POSITION STATEMENT

Compulsory Treatment

VMIAC

ACKNOWLEDGEMENT OF COUNTRY

VMIAC recognises Aboriginal and Torres Strait Islander peoples as the First Peoples of this continent and the Islands of the Torres Strait.

In doing so, we acknowledge out shared history, recognise the right to self-determination and the importance of connection and access to Country.

VMIAC works across Victoria and acknowledges the Traditional Custodians of the lands and waters on which we are privileged to work and live.

We acknowledge and respect distinct Aboriginal and Torres Strait Islander cultural differences, beliefs, values, and languages.

We acknowledge that this land was never ceded and pay our respects to Elders past and present.

Position Statement:
Compulsory Treatment

1. Purpose

1.1. This statement establishes VMIAC's position on compulsory mental health treatment in Victoria and our expectations of Government, statutory bodies, and service providers. It reaffirms our unequivocal goal: to bring an end to all forms of compulsory treatment in Victoria.

1.2. Compulsory treatment is not a minor flaw in an otherwise functional system. It is the defining feature of a mental health system built on carceral logic, where control is prioritised over consent. Through legal authority and clinical power, the State justifies removing a person's rights and autonomy, treating distress as something to be contained rather than understood. These practices are sustained by institutional cultures that normalise coercion and present it as care.

1.3. Government holds both the power and the responsibility to end forced psychiatric treatment. However, legislative change alone will not achieve this. It requires sustained investment in voluntary and culturally safe supports, the removal of legal frameworks that permit coercion, recognition and redress of harm, and a fundamental shift in how services respond to distress and crisis.

1.4. This work must be led by people with lived experience of compulsory treatment, whose knowledge cannot be gained through observation alone. Our experiences offer critical insight into both the harms of coercion and alternatives that are grounded in dignity and consent.[*] People should not be required to surrender their autonomy in order to receive care. The goal of mental health reform should not be to make compulsory treatment safer or kinder, but to render it unnecessary.

2. Defining compulsory treatment

2.1. Compulsory treatment refers to any mental health assessment or intervention carried out without a person's free and informed consent. In Victoria, it is authorised under the *Mental Health and Wellbeing Act 2022*, which allows clinicians to override a person's decision-making based on assessments of risk or capacity.[1]

[*] VMIAC acknowledges that some consumers have described compulsory treatment as helpful or necessary in retrospect. We view this not as evidence of the value of coercion, but as a reflection of the system's failure to provide appropriate voluntary supports. When real alternatives are not available, compulsory treatment can appear to be the only option.

2.2. These powers allow involuntary detention and forced treatment. They are justified as preventing harm, despite relying on risk assessments that have no demonstrated ability to predict future behaviour.[2]

2.3. There are two main types of compulsory treatment orders in Victoria:

- Inpatient Treatment Orders: Authorise detention and treatment in a hospital or mental health facility without consent.
- Community Treatment Orders (CTOs): Require a person to comply with treatment while living in the community, with the possibility of involuntary rehospitalisation for non-compliance.

2.4. Under these orders, individuals may be subjected to:

- Forced medication, including antipsychotic or other psychotropic drugs, sometimes via long-acting injectable formulations.
- Electroconvulsive therapy (ECT), which can be administered without consent when authorised by the Mental Health Tribunal.
- Surveillance and restrictive conditions under CTOs that may impede autonomy in daily life.

3. Background

3.1. Coercion has been embedded in psychiatry since its inception.[†] Mental health systems have long used involuntary detention and treatment to manage distress and behaviour deemed disruptive or non-compliant, positioning these practices as therapeutic responses rather than as forms of social control.

3.2. Australia has recorded some of the highest rates of compulsory mental health treatment internationally.[3] Prior to the Royal Commission into Victoria's Mental Health System (the Royal Commission), Victoria recorded the highest use of CTOs nationally, and among the highest internationally.[4] While more recent data shows variation between jurisdictions,[5] Victoria continues to rely heavily on compulsory treatment, with significant differences in use across regions and services.

3.3. Reducing compulsory treatment was a central aim of the Royal Commission, which explicitly urged Government to ensure it is used only as a last resort.[6] However, since its conclusion in 2022, there has been little measurable progress. CTOs remain widespread, publicly accessible data is limited, and no clear implementation pathway exists to reduce or phase out compulsory treatment.

[†] A restrictive practice is any practice or intervention that limits a person's human rights or freedom of movement. VMIAC uses the term *coercive practices* to emphasise the power imbalance and the absence of free and informed consent that characterise these interventions. For further detail, see VMIAC's Coercive Practices Position Statement [link].

4. Human rights concerns

4.1. There is growing international recognition that compulsory psychiatric treatment causes harm and is inconsistent with multiple international human rights obligations. Key protections include:

4.1.1. The Convention on the Rights of Persons with Disabilities (CRPD), in particular:

- Article 12: Equal recognition before the law.
- Article 14: Liberty and security of person.
- Article 15: Freedom from torture or cruel, inhuman or degrading treatment or punishment.
- Article 16: Freedom from exploitation, violence and abuse.
- Article 17: Protection of personal integrity.[7]

4.1.2. The Optional Protocol to the Convention Against Torture (OPCAT), which requires the prevention of torture and ill-treatment in all places of detention, including mental health facilities.[8]

4.1.3. The International Covenant on Civil and Political Rights (ICCPR), which protects the rights to liberty, security of person, and freedom from arbitrary detention and ill-treatment.[9]

4.1.4. The United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP), which affirms the rights of Indigenous peoples to self-determination, cultural integrity, and free, prior and informed consent.[10] Compulsory treatment and involuntary detention are inconsistent with these principles and raise particular concerns for Aboriginal and Torres Strait Islander peoples given the ongoing impacts of colonisation, systemic racism, and the lack of culturally safe mental health care.

4.2. While Australia has ratified the CRPD and OPCAT, it maintains interpretive declarations[‡] that significantly weaken their protections. These declarations allow for ongoing forced treatment and detention without consent – practices that directly contravene the spirit and intent of these treaties.

4.3. UN treaty bodies have repeatedly found Australian mental health laws to be inconsistent with international human rights obligations.[11] The CRPD Committee has called for the repeal of all laws permitting compulsory treatment and for the development of legal frameworks that uphold the right to informed consent. The UN Special Rapporteur on Torture has stated that forced psychiatric interventions, including involuntary medication and ECT, may constitute torture or ill-treatment when imposed without free and informed consent.[12,13]

[‡] In international law, an interpretive declaration is a statement made by a country when ratifying a treaty that clarifies their understanding as to the meaning or scope of that treaty or provisions contained within it. It is not intended to exclude or modify the legal effects of a treaty.

4.4. Leading international bodies, including the World Health Organisation (WHO) and the World Psychiatric Association (WPA), now recognise the harm caused by coercive practices and call for a global shift towards voluntary, rights-based models of mental health care.[14,15]

5. Compulsory treatment causes profound harm

5.1. While human rights violations are sufficient reason to oppose compulsory treatment, the most urgent concern is the harm it causes. These practices are not neutral or therapeutic. For many consumers, they are experienced as violent, traumatic, and deeply dehumanising.

5.2. Consumers consistently report that compulsory treatment causes lasting psychological harm and compounds existing trauma. Many describe post-traumatic stress and ongoing fear of services, along with a profound sense of violation and powerlessness.[16,17] Rather than supporting recovery, compulsory treatment reinforces cycles of fear and avoidance.

5.3. Forced treatment erodes trust in the mental health system. Many people disengage from support after compulsory treatment, even when in crisis, because they associate support with the threat of force rather than care.[18]

5.4. Common interventions, particularly antipsychotic medications and ECT, carry serious and sometimes irreversible side effects. These include metabolic and movement disorders, memory loss, cognitive impairment, sedation, and other long-term impacts on physical and mental health.[19,20,21]

5.5. Compulsory treatment causes the greatest harm to those already affected by systemic injustice, particularly First Nations Australians and people from CALD or migrant backgrounds, who are subjected to it at disproportionately high rates.[22,23] For many, the harm is compounded by disconnection from community and the absence of culturally safe care.

5.6. *These harms are not rare or isolated.* They are well-documented across consumer testimony, in the research literature, and through multiple government inquiries.[24,25] Yet the current system fails to acknowledge or address these harms, leaving many without recognition, redress, or support.

6. VMIAC's position

6.1. VMIAC condemns compulsory treatment as a form of inhumane, state-sanctioned violence. It is not care; it is coercion. It causes lasting trauma, strips people of their dignity and autonomy, and violates the fundamental human rights to liberty, bodily integrity, and freedom from torture and ill-treatment. We reject forced treatment in all its forms, without exception.

6.2. A mental health system built on coercion cannot be described as rights-based. Ending compulsory treatment requires its total and unconditional elimination, not euphemistic

rebranding or superficial reforms that preserve the status quo. Anything less will preserve the same harms under a different name.

6.3. Effective alternatives to compulsory treatment already exist and have been demonstrated internationally. Peer-led, trauma-informed, voluntary, and rights-based approaches have been shown to reduce harm, increase engagement, and improve outcomes for individuals, workers, and communities.[26,27,28] The World Health Organisation and the Lancet Commission on Global Mental Health both call for urgent investment in these models.[29]

6.4. Despite this evidence, rights-based alternatives remain chronically underfunded and largely inaccessible in Victoria. The system continues to rely on coercion because it refuses to invest in voluntary and culturally safe supports. CTOs, in particular, are highly resource-intensive and costly to administer.[30] The continued use of coercion diverts resources away from approaches that would genuinely support healing and recovery.

6.5. *We reject the false and dangerous binary that frames forced treatment as the only option in the absence of real alternatives.* This logic has enabled decades of systemic abuse. Real change demands real investment, not just in funding, but in time, relationships, and the courage to do things differently. It requires leadership grounded in lived experience, and a commitment to care that is built on consent, not control. **The measure of a mental health system lies not in how much coercion it can justify, but in how little coercion it requires.**

7. Recommendations

7.1. Eliminate compulsory treatment

- Amend the *Mental Health and Wellbeing Act 2022* to explicitly prohibit all forms of compulsory treatment, in line with international human rights obligations.
- Develop and implement a time-bound strategy with dedicated funding to eliminate all forms of compulsory mental health treatment in Victoria as a matter of urgency.
- Ensure this strategy is co-produced with consumers and underpinned by lived experience leadership.

7.2. Replace coercion with real alternatives

- Significantly expand access to voluntary, culturally safe, peer-led mental health supports.
- Increase investment in community-based responses that are non-coercive, including crisis alternatives, step-up/step-down supports, and consumer-run services.

7.3. Guarantee legal and advocacy protections

- Ensure timely access to free legal representation for all Mental Health Tribunal and review processes.
- Require all Tribunal decisions to be published in full, with identifying details removed.

7.4. Embed human rights in clinical practice

- Require all clinicians working in mental health services to complete regular human rights training focused on applying human rights in everyday practice.

7.5. Ensure transparency and accountability

- Mandate public reporting on the use of compulsory treatment, including data disaggregated by age, gender, First Nations status, cultural background, LGBTQIA+ status, service provider, and location.
- Introduce real consequences for services and individual staff who breach human rights or fail to reduce coercion.

7.6. Establish a national Human Rights Act

- VMIAC supports the introduction of a federal Human Rights Act that affirms the rights of all Australians, including the right to refuse treatment and the right to be free from torture and ill-treatment.

7.7. Acknowledge and redress harm

- Publicly acknowledge the systemic harm caused by compulsory treatment.
- Create accessible pathways for redress, including apologies, restorative processes, peer-led support, and where appropriate, financial compensation.

---

[1] *Mental Health and Wellbeing Act 2022 (Vic),* Chapter 4 – Compulsory assessment and treatment. https://www.legislation.vic.gov.au/as-made/acts/mental-health-and-wellbeing-act-2022

[2] Hawton, K., Lascelles, K., Pitman, A., Gilbert, S., Silverman, M. (2022) 'Assessment of suicide risk in mental health practice: shifting from prediction to therapeutic assessment, formulation, and risk management'*, Lancet Psychiatry*. https://doi.org/10.1016/S2215-0366(22)00232-2

[3] Light, E. (2019) 'Rates of use of community treatment orders in Australia', *International journal of law and psychiatry*, 64: 83-87. https://doi.org/10.1016/j.ijlp.2019.02.006

[4] Light, E., Kerridge, I., Ryan, C. & Robertson, M. et al. (2012) 'Community Treatment Orders in Australia: Rates and Patterns of Use', *Australasian Psychiatry*, 20(6): 478-481. https://doi.org/10.1177/1039856212466159

[5] Kisely, S., Bull, C., Zirnsak, T., Shahwan, S., Wong, M.-L., Siskind, D. & Brophy, L. (2025) 'Variations between, and within, jurisdictions in the use of community treatment orders and other compulsory community treatment: Study of 402,060 people across four Australian states', *BJPsych Open*, 11(2): e57. https://doi.org/10.1192/bjo.2025.23

[6] Department of Health (2025) *Recommendation 55 – Ensuring compulsory treatment is only used as a last resort*, Victorian Government. https://www.health.vic.gov.au/mental-health-reform/recommendation-55

[7] United Nations (2006) *Convention on the Rights of Persons with Disabilities*, Treaty Series, 2515, 3. https://www.ohchr.org/en/instruments-mechanisms/instruments/convention-rights-persons-disabilities

[8] United Nations (2002) *Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT)*, A/RES/57/199. https://www.ohchr.org/en/instruments-mechanisms/instruments/optional-protocol-convention-against-torture-and-other-cruel

[9] United Nations (1966) *International Covenant on Civil and Political Rights*, Treaty Series, vol. 999, p. 171, 16 December 1966. https://www.ohchr.org/en/instruments-mechanisms/instruments/international-covenant-civil-and-political-rights

[10] United Nations General Assembly (2007) *Declaration on the Rights of Indigenous Peoples*, 2 October 2007, Resolution 61/295. https://www.un.org/development/desa/indigenouspeoples/wp-content/uploads/sites/19/2018/11/UNDRIP_E_web.pdf

[11] UN Committee on the Rights of Persons with Disabilities (2019) *Concluding observations on the combined second and third periodic reports of Australia*, CRPD/C/AUS/CO/2-3, United Nations. https://digitallibrary.un.org/record/3848618?v=pdf

[12] Mendez, J. E. (2013) *Report of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, A/67/279, United Nations. https://digitallibrary.un.org/record/745883?ln=en&v=pdf

[13] UN Human Rights Council (2020) *Report of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, A/HRC/43/49, United Nations. https://www.ohchr.org/en/documents/thematic-reports/ahrc4349-report-psychological-torture-and-ill-treatment

[14] World Health Organization & Office of the United Nations High Commissioner for Human Rights (2023) *Mental health, human rights and legislation: Guidance and practice*, ISBN 9789240080737, HR/PUB/23/3. https://www.who.int/publications/i/item/9789240080737

[15] Herrman, H., Allan, J., Galderisi, S., Javed, A., Rodrigues, M. & WPA Task Force on Implementing Alternatives to Coercion in Mental Health Care (2022) 'Alternatives to coercion in mental health care: WPA Position Statement and Call to Action', *World psychiatry: official journal of the World Psychiatric Association* (WPA), 21(1): 159–160. https://doi.org/10.1002/wps.20950

[16] Edan, V., Brophy, L., Weller, P. J., Fossey, E. & Meadows, G. (2019) 'The experience of the use of Community Treatment Orders following recovery-oriented practice training', *International Journal of Law and Psychiatry*, 64: 178-183. https://doi.org/10.1016/j.ijlp.2019.04.001

[17] Harvery, M., Harrington, R., Morgan, M., Yule, E. & Wright, S. (2025) 'Community Treatment Orders in Australia in the context of international literature: A narrative review of consumers, families, and health professionals' perspectives', *International Journal of Mental Health Nursing,* 34(3): e70061. https://doi.org/10.1111/inm.70061

[18] McMillan, J., Lawn, S. & Delany-Crowe, T. (2019) 'Trust and Community Treatment Orders', *Frontiers in Psychiatry*, 10(349). https://doi.org/10.3389/fpsyt.2019.00349

[19] Tenback, D., van Harten, P., Slooff, C. & van Os, J. (2010), 'Incidence and persistence of tardive dyskinesia and extrapyramidal symptoms in schizophrenia', *Journal of psychopharmacology*, 24(7): 1031-5. https://doi.org/10.1177/0269881109106306

[20] González-Pando, D., González-Menéndez, A., Aparicio-Basauri, V., Sanz de la Garza, C.L., Torracchi-Carrasco, J.E. & Pérez-Álvarez, M. (2021) 'Ethical Implications of Electroconvulsive Therapy: A Review', *Ethical Human Psychology and Psychiatry*, 23(1): 25-38. https://doi.org/10.1891/ehpp-d-21-00002

[21] Stroup, T. S. & Gray, N. (2018) 'Management of common adverse effects of antipsychotic medications', *World psychiatry : official journal of the World Psychiatric Association (WPA)*, 17(3): 341–356. https://doi.org/10.1002/wps.20567

[22] Kisely, S., Yu, D., Maehashi, S. & Siskind, D. (2021) 'A systematic review and meta-analysis of predictors and outcomes of community treatment orders in Australia and New Zealand', *Australian and New Zealand Journal of Psychiatry*, 55(7): 650–665. https://doi.org/10.1177/0004867420954286

[23] Australian Institute of Health and Welfare (2026*) Involuntary treatment: Figure Invol.4—Involuntary treatment proportions and population rates in Australian public mental health care by demographics, service setting and year*, AIHW. https://www.aihw.gov.au/mental-health/topic-areas/safety-quality/involuntary-treatment

[24] Victoria Legal Aid (2024) *Being believed, being heard: Stories of compulsory mental health treatment in Victoria*. https://www.legalaid.vic.gov.au/hearing-and-believing-people-lived-experience-compulsory-mental-health-treatment

[25] Department of Health (2023*) Independent review of compulsory treatment and decision-making laws*, Engage Victoria. https://engage.vic.gov.au/project/independent-review-of-compulsory-treatment-and-decision-making-laws/timeline/33460

[26] Mental Health Europe (2019) *Promising practices in prevention, reduction and elimination of coercion across Europe*. https://mhe-sme.org/wp-content/uploads/2019/01/Coercion-Report.pdf

[27] Gooding, P. & McSherry, B. (2018) 'Alternatives to Compulsory Detention and Treatment and Coercive Practices in Mental Health Settings', *Journal of law and medicine*, 26(2): 300–305. https://pubmed.ncbi.nlm.nih.gov/30574718/

[28] Gooding, P., McSherry, B., Roper, C. & Grey, F. (2018) 'Alternatives to coercion in mental health settings: A literature review', Melbourne Social Equity Institute, University of Melbourne. https://socialequity.unimelb.edu.au/news/latest/alternatives-to-coercion

[29] Gill, N., Drew, N., Rodrigues, M., Muhsen, H., Morales Cano, G., Savage, M., Pathare, S., Allan, J., Galderisi, S., Javed, A., Herrman, H. & Funk, M. (2024) 'Bringing together the World Health Organization's QualityRights initiative and the World Psychiatric Association's programme on implementing alternatives to coercion in mental healthcare: a common goal for action', *BJPsych open*, 10(1): e23. https://doi.org/10.1192/bjo.2023.622

[30] Gooding, P. (2015) 'Compulsory psych treatment in the home is ineffective, costly and violates human rights', *The Conversation*. https://theconversation.com/compulsory-psych-treatment-in-the-home-is-ineffective-costly-and-violates-human-rights-51257

Phone: (03) 9380 3900
Email: reception@vmiac.org.au
Office: Level 3, 80 Dorcas Street, Southbank, VIC, 3006

vmiac.org.au