPONSES
Yes, consumers should always be allowed to refuse a family member or next of kin being appointed as a decision-maker	95.83% 46
No, the law should grant decision-making power to the consumer's next of kin regardless of what the consumer wants	4.17% 2
TOTAL	48

Consumers surveyed on this issue also strongly supported consumer rights to decide if they want a decision-maker appointed and supported the use of supported decision-making for this purpose.

Ultimately, while there should be a process for appointing a decision-maker when a consumer does not have one and is unable to appoint one, this should only be done in exceptional circumstances where the consumer is unable to provide consent and attempts at supported decision-making have failed.

Recommendations

28. Ensure there is a process established for consumers to appoint decision-makers even if they are assessed as lacking capacity for treatment decisions.
29. Require the use of supported decision-making to assist consumers to make their own choice about appointing a decision-maker, rather than having one assigned for them.
30. Give the Tribunal the power to hear disputes about decision-makers and to make orders to uphold the consumer's decision in line with their will and preferences, so long as these can be established.
31. Adopt the process for appointing decision-makers on behalf of consumers as set out in the *Medical Treatment Planning and Decisions Act* but amend the process so that

consumers have veto power in relation to appointing next of kin or family; and so, an independent decision-maker can only be appointed in the most exceptional circumstances (e.g., when multiple attempts at supported decision-making have failed).

Question 11: What changes could strengthen advance statements? Are there alternatives that could work better than advance statements?

Creating a system where advance statements are legally binding, such as in the general health system, would go a long way towards ensuring mental health consumers are treated equally. Both consultation and survey respondents overwhelmingly supported making advance statements binding, with just over 83% of those surveyed agreeing this should be done.

At present, advance care directives under the MTPD Act do not apply to people being treated compulsorily for mental health. One way to potentially increase the uptake of advance statements could be to permit consumers to include their preferences for mental health treatment in their advance care directive, alongside their general health preferences. Binding mental health advance statements should also be retained for consumers who prefer to keep these separate. Another option is creating a centralised database, so people can easily upload their advance statements and implement an obligation on services to check this data-base when they first meet a consumer.

It is not just consumers on assessment orders who are at risk of compulsory treatment – any inpatient is. Using advocates or other support workers to help voluntary consumers draft an advance statement when they are admitted as inpatients would better protect them and potentially increase the uptake of advance statements. Services should be obligated to provide information on how to make advance statements to voluntary consumers upon admission. They could be referred to an advocate or lawyer, or to the Mental Health Legal Centre's advance statement tool (so long as they had access to technology).

Recommendations

32. Make advance statements in mental health binding.
33. Amend the law around advance care directives so preferences for mental health treatment and values statements can be included.
34. Empower advocates, nominated decision-makers or independent decision-making supporters to assist voluntary inpatients to draft advance statements if they do not already have one as soon as possible after they are admitted.
35. Require services to provide information about advance statements to voluntary consumers as they are admitted.

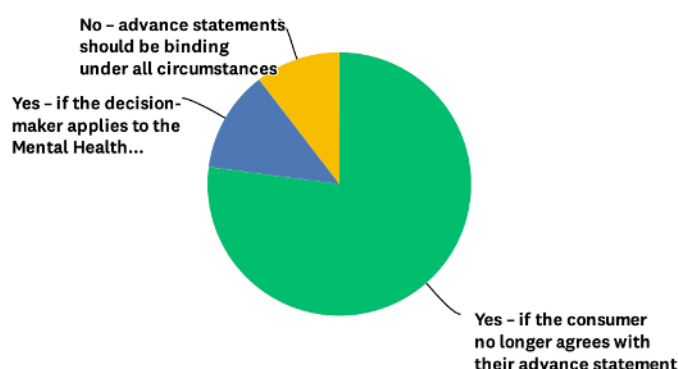
Question 14: Are there any circumstances where it might be appropriate to override an advance statement? If so, what are they?

Based on our survey results, 77% of consumers surveyed believed advance statements should be able to be overridden if the consumer no longer agrees with it. This should apply when a consumer doesn't have decision-making capacity, is in an altered state and unable to consent to treatment, but consistently objects to the treatment that they consented to in their advance statement.

Only a limited number of survey respondents supported other reasons for overriding advance statements or not allowing for advance statements to be overridden. VMIAC's position is that consumers should never be forced to stand by their advance statement when they no longer agree with it, including when they lack capacity.

Q10 Should there be any circumstances under which an advance statement can be overridden?

Answered: 48 Skipped: 7



ANSWER CHOICES	RESPONSES	
Yes – if the consumer no longer agrees with their advance statement	77.08%	37
Yes – if the decision-maker applies to the Mental Health Tribunal to have it overridden	12.50%	6
No – advance statements should be binding under all circumstances	10.42%	5
TOTAL		48

However, one issue requiring consideration is where a consumer provided advanced refusal to treatment, but later changes their mind and consents to treatment in circumstances where they are assessed as lacking capacity. In these circumstances, the potential for trauma that could result from a consumer being given a treatment they had originally refused in advance is high. Coercion would also be a risk of overriding advance *refusals*. To ensure that consumers' will, and preferences are upheld, overriding advance *refusals* should only be permitted if the consumer currently has decision-making capacity and makes a competent decision to change their advance statement.

Recommendations

36. Allow consumers to override consent to treatment in advance statements if they no longer consent (even if they lack capacity)
37. Ensure consumers cannot override advance refusal of treatment unless they currently have decision-making capacity and make a competent decision to make a new advance statement.

Part C: Compulsory assessment and treatment

Question 15: Are there any criteria that are particularly problematic?

Question 16: What changes could be made to the assessment and/or treatment criteria?

The compulsory assessment criteria

In general, consultation participants believed assessment criteria are too broad, open to interpretation and needed to be better defined. They raised concerns that the criterion ‘appears to have a mental illness’ was problematic and should be set at a higher bar.

One suggestion was two people should be required to form ‘a reasonable belief’ that a person has a mental illness. Another suggestion was that, instead of the criteria focusing on the presence of ‘mental illness’ and subsequent need for treatment, the focus could be on whether the person in question agreed with the need for treatment or support, or if they could recognise, they needed help.

People in the focus group provided examples such as being in crisis and asking to go to hospital by ambulance, and instead finding themselves put on an assessment order and taken to hospital by police. There were concerns discussed about ensuring people who want help are not subjected to assessment orders or police escorts needlessly.

As raised earlier in this submission, criterion relating the need for treatment to ‘*prevent serious deterioration or harm from occurring to the person or another person*’ focuses too much on risk, is too broad and does not require enough immediacy from the situation. Consumers told us the criteria should require that deterioration or risk of harm is both serious and *immediate*.

Again, rather than focusing on whether the treatment criteria apply, assessments should focus on wrap around support needs. Ultimately, we believe the criteria should be amended in consultation with consumers, who are able to provide valuable insight into how it affects them and what might be more helpful.

Recommendations

38. Revoke the current assessment criteria.
39. Codesign new assessment criteria with consumers and people with lived experience that are:
 - a. less focused on risk, and
 - b. ensure the purpose of assessment is to conduct a holistic assessment of the consumer’s needs, will and preferences, rather than simply assessing whether the treatment criteria apply.

The compulsory treatment criteria

Like the assessment criteria, consumers in our consultation believed compulsory treatment criteria are too broad, unclear and need to be narrowed. They made similar suggestions about the *immediacy* of risk to the person or others. They also raised concerns regarding how ‘deterioration’ is assessed when often the psychiatrist doing the assessment don’t know the consumer and fail to check historical records. There was a strong view among the consultation group that there should be a requirement compulsory treatment is only used as a last resort and is only permitted in exceptional circumstances.

Consultation participants thought the compulsory treatment criteria must start with the presumption that treatment will be voluntary. They again suggested a requirement that the

person is refusing help or support, so that treatment orders couldn't be made for consumers who wanted help. Consumers also strongly supported the inclusion of decision-making capacity in the criteria, that the presumption of capacity must remain; and the criteria must require all attempts at supported decision-making have been made and demonstrated to fail.

Additionally, there should be a requirement that treatment is provided is in line with the consumer's will and preferences.

VMIAC believe these changes should be codesigned with people who have lived experience, and we recommend co-designing separate 'emergency treatment criteria' that apply only in exceptional circumstances which are sufficiently narrow to ensure they can't be overused.

Recommendations

40. Revoke the current treatment criteria.
41. Use codesign to develop new treatment criteria with people who have lived experience, ensuring:
 - a. *There is a presumption that compulsory treatment criteria do not apply, even when a person lacks capacity, and voluntary treatment is always preferred.*
 - b. *Capacity is included in the treatment criteria and there is a presumption the person has capacity.*
 - c. *The criteria include the test for capacity, amending it to ensure it is not overused and noting in the criteria that capacity can fluctuate or return.*
 - d. *There is a requirement of sufficient attempts at supported decision-making have been made and failed, and that this is able to be demonstrated.*
42. Compulsory treatment is limited to the most exceptional circumstances and is only used as a last resort, or to prevent serious and *imminent* harm to another person.
43. Compulsory treatment is only used to give effect to the consumer's will and preferences.
44. Use codesign with consumers and people with lived experience to define emergency treatment, ensuring that it is sufficiently narrow not to be overused.

Question 17: Should the compulsory assessment and treatment criteria include a decision-making capacity criterion? What are the considerations?

VMIAC believe the compulsory treatment criteria should include a decision-making capacity criterion and that the presumption of capacity should be protected even with capacity as one of the criteria. In other words, the treatment criteria should not be assessed unless the decision-maker has reason to believe capacity may be an issue *and* is able to establish that a person lacks capacity. However, lacking capacity should not automatically mean a person requires compulsory treatment. Supported decision-making should always be the starting point, including when a consumer lacks capacity and this should be reflected in the criteria.

The test for assessing capacity should be included in the criteria and include recognition that capacity can be recovered or can fluctuate, and that it is decision specific. We recommend revising the test for capacity in line with Justice Bell's interpretation of the test in *PBU & NJE v Mental Health Tribunal*, which stated the relevant test is whether or not the person is *capable* of understanding, remembering, using, weighing, and communicating information about the decision, and not whether they *actually* do these things when making their decision¹⁶.

¹⁶ PBU & NJE v Mental Health Tribunal [2018] VSC 564, 182.

Consumers in our consultation strongly supported clarifying the test for capacity and we believe that Justice Bell's interpretation ensures clarity as well as setting a low enough bar that most consumers should be judged to be competent. This is important if we are going to succeed at reducing the use of compulsory treatment.

Respondents to our consultations were also concerned that compulsory treatment or the threat of it causes so much distress it may be possible the person is assessed as lacking capacity when they may be afraid of being treated against their will. They noted distress tends to influence assessments of capacity and is an issue which needs to be addressed. Therefore, it was suggested a person should be assessed for capacity more than once, to give them a chance to become less distressed. Additionally, a safeguard for the assessment of capacity could be a requirement for two independent decision-makers to make the assessment to provide a safeguard against compulsory treatment where people are highly fearful.

As already stated, the only exception to the capacity criterion should be where a person is seriously threatening to harm another. In these circumstances, we believe a treatment order should be made even if the consumer has decision-making capacity.

Recommendations

45. Include decision-making capacity as one of the treatment criteria, clearly stating that capacity can fluctuate or be regained, and is decision specific.
46. Maintain the presumption of capacity, so the treatment criteria can only be assessed when the decision-maker has reason to believe a person lacks capacity and assesses them as lacking capacity.
47. Include in the criteria an amended test for capacity in line with Justice Bell's interpretation in *PBU & NJE v Mental Health Tribunal*.
48. Implement safeguards for the assessment of capacity, such as requiring that the assessment be made on more than one occasion and requiring that two independent decision-makers conduct the assessment.
49. Exclude situations where the consumer is seriously threatening immediate harm to another from capacity assessments.

Question 18: Who should be able to sign off on:

- **An assessment order.**
- **A temporary treatment order.**
- **A treatment order.**

Assessment orders

Assessment orders do not, and likely will not, require an assessment of capacity. Therefore, there is no reason to permit an appointed substitute decision-maker to make an assessment order, because without having a determination of capacity to legitimise their decision, they have no special expertise that would be of assistance in making assessment orders.

VMIAC have been told by consultation participants that assessment orders are currently regularly misused by clinicians. However, we believe mental health clinicians are still the most appropriate people to make assessment orders to ensure the misuse of assessment orders cannot extend to other stakeholders, such as family or carers.

Given even the most well-meaning family member the power to place their loved one on a binding assessment order that restricts their human rights without that person's consent could

be detrimental to their relationship¹⁷. The situation also poses other significant risks if family violence is present. There should be mechanisms in place to ensure that the criteria for making an assessment order are always met, that consumer rights are upheld as much as possible, and that they are not misused the way that they are at present.

Consumers strongly supported having two people sign off on assessment orders and recommended that the second person is independent to provide additional oversight. If both clinicians agreed that a person met the criteria for assessment, then the order could be made.

Temporary treatment orders

Based on our survey, 56.25% of respondents believed that a consumer's authorised decision-maker should be permitted to sign off on temporary treatment orders. However, another 39.58% believed consumers themselves should always be able to make decisions about whether they were placed on an order. This could be done by, for example, consenting to compulsory treatment via an advance statement. Ultimately, all respondents preferred the option of the consumer's nominated decision-maker making the decision about whether to put them on an order.

We recommend an approach that uses different decision-makers for different treatment criteria. Capacity, for example, could be assessed independently with a requirement that it is signed off by two independent decision-makers to ensure the consumer was truly lacking capacity. This would have the additional benefit of being able to be delegated to professionals who have a solid understanding of capacity, rather than relying on the person appointed by the consumer to understand this area of law.

Additionally, if the presence of 'mental illness' and subsequent need for treatment are retained as criteria, psychiatrists could play a role determining these criteria as they require the use of clinical expertise in their assessment. Ideally, VMIAC would prefer a process requiring multiple parties to sign off on a compulsory treatment order, including a clinician, someone with some legal expertise to assess capacity, and a person's chosen decision-maker.

Treatment orders

Treatment orders are currently made by the Mental Health Tribunal and can apply for up to six months. This is a significant duration of time to have liberty and autonomy restricted and is inconsistent with least restrictive practice principles. Given the current goal of the Royal Commission to reduce compulsory treatment, the Tribunal should be required to make orders for consumers for significant periods when authorised psychiatrists (at present) and potentially other decision-makers could be permitted to make compulsory treatment orders.

We disagree that two different types of treatment order, one that is temporary and one that can be made for extended periods are needed. This is not consistent with the Royal Commission goals. While the Tribunal may retain its function of hearing appeals, we envisage it could be more geared towards oversight than making treatment orders.

One implication of this would be that ECT orders could no longer be made against someone's will. We see this as a benefit, because ECT is an invasive treatment that can cause extreme trauma when forced on people¹⁸. One exception to this could be where a consumer has consented to its use in an advance statement.

¹⁷ Kanna Sugiura, Elvira Pertega & Christopher Holmberg, 'Experiences of involuntary psychiatric admission decision-making: a systematic review and meta-synthesis of the perspectives of service users, informal carers, and professionals' (2020) 73 *International Journal of Law and Psychiatry* 101645, 5.
¹⁸ Chris Maylea, Witness statement to the Royal Commission into Victoria's Mental Health System, Royal Commission into Victoria's Mental Health System (30 April 2020) para 45.

Recommendations

50. Continue the current practice of allowing medical practitioners and mental health practitioners make assessment orders.
51. Implement a safeguard that requires an assessment order to be signed off by two independent clinicians.
52. Implement a requirement that two independent decision-makers with experience in capacity must sign off on the capacity criterion before a compulsory treatment order can be made.
53. If the presence of 'mental illness' and a subsequent need for treatment are retained as criteria, require that the assessment of these criteria is conducted by a psychiatrist.
54. Implement a review process for compulsory treatment orders that is triggered within a few days, but no longer than a week after an order has been made.
55. Review the functions of the Mental Health Tribunal and revoke its power to make treatment orders.

Question 20: Are there exceptional circumstances in which community treatment orders are appropriate?

Considering the use of treatment orders will be changing, we believe community treatment orders are not necessary. If a person can live in the community, then they should be competent to make their own treatment decisions.

Additionally, given the protracted nature of many community treatment orders, they are not consistent with either least restrictive practice or with the goal of immediately reducing the use of compulsory treatment. They are also used too commonly, as demonstrated by the Tribunal's most recent Annual Report – for the year 2021 – 2022, 61% of all treatment order hearings resulted in a consumer being placed on a community treatment order, compared to only 33% resulting in inpatient orders¹⁹.

If Victoria is committed to reducing the use of compulsory treatment, eliminating the use of community treatment orders seems like a highly effective way to do so, especially considering the lack of evidence of their benefit. Though community treatment orders seem less restrictive than inpatient orders, they still limit some of the most fundamental rights of consumers, including the right to liberty and the right to physical and mental integrity,²⁰ often leading to feelings of hopelessness and a lack of self-efficacy, both of which can impede recovery.²¹

The only exception for a community treatment order that may be acceptable is where a consumer has provided advance consent via a binding advance statement to being placed on one. Despite there being no strong evidence to suggest they are effective,²² consumers should have the right to choose to be on a community treatment order if they believe that it is helpful to them.

Recommendations

56. Limit the use of community treatment orders to circumstances where consumers have provided advance consent via a binding advance statement.

¹⁹ Mental Health Tribunal, Annual Report 2021 - 2022 (10 August 2022) 22.

²⁰ Convention on the Rights of Persons with Disabilities, opened for signature 13 December 2006, A/RES/61/106 (entered into force 3 May 2008) art 17.

²¹ Health Talk Australia, Community treatment orders (Web page) < <https://www.healthtalkaustralia.org/supported-decision-making/community-treatment-orders/> >

²² Kisely SR, Campbell LA, O'Reilly R, 'Compulsory community and involuntary outpatient treatment for people with severe mental disorders' (2017) 3(1) Cochrane Database Syst Rev 49.

57. Ensure consumers are permitted to provide advance consent to community treatment orders via their advance statement.

Question 21: What changes to existing or planned oversight mechanisms are required to better protect the rights of compulsory patients?

The Terms of Reference of the Independent Review state the Panel must investigate how to reduce the use of compulsory treatment, including what safeguards should apply to its use. Safeguards are critical if we are to achieve the vision of the Royal Commission, reduce the use of compulsory treatment immediately and increase accountability.

To be most effective, safeguarding should apply at different stages of the process, and be wide-ranging. Some safeguards that could be helpful include:

- strengthening the application of human rights, e.g., requiring that the test for limiting rights as set out in the Charter is incorporated into the legislation and must be met in any circumstance where a decision-maker is authorised to limit consumer rights.
- Creating additional rights for people placed on a compulsory treatment order, such as a right to appeal the order at the Tribunal before treatment commences and to have that appeal heard within seven days,
- a right to have a legal representative assist in the appeal.
- the right to get an independent second opinion prior to treatment starting and to have that opinion provided within a reasonable time,
- the creation of offences or penalties relating to breaching the informed consent provisions (for example, by using coercion), especially in circumstances where treatment given has been particularly invasive, such as high dose or long-acting antipsychotics, or ECT. We note this is already done in other jurisdictions.

Consumers also suggested limiting the duration of treatment orders and implementing a review process e.g., a review 24 hours after an order being made to confirm a person still met the criteria. Having the order independently reviewed within a few days to a week at most would help to ensure that unnecessary or overly restrictive treatment was limited.

Another possibility is for the Mental Health Tribunal to play a role in system oversight. We envisage a role for the Tribunal where its expertise could be used to hold clinicians and other decision-makers accountable, rather than to subject consumers to orders. If the use of compulsory treatment is truly to be reduced, strong oversight of its use is critical.

The Tribunal could play a role in hearing appeals of treatment orders, as it currently does, but with a renewed focus on limiting the circumstances where compulsory treatment can be used. For example, based on its most recent annual report, only the minority of orders were revoked, regardless of whether the consumer has applied to have the order revoked or the authorised psychiatrist has applied to make the order – the total number of revocations for that period was only 6% of all treatment order hearings.²³ VMIAC believe a shift in its culture and purpose could go a long way towards changing this.

A new focus on appeals or even reviewing the improper use of assessment orders or treatment orders, would orient the Tribunal towards upholding consumer rights and ensuring clinician and decision-maker accountability, making it an important safeguard. While it is not currently clear how accountability of other decision-makers will be enforced, VMIAC believe the Tribunal is well placed to perform this function, with its combination of clinical, legal, and community-based expertise.

23 The Mental Health Tribunal, Annual Report 2021 – 2022 (10 August 2022) 23 – 24.

The Mental Health and Wellbeing Commission ('the MHWC') should retain its role as set out in the new Act. However, if the Tribunal were to play a role in oversight and accountability, it would follow that it could identify and refer matters to the MHWC, where relevant to its functions.

Recommendations

58. Require the test for limiting human rights as set out under the Charter is incorporated into the legislation and be met in any circumstances where a decision-maker is permitted to make decisions that affect a consumer's rights.
59. Create additional rights for consumers, including:
 - a. The right to appeal their order at the Tribunal before treatment commences; and the right to have the appeal heard within 7 days.
 - b. The right to have a legal representative at all hearings before the Tribunal.
 - c. The right to a second opinion on a treatment order prior to treatment starting, and for this opinion to be provided within a reasonable timeframe.
 - d. The creation of offences for failing to obtain fully informed consent to treatment where the treatment is given on a voluntary basis (including where the consumer is coerced into accepting treatment).
60. Limit the duration of treatment orders to seven days, after which time they must be subject to review.
61. Change the role of the Mental Health Tribunal so it is no longer responsible for making treatment orders, but rather plays a role in system oversight including:
 - a. Hearing appeals
 - b. Hearing matters where the consumer's decision (after using supported decision-making) is in question and ensuring that any decision is made in line with their will and preferences (whether or not the consumer's decision is affirmed)
 - c. Hearing and determining matters where there are allegations an assessment or treatment order has been improperly used.
 - d. Ensuring clinicians and other decision-makers are accountable, including ensuring they followed proper process to make a decision, and the decision was the correct one under the circumstances.

Question 22: How soon after a person is placed on a compulsory assessment or treatment order should there be some form of independent review?

As stated, we believe that consumers should be reviewed within seven days of a treatment order being made.

Assessment orders are currently made for 24 hours, with the possibility to extend them twice (up to a maximum of 72 hours). We believe this is appropriate if assessment orders are reformed in line with our recommendations. This will enable the assessor to get to know and understand the consumer more, which is necessary for recommending steps to address their safety and distress. The option of extending the time will also give the consumer a chance to receive emotional and psychological support to assist them to alleviate their distress.

The application of emergency treatment criteria should be assessed at short intervals (for example, every few hours) to ensure that treatment ceases as soon as the crisis is addressed.

Recommendations

62. Require that consumers are reviewed within seven days of a treatment order being made.
63. The time limits that currently exist for assessment orders are appropriate and should remain a feature of the reformed system.
64. Require that the emergency treatment criteria are reassessed every few hours until the emergency is addressed, and treatment is no longer required.

Question 23: For what purpose could a substitute decision-maker make treatment decisions for a compulsory patient?

A person's nominated decision-maker should make treatment decisions when a person is on a compulsory treatment order. These decisions should be informed by the advice of mental health or other relevant professionals, in line with our proposed expanded definition of 'treatment' (as stated above in question 1). This advice could be provided by:

- Psychiatrists
- Psychologists
- Mental Health social workers
- Occupational therapists

We believe there could also be therapeutic benefits to exploring advice from social services such as family violence, homelessness, trauma specialist services etc so long as the advice came from the person's case manager or formal support within these services. Their decision must ultimately be based on what the person's will and preferences are, or what decision the person would have made if they were in a position to do so.

The purpose of the treatment decision must be to prevent more harm than the treatment causes to the person.

65. A person's nominated decision-maker should make treatment decisions for a person who is being treated compulsorily in line with that person's will and preferences. The decision-maker may rely on relevant opinions and advice from mental health or other professionals, including social support services, when making their decision, in line with the expanded definition of 'treatment' under question 1.
66. The purpose of treatment must be to prevent more harm than the treatment causes.