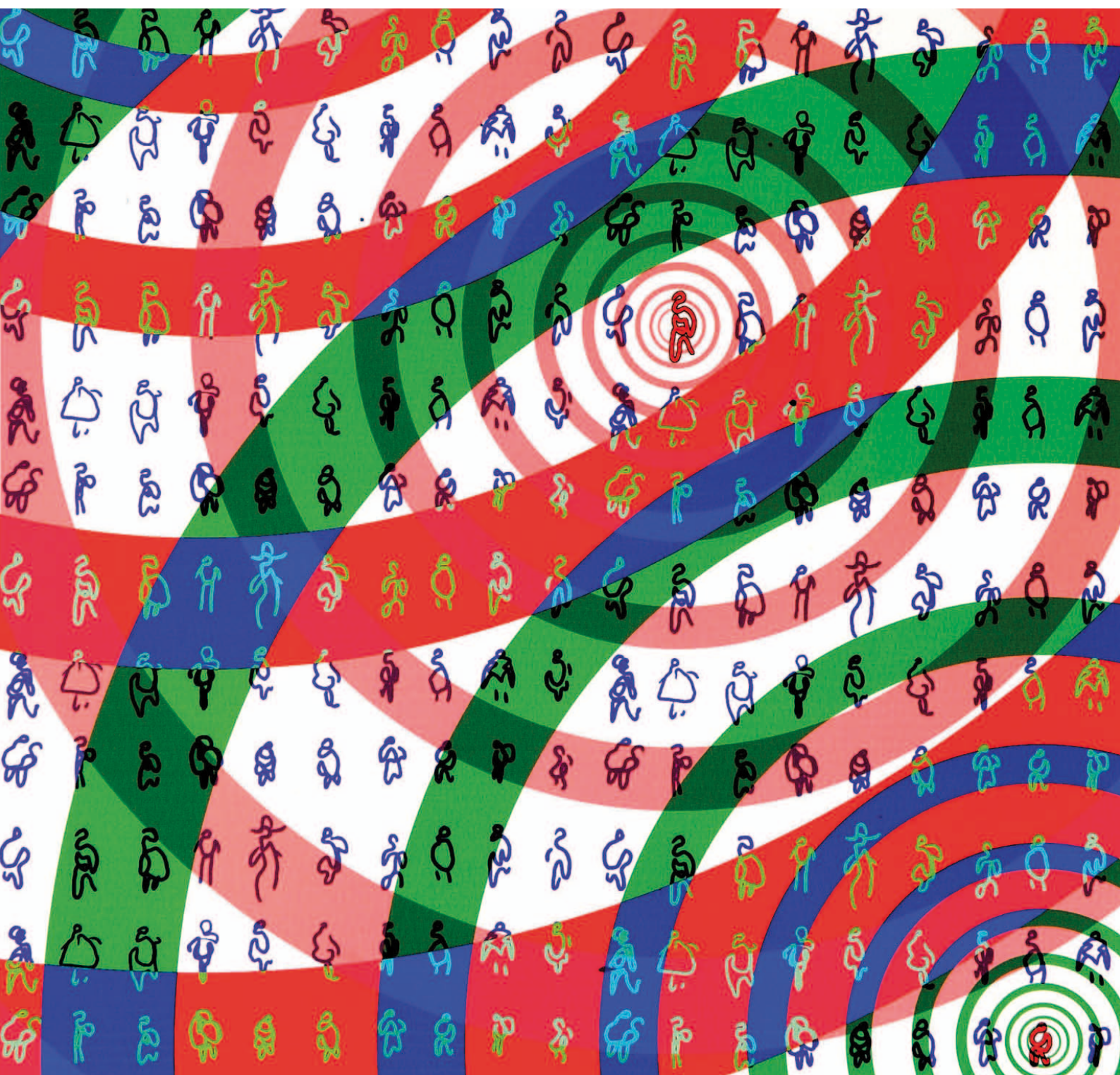


Review of the *Mental Health Act 1986*

Community consultation report – July 2009





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Cover artwork

Richard McLean, *3 People*, 1999, digital print, 33 x 48.4cm, from the series *Ego and Soul*.

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Richard McLean is a trained and exhibiting multimedia artist and mental health advocate. He has published two books about his experiences and work; *Recovered not Cured: a journey through schizophrenia* and *Ego and Soul*.

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Panel foreword

It is apparent from the extent of the community's eagerness to have a say in the review of Victoria's *Mental Health Act 1986* that there is a high level of interest in this complex piece of law.

The Mental Health Act raises questions about human rights and legal processes, and about society's responsibility for those who lack capacity to adequately care for themselves. It arouses passionate debate about how best to achieve a better state of health for people with a serious mental illness, as well as an enhanced capacity to enjoy the rights of citizenship. The intensity of the debate over the balancing of competing interests – those of the individual with an illness, their carers and families, health professionals, emergency service personnel and the community at large – was evident during the community consultation process.

The Community Consultation Panel, established by the Minister for Mental Health, the Hon Lisa Neville MP, was initially chaired by Mr Ben Bodna AM who very sadly passed away in October 2008. He had already undertaken a great deal of work on the review with his trademark passion and energy.

The panel facilitated community input in a number of ways. It attended a number of meetings of the Expert Advisory Group, which was established by the Minister to provide input to the drafting of a consultation paper. It met with a large number of organisations and groups that have a special interest in mental health. This occurred both before and after the issuing of the consultation paper. Following that paper's release in December 2008 the panel conducted 14 public forums each held over the greater part of a day in metropolitan and regional centres ranging from Ballarat to Bairnsdale.

Those attending the forums were able to put forward their ideas in small groups with facilitators, to write thoughts on 'graffiti' walls, to fill in workbooks, to speak to panel members and to listen to the reporting back from other small groups. In addition they were able – as were many others – to make written submissions to the review.

The report that follows seeks to reflect the substantial quantity of information and ideas received from people who have experienced mental illness. These include people who have experienced involuntary treatment, those who have cared for them, clinicians and health workers from the public and private sectors, lawyers and many others who are touched by mental illness. The report does not attempt to capture every thought but rather to reflect the breadth of views and where possible to indicate areas of consensus.

Two powerful themes were evident in the response from the community. They are the need to protect the human rights of people and the need to promote improvements in the health of those who experience serious mental illness.

These themes, of course, encapsulate the primary critical tension within the Mental Health Act. For the most part mental health laws, both in Australia and overseas, exist primarily to safeguard the rights of people who are treated without their consent. They recognise that when there are limitations on human rights then there must be added protections and checks on the provision of mental health services.

The review of the Act presents an opportunity to strengthen human rights by making explicit some underlying principles and by modernising the Act. The issues covered include involuntary detention and the provision of treatment, the external review of decisions, the use of restraint and seclusion and the administration of electroconvulsive therapy. These matters and others are dealt with in this report.



There is an underlying principle in health law that a person with the capacity to make decisions can consent to or refuse medical treatment. It is presumed that a person has capacity until that presumption is properly displaced. The Act can reinforce the presumption of capacity and recognise that incapacity is time and decision specific. Despite the imposition of an involuntary order, a person may still be able to make some decisions and participate in others, particularly with appropriate support. It follows that the new Act should recognise the importance of always seeking to ascertain a person's wishes and to give effect to them wherever possible.

Choice, to the extent that it can be exercised and provided for, is an important principle not only in promoting human rights but also in promoting recovery.

The second theme, that of promoting improved mental health, also presents challenges in balancing views. There is no disagreement about the goal of achieving good health as far as is possible, but the extent to which this goal can be legislated for is the subject of differing views among those consulted.

Clinicians generally argued it is inadvisable to legislate in a way that prescribes how clinical services should be delivered. Yet, those consulted mostly shared the view that better health outcomes are more likely to be achieved when a person participates in their treatment and care. Participation can be enhanced in the Act. This can be achieved, for example, by requiring a person's wishes to be taken into account – including by the recognition of advance statements – and by imposing requirements on treatment, care and recovery plans. In addition, better health outcomes can result by using effective complaints processes, clinical audits and codes of practice. These processes can help to drive service improvement.

The Community Consultation Panel has been very ably supported by the legislative review team within the Mental Health and Drugs Division of the Department of Human Services (the department). It is most appreciative of the work done by Ms Emma Montgomery and the members of her team.

The review has benefited greatly from those attending consultations and from the written submissions. The panel and the department's review team wish to thank all the people and organisations who participated in the consultation phase for their generosity in sharing their experience and expertise. In particular, the input from people who have experienced involuntary treatment and their carers who were able to attend forums was greatly appreciated. The information gathered at these forums as well as information provided in written submissions is really important.

Balancing rights that at times conflict is a complex and delicate task. We are firmly of the view that the contributions to the consultation phase of this review will lead to a more effective and modern legislative framework in which both rights and better mental health are promoted.

We present this report to the Minister for her consideration.

Julian Gardner

Dominique Saunders

Wayne Schwass

Abbreviations used in this report

consultation paper	<i>Review of the Mental Health Act 1986 Consultation paper – December 2008</i>
CTO	community treatment order
Disabilities Convention	<i>International Convention on the Rights of Persons with Disabilities</i>
ECT	electroconvulsive therapy
GP	general practitioner
PDRS services	psychiatric disability rehabilitation and support services
Sub	Submissions received in response to the <i>Review of the Mental Health Act 1986 Consultation paper – December 2008</i>
the Act	<i>Mental Health Act 1986</i>
the board	Mental Health Review Board
the Charter	<i>Victorian Charter of Human Rights and Responsibilities</i>
the department	Department of Human Services
the Minister	Minister for Mental Health
the panel	Community Consultation Panel
VCAT	Victorian Civil and Administrative Tribunal

Terminology used in this report

Debate continues about appropriate terminology to describe people who have a mental illness and are subject to involuntary orders, and their supporters. For the purposes of this paper, ‘carer’ is used to describe a person involved in the ongoing care or support of a person with mental illness.

Background to the review and consultation process to date

Introduction

Victoria's Minister for Mental Health announced this review of the *Mental Health Act 1986* in May 2008. The purpose of the review is to examine whether the Act provides an effective and contemporary legislative framework for the treatment and care of Victorians with a serious mental illness.

Community Consultation Panel

In June 2008 the panel was appointed to conduct the consultation phase of this review. The panel comprised Mr Ben Bodna AM, Ms Dominique Saunders and Mr Wayne Schwass. Sadly, Ben Bodna, the inaugural chair of the panel, passed away suddenly in October 2008. Mr Julian Gardner has since been appointed to chair the panel.

The panel led the public consultations and has prepared this report to advise the Minister of proposals for reform. The panel is supported by the Department of Human Services' legislation review team. The panel comprises the following people.



Mr Julian Gardner, Chair

Mr Gardner is a legal consultant specialising in human rights and social justice. He recently led a review of the *Equal Opportunity Act 1995* and was Victoria's Public Advocate from 2000 to 2007. Prior to that, Mr Gardner was president of the Mental Health Review Board.



Ms Dominique Saunders

Ms Saunders is Corporate Counsel at Western Health, sessional lawyer member of the Mental Health Review Board and a council member of the Law Institute of Victoria. Ms Saunders has previously worked as an advocate for mental health consumers and has a strong background in human rights law.



Mr Wayne Schwass

Mr Schwass' own personal experience with depression was the driving force behind him establishing The Sunrise Foundation of which he is the CEO. Mr Schwass played 282 VFL/AFL games for North Melbourne and the Sydney Swans between 1988 and 2002. He was a member of North Melbourne's 1995 pre-season premiership team and the 1996 AFL Centenary Premiership team.

Expert Advisory Group

In June 2008 the Expert Advisory Group was also appointed. The members of this group are Mr Julian Gardner (chair), Ms Lisa Brophy, Dr Thomas Callaly, Ms Isabell Collins, Dr Ian Freckleton SC, the Hon Jim Kennan SC, the Hon Rob Knowles, Mr John McGrath AM and Ms Vivienne Topp. The group's key task was to provide expert advice to inform the development of the *Review of the Mental Health Act 1986 Consultation paper – December 2008*.

Community consultation process

In December the consultation paper was released. Its purpose was to stimulate discussion, raise key issues and invite submissions. A shorter paper entitled *Review of the Mental Health Act 1986 some key questions – December 2008* was also released. This paper posed key questions for people to respond to in their submissions. A total of 4000 copies of the consultation papers were distributed to interested people and organisations. The consultation papers are available on the department's website at <www.health.vic.gov.au/mentalhealth/mhactreview>.

Following release of the consultation papers, the panel led 14 public forums in metropolitan Melbourne and regional Victoria, including two statewide forums for people with a mental illness and carers. In addition, the panel conducted a series of presentations and meetings with key stakeholders. The closing date for submissions was 27 February 2009. A total of 219 written submissions were received from a range of interested people and organisations. The submissions are also available on the department's website. Further information about the community consultation process can be found in the appendices to this report.

Purpose and structure of this report

Purpose

The purpose of this report is to outline the community's views about reform of the Act raised during public forums, consultations and written submissions, and provide the panel's commentary.

Structure

This paper is structured around the following sections:

- modernising the law
- minimising use of orders and restrictive interventions
- supporting patient participation and carer involvement
- monitoring and promoting patient care, wellbeing and rights
- improving responsiveness to specific needs.

Each section will discuss present challenges identified by the community, followed by an outline of the community's views about reform raised in public forums, consultations and written submissions. Each section concludes with the panel's commentary.



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1 Modernising the law



1. Modernising the law

Community consultations highlighted several broad ways in which the Act is significantly outdated and in need of substantive reform. This section will outline the community's views and the panel's commentary on proposed reforms to modernise the law. Issues addressed include:

- threshold issues
- human rights issues
- objects of the law and principles of treatment and care
- codes of practice.

The appropriateness of involuntary treatment is a fundamental issue for this review. Although community views are mixed, the majority of submissions identify the need for involuntary treatment, accompanied by robust safeguards to protect human rights.

Innumerable consumers have stated to the Victorian Mental Illness Awareness Council that if it were not for involuntary detention they would simply not be alive today and on that basis they support the provision in the Act. Others (far less in number) on the other hand believe involuntary detention should not be allowed to occur.

(Sub 35, Victorian Mental Illness Awareness Council, p.4)

Several submissions call upon the government to consider whether involuntary treatment is consistent with the *Charter of Human Rights and Responsibilities* (the Charter) and other human rights instruments.

During consultations the panel met with the President of the Victorian Civil and Administrative Tribunal (VCAT), the Honourable Justice Bell. Justice Bell informed the panel that he was about to deliver the first judicial decision in relation to the Charter and review of involuntary orders. The panel therefore took into account the decision in the matter of *Kracke v Mental Health Review Board & Ors (General)* [2009] VCAT 646 (the Kracke decision). Justice Bell states at paragraph 694:

The purposes of the Mental Health Act are to ensure mentally ill people who cannot or do not consent get medically necessary care, treatment and protection. Since the treatment will be involuntary, achieving that purpose will seriously interfere with the human rights of patients. Consistently with its purposes, the legislation attempts to protect those rights as far as possible. The purposes of the legislation are therefore to ensure that such treatment is given only, first, when medically necessary according to definite criteria and, second, subject to strict safeguards that protect the human rights of patients as far as possible.

In light of developments in human rights and mental health legislation in Australia and internationally, the overwhelming community view is that the rights protections in the current Act are insufficient. Many submissions state that human rights considerations should inform a complete overhaul of Victoria's approach to mental health.



A number of submissions question the appropriateness of retaining stand-alone mental health legislation. They argue for the introduction of generic legislation governing capacity and supported decision making across a range of contexts, including mental health.

Various submissions identify the need to modernise the Act to better promote voluntary treatment, assisted decision making, rights protections and carer involvement. In particular, there are significant concerns about the current predominantly substitute decision-making model of the Act that is based on a presumption that people with a mental illness are incapable of making their own decisions. It is suggested that the new Act should enable a person's wishes, beliefs and values to be taken into account wherever possible.

There is also concern that the current legislation is too focussed on acute care and requires a clearer recovery focus.

In addition, submissions state that the current legislation is unwieldy and difficult to read and that a new Act needs to be supported by codes of practice.

1.1 Threshold issues

Challenges identified by the community

Many threshold issues of significant importance for this review were identified during community consultations. Key issues include the:

- relevance and appropriateness of maintaining stand-alone mental health legislation
- lack of enforceability of the Act
- limitations of the current definition of mental illness
- need to improve recognition of the role of carers in the Act.

The consultation paper outlined the government's intention to maintain a scheme for involuntary treatment under separate mental health legislation. Several submissions argue that it is discriminatory to retain stand-alone mental health legislation. Some submissions comment on the need for further debate and analysis about the human rights limitations of continuing involuntary treatment.

In the context of growing worldwide recognition of the fundamental importance of human rights, it is becoming increasingly difficult to see how a stand-alone legislation authorising the involuntary treatment of persons living with a mental illness, notwithstanding that person's capacity to make decisions, can exist justifiably.

(Sub 195, Mental Health Legal Centre, pp.24–25)

There are criticisms about the lack of enforcement of the Act with one submission stating the current Act is viewed as a 'toothless tiger' (sub 140, confidential). The Ministerial Advisory Committee for Mental Health states that its most important issue is accountability within the mental health system. It states that: 'Accountability mechanisms within the Act are insufficient. The new Act must require accountability on the part of clinicians and mental health services through independent monitoring, clinical audits, and independent complaints handling' (sub 218, p.1).

In terms of the application of the legislation, a number of submissions, including from the Mental Illness Fellowship Victoria, discuss the need for a broader definition of mental illness (sub 167, p.9). There are also calls for the new Act to regulate the provision of treatment and care on a voluntary basis. This issue is considered later in this report.

Many carers submit they are often excluded from the treatment process. As one submission states, ‘the huge impact that decisions made by patients, doctors, etc, have on the lives of carers and on the broader community is largely ignored’ (sub 109, Pak, J, p.3).

Community views about reform

The following reforms were among those suggested:

- adopt generic capacity legislation rather than stand-alone mental health legislation
- limit involuntary treatment as a last resort
- recognise cultural conceptions of mental illness and broaden the definition of mental illness
- greater recognition of the role of carers.

It is suggested that, similar to recent developments in the Australian Capital Territory, Victoria should adopt generic capacity legislation, rather than maintain stand-alone mental health legislation.

A rights-oriented approach would create a more generic capacity-based legislation that does not discriminate between ‘mental’ and ‘physical’ illness [footnote omitted].

(Sub 195, Mental Health Legal Centre, p.26)

The submissions of the Law Institute of Victoria, Human Rights Law Resource Centre, Federation of Community Legal Centres, and Victorian Human Rights and Equal Opportunity Commission also raise this argument.

A number of submissions support retention of involuntary treatment, but only as a last resort and with stricter rules of application to protect people’s rights and autonomy. Involuntary orders are discussed in more detail later in this report.

It is suggested that the new Act should recognise cultural understandings of mental illness. For example, the Gippsland Community Legal Service supports placing the definition of mental illness within a social and cultural context: ‘For example in some cultures an extended period of mourning and exclusion from participation in social life is encouraged, after the death of a close relative.’ However, in the Legal Service’s experience this kind of behaviour has been used as grounds for an involuntary order (sub 166, p.2).

In addition, the Victorian Aboriginal Legal Service Cooperative argues ‘the unique conception of what Indigenous Australian communities consider constitutes mental health and wellbeing, as well as what is considered mental illness, must be recognised and incorporated into legislation that deals with decisions around the treatment of persons’ (sub 212, p.3).

A number of submissions seek a broader definition of mental illness that includes other conditions. According to the Mental Illness Fellowship Victoria the ‘present exclusion of persons with anti-social personality from the Act results in the exclusion of an entire category of people from care’ (sub 167, p.9).

Some suggest that the definition in the new Act should allow for people with borderline personality disorder to be placed on orders. This is because they ‘often find difficulty in gaining access to mental health services, even though, when in crisis, their condition clearly comes within the definition of mental illness given in the Act’ (sub 181, Mind, p.7).



A number of submissions raise the issue of dual diagnosis in relation to the definition of mental illness (for example, sub 181, Mind, pp.7–8; graffiti wall comment, Keysborough forum). The Victorian Dual Diagnosis Leadership Group is of the view that the current definition of mental illness should be retained. However, it recognises the need for increasing awareness of impulse control dual diagnosis disorders (sub 117, pp.6–7).

Other submissions, for example, from the Office of the Public Advocate, support a general broadening of the definition of mental illness (sub 192, p.21; sub 173, Rafferty, J, p.2).

However, a number of submissions seek retention of the current definition of mental illness (see, for example: sub 90, Monash University, p.17; sub 146, Health and Community Services Union, pp.7–8; sub 198, Forensicare, p.5; sub 71, Peter James Centre, p.2).

Various groups assert that the role of carers needs to be recognised explicitly in the new Act in a range of different contexts, including during assessment, treatment decisions, and at external review hearings. For example, beyondblue supports the need for the new Act to formally recognise the role of families and carers (sub 180, p.3). Similarly, ARAFEMI, a peak support agency for carers of people with a mental illness, believes carer needs should be better addressed in the new Act, suggesting this could be done through introducing separate carer assessments at admission (sub 186, pp.4–5).

Often carers observe and are told things by the patient that the doctors don't know about, but can help with the treatment and diagnosis of the condition. Carers opinions and questions should be acknowledged and respected.

(Workbook comment, sent via mail)

The carers need to be included, as they have the long term knowledge of the client, and need to live with the consequences, although they have no input into the decision making.

(Workbook comment, Ringwood forum)

In contrast, various submissions suggest that carers and families can sometimes exacerbate the situation.

It was my family making stupid complaints about me that landed me in the psychiatric ward.

(Sub 31, confidential)

Information sharing with carers and families is considered elsewhere in this report.

Panel's commentary

A number of fundamental issues have been raised by the community in relation to the Act and how it should be reformed. One particular issue is the appropriateness of maintaining stand-alone mental health legislation, with a number of submissions proposing generic capacity legislation instead. Although we see merit in generic capacity legislation, this issue is outside our terms of reference.

We also note community support for improved accountability under the new Act. A range of areas are identified in this report to improve compliance with the new Act. These include: enhanced complaints and monitoring functions; enhanced appeal and review processes (as well as appropriate support for people undertaking these processes); provisions for codes of practice that can be taken into account by courts and tribunals; and increased use of clinical audits.

The community has also emphasised limitations in the scope of the current Act, particularly in relation to the role of carers, the Act's definition of 'mental illness', and its silence in relation to cultural conceptions of mental illness.

Carers play an important role in the treatment and care of people with a mental illness. Recognising carers formally in the new Act would be in line with the government's mental health strategy, *Because mental health matters*. Later in this report we discuss a potential requirement for critical information to be shared with carers in particular circumstances.

The definition of mental illness involves clinical considerations and we believe expert advice is needed about an appropriate definition that would reflect the intended scope of the new Act.

Later in this report we identify the issues raised by the community in relation to the specific needs of cultural groups.

1.2 Human rights issues

Currently the Act contains safeguards designed to protect the rights of people subject to involuntary orders. These include: criteria limiting who can be subject to an involuntary order; requirements for the provision of rights statements and treatment plans; regulation and licensing of ECT; regulation of restraint and seclusion; and external review requirements.

Challenges identified by the community

The community raised a number of issues in relation to human rights. These include:

- the Act is outdated in its rights protections
- whether involuntary treatment is consistent with the Charter and the Disabilities Convention
- the need to ensure that limitations on rights are justified in accordance with the Charter and the Disabilities Convention.

Because the Act has not been comprehensively reviewed for two decades, the overwhelming community view is that it is outdated in its rights protections. A number of submissions note that the introduction of the Victorian Charter and Disabilities Convention has significantly altered the human rights landscape.

The review of this Act and its radical reform to a human rights framework is well overdue.

(Sub 116, Hall-Bentick, F, p.2)

The Victorian Equal Opportunity & Human Rights Commission describes this review as one of the most important in Victoria in recent years and a unique opportunity to address serious human rights issues in mental health treatment and care (sub 115, p.2).

Victoria's current Mental Health Act ... represents the most serious intrusion upon an individual's Charter rights of any legislation in the state. There are numerous limitations of Charter rights in the [Act] but the most serious is that it gives legal sanction to medical treatment without consent ...

(Sub 161, Webb, Dr D, p.1)



Bearing in mind the Charter and the Convention, the government must rigorously consider the threshold issue of whether the existence of involuntary treatment is consistent with human rights.

(Sub 195, Mental Health Legal Centre, p.44)

In relation to limitations on rights, Justice Bell in the Kracke decision, states at paragraph 27:

... the interests of people and groups living in society sometimes conflict and must sometimes be balanced. Therefore, in certain cases, human rights may need to be limited. That is why, under the Charter, human rights are not seen to be absolute. But they can only be limited according to a stringent standard of justification.

Limitations can only be imposed under law, must be reasonable and demonstrably justified, and go only so far as is necessary in the interest of a free and democratic society that respects the dignity of the individuals who make it up [footnote omitted].

Community views about reform

There is overwhelming support for improving the rights safeguards in the new Act. Community views about reform are addressed throughout this report.

The Victorian Equal Opportunity & Human Rights Commission argues that a revised Act, consistent with human rights principles, will result in mental health law and practice that leads in its vision, its legal coherence and in its humanity (sub 115, p.2).

A number of submissions believe the new Act must be underpinned by principles of autonomy (sub 115, Victorian Equal Opportunity & Human Rights Commission, p.26). Further, section 10(c) of the Charter protects the right to be free from medical treatment without full, free and informed consent. In this context, Justice Bell in the Kracke decision emphasises the importance of personal autonomy. He states at paragraph 570:

The right is especially important in the context of treating someone for mental illness. People can be extremely sensitive about taking the powerful drugs that are often prescribed. However medically necessary they may be, the drugs can cause alterations to mood, behaviour and body weight, as well as personal appearance, which can be very distressing ... such drugs can affect the very 'reality' in which a person lives. Section 10(c) of the Charter recognises the importance of this right to refuse, because it respects the personal dignity and autonomy of people with mental illness.

Liberty Victoria notes that any involuntary treatment regime must respect the human rights of people with mental illness. According to Liberty Victoria, this 'requires, at a minimum, that people with mental illness are presumed to have legal capacity unless it can clearly be demonstrated that they are incapable of providing informed consent to their treatment or care' (sub 163, p.2).

Section 10 of the Charter on 'Protection from torture and cruel, inhuman or degrading treatment' makes clear that a person must not be subjected to medical treatment without his or her full, free and informed consent. It is significant that this right is stated in this section of the Charter as freedom from torture is considered one of the few inviolable or 'non-derogable' human rights. At the very least, medical treatment without consent must be considered one of the most serious Charter rights that should not be limited lightly.

(Sub 161, Webb, Dr D, p.1)

A key issue raised by many submissions is whether retention of a regime of involuntary detention and treatment is compatible with the human rights engaged by the Charter. A number of submissions discuss this issue, including the circumstances in which reasonable limits may be placed on a human right.

A human right may be subject under law only to such reasonable limits as can be demonstrably justified in a free and democratic society based on human dignity, equality and freedom and taking into account all relevant factors.

Section 7(2) of the Charter sets out the following inclusive list of these relevant factors:

- (a) the nature of the right;*
- (b) the importance of the purpose of the limitation;*
- (c) the nature and extent of the limitation;*
- (d) the relationship between the limitation and its purpose; and*
- (e) whether there is any less restrictive means reasonably available to achieve the purpose that the limitation seeks to achieve (footnotes omitted).*

(Sub 5, Human Rights Law Resource Centre, pp.9 -10)

The Victorian Equal Opportunity & Human Rights Commission notes a failure to ensure that proper safeguards are put in place when a person receives involuntary treatment for mental illness engages rights under the Charter and under the Disabilities Convention (sub 115, p.22).

Panel's commentary

There is a community view that the Act is outdated in its rights protections.

In considering this view it is helpful to refer to the Honourable Justice Bell who recently summarised the many Charter rights engaged by involuntary orders in the Kracke decision at paragraph 741:

In summary:

- *making an involuntary treatment order engages the patient's rights to freedom from medical treatment without their full, free and informed consent (s 10(c)), to freedom of movement (s 12), to privacy (s 13(a)) and the various aspects of the right to liberty in (s 21(1), (2) and (3))*
- *making a community treatment order engages a patient's rights to freedom from medical treatment without their full, free and informed consent (s 10(c)), to freedom of movement (s 12) and to privacy (s13(a))*
- *reviewing (or failing to review) an involuntary or community treatment order engages the same rights as making an involuntary treatment order.*

Limitations on human rights brought about by mental health legislation should be proportionate and include effective safeguards. This is illustrated by the statement of Justice Bell in the Kracke decision, at paragraph 709:

Because treatment orders authorise giving involuntary medical treatment, they necessarily involve serious human rights breaches. The medical authorities and others involved in making orders and giving treatment are therefore in an extremely powerful position. The patients are in a very vulnerable position.



The Charter and Disabilities Convention provide a clear impetus and framework to improve the rights safeguards in the new Act. We note that the government will need to prepare a statement of compatibility with the Charter when the new Act is introduced into Parliament. A number of the potential reforms discussed throughout this report are aimed at improving human rights protections in the new Act. Some of these are:

- strengthening the rights-based approach in the objects and principles of treatment and care in the new Act
- encouraging voluntary treatment wherever possible
- changes to the criteria for involuntary orders
- a new guiding principle that reflects a presumption of capacity for people with a mental illness and enhanced requirements in relation to obtaining informed consent to treatment (reforms such as advance statements and a nominated person scheme are required to support the presumption of capacity)
- a staged orders scheme and a more robust external review system including second psychiatric opinions
- improved protections on the use of restrictive interventions including all forms of restraint and seclusion
- enhanced safeguards on the performance of ECT
- improved information sharing provisions to protect patient privacy and enhance co-ordinated care
- enhanced monitoring and complaints mechanisms
- improved recognition for people with specific needs.

1.3 Objects of the law and the principles of treatment and care

Currently the stated objects of the Act include the provision of care, treatment and protection of people who have a mental illness who do not or cannot consent to that care, treatment or protection. The Act also contains a set of principles to guide the provision of treatment and care. In summary, the principles focus on the provision of: timely and high quality treatment and care; treatment in the community and near a person's home and family wherever possible; promotion of self-reliance; responsiveness to specific needs and best health needs; multidisciplinary treatment and care by appropriately qualified professionals; and inclusive treatment planning.

Challenges identified by the community

A number of submissions note that the Act's objects and principles are outdated and have not kept step with developments in human rights or treatment and care.

The [Act] is more than 20 years old and reflects an outdated and inappropriate approach to the care and treatment of people with mental illness.

(Sub 155, Human Rights Law Resource Centre, p.2)

Since the introduction of the [Act] there have been numerous changes in the functioning of the public mental health system, in treatment paradigms and in our understanding of what constitutes best practice. These changes include the development of a recovery perspective, a focus on human rights issues and an increasing recognition of the importance of carers to consumers' lives and well-being. It is imperative that the new Act reflects these developments in order to provide a legislative framework that is genuinely responsive to the current needs of consumers, carers and service providers alike.

(Sub 105, Victorian Mental Health Carer's Network, p.1)

Community views about reform

Views expressed during community consultations identified support for modernising the objects and principles. This review was identified as an opportunity to address the tension between rights and risks inherent in mental health and similar legislation that governs the care of the disempowered (workbook comment, Benalla forum).

Liberty Victoria suggests that the objects in the Act should explicitly recognise the principles set out in Article 3 of the Disabilities Convention, namely:

- (a) Respect for inherent dignity, individual autonomy including the freedom to make one's own choices, and independence of persons;*
- (b) Non-discrimination;*
- (c) Full and effective participation and inclusion in society;*
- (d) Respect for difference and acceptance of persons with disabilities as part of human diversity and humanity;*
- (e) Equality of opportunity;*
- (f) Accessibility;*
- (g) Equality between men and women;*
- (h) Respect for the evolving capacities of children with disabilities and respect for the right of children with disabilities to preserve their identities.*

(Sub 163, Liberty Victoria, p.3)

Victoria Legal Aid suggests that the principles of the new Act should require that a person's views, wishes, beliefs and values should be taken into account wherever possible. It also suggests that the new Act should better promote voluntary treatment, rights protections and carer involvement (sub 145, pp.4-5). Many submissions, including those from ARAFEMI and the Office of the Public Advocate, make similar suggestions (see sub 186, pp.1-5; sub 192, pp.2-3). These issues are addressed throughout this report.

There is support for the new Act to focus on recovery. Participants at the Ringwood forum saw recovery as a vital aim of the legislation, encompassing the concepts of wellbeing, empowerment and control over your life, social rehabilitation, social inclusion, and social normality (workbook comment, Ringwood forum). The Mental Illness Fellowship Victoria believes the 'Act's role in supporting and promoting recovery from mental illness, can be significantly strengthened through a widening of its focus to include attention to the social dimensions of people's lives' (sub 167, p.9).



Several submissions suggest that recovery should be defined in the new Act and there are numerous perspectives on how best to express this. For example, the Mental Health Legal Centre suggests that ‘recovery’ must be understood as regaining a sense of self, rather than from a clinical perspective (sub 195, pp.22–23). According to the Ministerial Advisory Committee on Mental Health, ‘[i]t should be recognised that consumers are experts in their own recovery’ (sub 218, p.1). Mental Health At Work submits that the definition of recovery in the new Act needs to be broadened to include the idea that recovery is a journey or a process, requiring a system of services that incorporates analysis, resourcing and rehabilitation (sub 135, p.4).

Another view is that recovery should be defined to ‘reflect the many ways that a person with a mental illness manages his or her disability in the process of reclaiming his or her life in the community.’ Several submissions also suggest that recovery should be included as one of the principles of the new Act to ensure recovery oriented services are provided (for example, sub 197, Inner South Community Health Centre p.2).

Key principles of Recovery used by [the Inner South Community Health Service] include:

- *Belonging and Acceptance by others*
- *Hope and Commitment*
- *Involvement in Meaningful Activity*
- *Redefining Self; (Incorporating illness as only one aspect of a multidimensional self).*
- *Overcoming Stigma*
- *Finding ways of Managing Symptoms*
- *Assuming Control*
- *Experiencing Success and Pleasure Reciprocity. Giving back to and regaining citizenship in broader community.*

(Sub 197, Inner South Community Health Service, pp.2–3)

A number of submissions suggest that the new Act should focus on early intervention. For example, Neami, a community psychosocial health and rehabilitation provider, acknowledges the Act was developed to manage acute care and treatment. However, it submits that a clearer articulation of the important role of earlier intervention services in managing and responding to mental illness is required (sub 52, p.2). Victoria Police believes an additional objective of the legislative reform should be to strengthen the capacity for early intervention (sub 217, p.2).

When possible, people suffering with acute psychosis and their families and carers, usually prefer early community treatment in the context of a comprehensive management plan, rather than involuntary inpatient treatment.

(Sub 15, confidential)

In this context various submissions discuss the benefit of including a right to treatment in the Act. The Victorian Mental Health Carer’s Network notes that a consistent problem with the public mental health system is limited access to appropriate treatment before crises occur. ‘It seems that the only rights consumers currently have with respect to treatment come into force by virtue of their involuntary status, far too late’ (sub 105, p.6).

All parties agree that early (voluntary) treatment and intervention benefits everyone – whether carer, consumer or service provider – and that there is a need to reduce involuntary treatment wherever possible. The legislation as it currently stands, however, fails to recognize early treatment of mental illness as a right, and fails to mandate the provision of pre-crisis treatment and care as one of the responsibilities of service providers.

(Sub 105, Victorian Mental Health Carer’s Network, pp.6–7)

Similarly, one submission argues the new Act must provide far greater impetus for the provision of services and rapid access to modes of treatment that are palatable to the person and to which the person may be more likely to consent (sub 142, Hamilton, Dr B, p.2).

The Victorian Equal Opportunity & Human Rights Commission points out that a large number of people with mental illness wish to access mental health services in Victoria, but cannot do so due to a lack of resources in the service system. According to the commission, this has implications for whether involuntary orders can truly be an option of last resort. The commission suggests that a ‘lack of access to mental health services is inconsistent with human rights and requires redress’ (sub 115, p.5).

ARAFEMI advises families are regularly told that ‘no service’ is available to them for a number of reasons. These include lack of beds, or that the person in question is not sick enough. According to ARAFEMI this results in the person being discharged to the community, which too often leads to the need for crisis intervention. ‘Upholding the right to treatment extends beyond the current Act, and to resources that are central to successfully implementing a new mental health Act based on the right to treatment’ (sub 186, p.3).

Panel’s commentary

Consultations supported changes to the objects and principles of the new Act so they include the promotion of voluntary treatment wherever possible, assisted decision making, and improved rights protections.

We see great value in the recognition of autonomy. It would be desirable for the new Act to be consistent with general health law where it is presumed that a person has capacity until that presumption is displaced. To this end, the new Act could reinforce the presumption of capacity and recognise that capacity is time and decision specific. Despite the imposition of an involuntary order, a person may still be able to make some decisions and participate in others, particularly with appropriate support. The new Act could reflect this position by emphasising the need to give effect to a person’s wishes wherever possible.

As we have already mentioned, the new Act should also formally recognise the important role of carers.

The panel believes the policy of early intervention has merit. However, it gives rise to the potential for conflict between the right to autonomy and the promotion of health. It is hoped that an assessment period that allows for intervention without necessarily requiring an involuntary order would, in part, satisfy these two potentially conflicting objectives.

We support the suggestion that the objects in the new Act explicitly recognise the principles set out in Article 3 of the Disabilities Convention. Further, the principles of treatment and care in the Scottish mental health legislation have merit and could be considered when framing principles of treatment and care for the new Act. In particular, we note the Scottish principles requiring reciprocity and beneficial treatment.



The principle of reciprocity means, where a person is required to comply with an order, there should be a parallel obligation on the mental health service to provide safe and appropriate services, including ongoing care following discharge from involuntary status. Under the principle of beneficial treatment any intervention must be likely to produce a benefit for the person that cannot reasonably be achieved other than by the use of the intervention.

For any principles to be effective they must be embedded in the protections throughout the new Act.

There is support for a recovery focus in the new Act and such a change would be consistent with contemporary approaches to mental health. However, we note that the task of translating the concept of recovery into a workable and practical definition will require careful consideration.

1.4 Codes of practice

Currently the Act does not provide for codes of practice. A code of practice is a document that provides practical guidance about how to understand and apply the law. Typically, a breach of a code of practice does not give rise to a legal right of action. However, a code may be referred to by a court or tribunal when determining matters arising under the legislation, including breaches.

Challenges identified by the community

Key issues identified in submissions and consultations include:

- the Act is often difficult to understand
- the need for practical guidance about the application of the Act
- the need to improve compliance with the Act.

Views expressed during community consultations highlighted significant problems in the operation of the current legislation due to shortcomings in understanding of the Act among some involved in its use. Participants at the Keysborough forum noted that ‘most people, including carers, don’t know there’s a relevant Act let alone what’s in it’ (workbook comment). Further, a number of submissions note that the Act is ‘unwieldy’ and ‘unreadable’ (see, for example: sub 90, Monash University, p.3).

Community views about reform

There is broad support for the new Act to include a power that enables the making of codes of practice. A participant at the Bendigo forum also suggested a plain-English guide to the Act (graffiti wall comment, Bendigo forum).

A number of submissions, including from health professionals, note the practical benefits of codes of practice. The Inner South Community Health Centre submits that codes would provide advice on how to achieve the objects and principles in the Act (sub 197, p.4). The Victorian Branch of the Australian Nursing Federation believes codes of practice are more dynamic than legislation. It argues codes would ensure more effective education and professional development (sub 51, p.14).

It is suggested that codes of practice should be developed in consultation with people who have been subject to involuntary orders and multidisciplinary professionals (workbook comment, Ringwood forum).

Panel's commentary

Various submissions identify the potential benefits of codes of practice. Codes could assist those who deal with the new Act, or who are subject to it, to understand its provisions as well as helping to facilitate compliance. Codes can also ensure more effective education and professional development in respect of the new Act.

Codes of practice also tend to be more dynamic than legislation, which is time-consuming to amend. It is far easier to amend codes of practice, for example, to reflect changes in best practice, than it is to amend legislation.

A number of practical issues would need to be addressed if codes of practice were introduced and these could be specified in the new Act, for example, the process to develop and issue codes of practice, their application and effect.

It is important to note the distinction between codes of practice and clinical practice guidelines. Codes of practice are intended to focus on the actions necessary to comply with the law. As stated above, a code may be referred to by a court or tribunal when determining matters arising under the legislation, including breaches. In contrast, clinical practice guidelines are intended to provide specialist advice in relation to medications and other clinical practice issues. Any codes of practice should be developed in consultation with a wide range of people, including professionals and those who have been subject to involuntary orders.





2 Minimising use of orders and restrictive interventions



2. Minimising use of orders and restrictive interventions

This section will outline the community's views and the panel's commentary on proposed reforms to minimise the use of orders and restrictive interventions. Issues addressed include:

- assessment period
- criteria for orders
- use of community treatment orders (CTOs)
- staged orders and external review
- restraint and seclusion.

The Act contains some safeguards designed to minimise the use of orders and restrictive interventions. These include: criteria for placing a person on an involuntary order; requirements for external review of involuntary orders within eight weeks after they are made and annually thereafter; and criteria for the use of mechanical restraint and seclusion.

Community consultations have highlighted that these requirements do not sufficiently limit the use of orders and restrictive interventions. A number of submissions argue there are inconsistencies between the current Act and human rights obligations in the Charter and the Disabilities Convention in this context.

There are criticisms of the current criteria for orders in the Act. In particular, many submissions criticise the criterion allowing a person who refuses treatment to be placed on an order.

Some believe the current orders are stigmatising. There are also major concerns regarding the duration and infrequent external review of orders, as well as the review process itself.

There is widespread support for the establishment of a staged orders scheme with involuntary orders of shorter duration with a fixed expiry date and more frequent external reviews.

Overall, submissions support the need for the new Act to require that treatment be provided in the least restrictive manner possible, including by limiting the use of involuntary orders and restraint and seclusion as a last resort.

2.1 Assessment period

The Act contains five criteria that must be met before a person can be placed on an involuntary order, including that the person 'appears to be mentally ill'. These criteria are considered in the next section of this report.

Any person made subject to an involuntary order must be examined by an authorised psychiatrist within 24 hours. The authorised psychiatrist must decide whether the person meets the criteria for involuntary orders under the Act, and must accordingly discharge or confirm the order.

Under many other mental health laws a person must have a diagnosis of mental illness (rather than the appearance of mental illness) to be placed on an involuntary order. Where it is unclear whether a person has a mental illness, many other jurisdictions provide a formal assessment period to enable more time for assessment.

Currently the Act does not provide for an assessment period because the appearance of a mental illness is sufficient for the purpose of an involuntary order.



Challenges identified by the community

A number of issues were raised by the community in relation to assessment and diagnosis.

- There is a view that ‘to appear to be mentally ill’ is not sufficient justification for an involuntary order.
- The processes in the current Act are inadequate to enable a thorough assessment to occur.

Various submissions argue that it is not appropriate to make a person subject to an involuntary order if he or she merely ‘appears to be mentally ill’ (see, for example: sub 195, Mental Health Legal Centre p.47; sub 35, The Victorian Mental Illness Awareness Council, p.5).

There is also concern that the Act does not adequately facilitate a thorough assessment because assessments must occur within 24 hours of admission (sub 133, confidential). In addition, submissions and forum participants note the need to de-stigmatise the process for persons with the ‘appearance of mental illness’ (workbook comment, Ringwood forum).

Community views about reform

The community consultations supported changes to the criteria for involuntary orders to require a diagnosis of a mental illness rather than only the appearance of a mental illness. There is also support for establishing an assessment period. An assessment period would allow time for a thorough assessment and diagnosis of a person who appears to be mentally ill but has not been diagnosed as having a mental illness for the purposes of making an involuntary order.

Introduction of assessment orders prior to involuntary treatment orders would be a welcome innovation, creating greater safeguards to people’s rights and allowing more time for thorough assessment.

(Workbook comment, Warrnambool forum)

It is recognised that an assessment period will limit the period for which a person can be detained without a diagnosis of mental illness. The Alfred Psychiatry, Alfred Health advises that separating involuntary orders into assessment and treatment stages with defined criteria would be a welcome development for practitioners in the field (sub 194, pp.4–5). Monash University submits that mental health assessments should also be able to be undertaken in the community where this is appropriate (sub 90, p.15).

Two models have been suggested for an assessment period. The first model would allow only people who do not have a clear diagnosis of mental illness to undergo an assessment period. The second model would require that all people be made subject to an assessment period prior to being placed on an involuntary order.

There are various views about the optimal length of an assessment period. Several participants at forums suggested a duration for an assessment period of two or three days (for example, workbook comment, Benalla forum).

Various submissions discuss whether treatment should be given during an assessment period. For example, Zimmerman acknowledges that drug-free assessment is ideal but suggests ‘it would be inhumane and dangerous to the patient, other patients and staff to deny any treatment to all patients in an assessment phase’. Zimmerman believes clinical judgment is required and that the new Act should permit this (sub 28, p.2). Austin Health supports a restriction on the use of long-acting injectable treatments during this period of time but not on the use of short-acting injectables such as acuphase and olanzapine. Austin Health submits that all other treatments should be allowed (sub 63, p.2).

Some submissions suggest there should be a requirement for a multidisciplinary assessment. Jekel believes there should be a right ‘to a full physical examination by a qualified medical practitioner who can determine whether an underlying and untreated physical condition is causing the mental state or emotional symptoms.’ Jekel is also of the view that no involuntary order should be made without this physical examination (sub 82, p.6). Similarly, the Mental Illness Fellowship Victoria sees the benefit of assessment orders and also favours inclusion of multidisciplinary opinions such as the person’s local general practitioner or the observations of a carer or family member (sub 167, pp.9–10).

A small number of people are not supportive of an assessment period due to the perceived administrative burden.

Assessment orders may increase paperwork and could be [an] additional responsibility without necessarily being useful.

(Workbook comment, Ringwood forum)

The Health Services Commissioner is concerned that assessment orders should not be allowed to unnecessarily delay treatment.

People suffering psychotic episodes can be extraordinarily distressed and desperately in need of urgent treatment. To delay this is inconsistent with human rights considerations.

(Sub 205, p.3)

Panel’s commentary

As outlined above, various submissions indicated that the criteria for involuntary orders should be changed so that a diagnosis of mental illness is required (rather than the current requirement that the person ‘appears to be mentally ill’). The establishment of an assessment period to underpin this change to the criteria for involuntary orders also received community support.

An assessment period could facilitate a detailed assessment for people who do not have a diagnosis of mental illness, and at the same time provide better responses to people in crisis or with complex presentations (including opportunities for early intervention). The aim of the assessment would be to promote better health care by determining: a person’s health care needs; whether an involuntary order is necessary to meet those needs; and whether the person meets the criteria for involuntary orders in the new Act.

Placing a limitation on the period that a person can be assessed without a diagnosis will better ensure that involuntary treatment is reasonably justified, as required by the Charter. Further safeguards could include a right to appeal and a requirement that a nominated person be notified.

We also note community support for multidisciplinary assessment. This is something that could possibly be outlined in codes of practice, as described earlier in this report.

Community opinion varied regarding the duration of an assessment period and whether or not treatment during this period should be permitted. It would seem that restricting the period of an assessment to 72 hours would help to ensure that the limitations on the person’s human rights are proportionate and reasonably justified.



The new Act could deal with the issue of whether treatment is provided during an assessment period in a number of ways. It would seem preferable that the new Act aligns with the emergency treatment provisions that apply in other areas of health, which are defined in section 42A(1)(c) of the *Guardianship and Administration Act 1986*. This provision allows the treatment of a person (without their consent) where necessary as a matter of urgency to prevent them from suffering or continuing to suffer significant pain or distress or to save the person's life or to prevent serious damage to the person's health.

2.2 Criteria for orders

The Act limits who can be treated involuntarily by defining 'mental illness' and establishing five criteria that must all be met before a person can be placed on an order. In summary the criteria allow for involuntary treatment in cases where: a person appears to be mentally ill; a person requires immediate treatment; treatment is necessary for health or safety (whether to prevent a deterioration or otherwise) or for the protection of the public; a person has refused or is unable to consent; and there is no adequate less restrictive treatment available.

Challenges identified by the community

Key issues raised by the community in relation to the criteria for orders are:

- there is potential inconsistency with the Charter and Disabilities Convention
- they are too widely and poorly defined
- they are inconsistent with other areas of health where people can refuse medical treatment
- there should be distinct criteria for CTOs.

A number of submissions, including from carers and those seeking early intervention, expressed concern that it was too difficult to obtain an order.

Waiting for this criteria for treatment can take months or years and in the meantime the sufferer is more and more degraded and robbed of his chances of recovery. His future withers and dies in front of the people who love and care for him.

(Sub 73, confidential)

More commonly, however, there were expressions of concern about it being 'too easy' for a person to be placed on an order under the Act.

...what is not in contention among consumers is that the Act in its current form allows services to far too readily make a person involuntary without the necessary holistic, objective and factual information and assessment required to support them.

(Sub 35, Victorian Mental Illness Awareness Council, p.4)

The Victorian Equal Opportunity & Human Rights Commission notes that allowing a person who has refused treatment to be placed on an order may not be consistent with the Charter (sub 115, p.20). The commission cites an argument raised by commentator Tina Minkowitz that non-consensual psychiatric and medical interventions could be viewed as torture, or cruel, inhuman or degrading treatment under the Disabilities Convention (sub 115, p.8).

As discussed earlier in this report, section 10 of the Charter requires that medical treatment only occur with full, free and informed consent. The Human Rights Law Resource Centre argues that international standards state where consent is refused by a person with capacity, treatment may nonetheless be administered without consent only where refusal is unreasonable (sub 5, p.26).

Several submissions argue the current criteria for an involuntary order are too widely defined or ill-defined. For example, the Victorian Aboriginal Legal Service submits that ‘protection’ of members of the public is very vague and does not indicate what members of the public are to be protected, and what they are to be protected from (sub 212, p.13).

The Mental Health Legal Centre believes ‘it may be considered unjustifiably pre-emptive to make a person subject to involuntary treatment where there is only an anticipated risk of harm, particularly where there may be problems with accurately predicting behaviour’ (sub 195, p.45).

Many point to the inconsistency with other areas of health, where people can refuse medical treatment.

The key argument used (when overriding both the right to freedom and the right to refuse treatment) is that the person is unable, due to impairment, to consent to something. The implication is that the person would consent to if they were fit, or were unimpaired at the time. But we know that people do refuse medical treatment everyday across all specialist fields, while considered fully fit to consent.

(Sub 142, Hamilton, Dr B, p.2)

Community views about reform of the consent criteria

Issues include:

- treatment should be voluntary wherever possible
- involuntary orders should only be available as a last resort
- people with capacity should have the right to refuse mental health treatment
- the criteria should focus on a person’s ability to make an informed decision rather than the fact of refusal
- the Scottish criteria for involuntary orders should be adopted. These include: that a person’s ability to make decisions about treatment is significantly impaired by their mental illness.

Many submissions emphasise that treatment on a voluntary basis must be paramount and that involuntary orders should only be used as a last resort.

... involuntary orders must over emphasise the need for informed and voluntary consent, the need to uphold the patient’s belief and autonomy, and must only be used as a last resort.

(Workbook comment, Traralgon forum)

Involuntary treatment should only be used as a last resort.

(Sub 23, Mortimer, S, p.5)



The key guiding principle of bodily integrity cannot be overstated. The new act should remedy the current situation where thousands live in justified fear of permanent damage from drugs forced into their body against their will.

(Sub 24, Odowd, B, p.2)

The prevailing view is that ability or capacity to consent should be considered, rather than refusal. For example, NorthWestern Mental Health's internal consultation supported the view that 'willingness to consent should not be considered, only capacity to consent' (sub 182, p.4).

The refusal of treatment implies that the person has the capacity to make that refusal. This is an area of significant debate as refusal of treatment may appear to be a rational response. Practitioners may be assisted by a definition that relates to a person's capacity to make an informed decision rather than to the fact of refusal.

(Sub 146, Health and Community Services Union, p.10)

The Law Institute of Victoria suggests that refusal of treatment by a person with the ability or capacity to consent to treatment should only be overridden by the board (sub 92, p.13).

The Victorian Equal Opportunity & Human Rights Commission believes human rights principles provide the necessary legal framework to eliminate arbitrariness and unreasonableness in clinical decision making. It states:

These human rights principles include taking measures to promote the autonomy of the person subject to involuntary treatment and ensuring that the treatment is subject to strict safeguards. They also include ensuring that any limit on the person's right to privacy and right to liberty and security of person (ie the general right to be free from medical treatment without consent) is imposed in a least restrictive manner.

(Sub 115, p.6)

The Victorian Mental Health Carer's Network believes 'in assessing capacity, the Act should require that information be gathered from sources other than the consumer, including carers, to enable a more comprehensive and informed assessment' (sub 105, p.8).

Many submissions favour the Scottish 'significant impairment' criterion and prefer its non-legalistic nature. For example, Zimmerman states that 'replacing the legalistic term 'capacity' with the Scottish concept of 'impairment due to mental illness of ability to make decisions about treatment' is much clearer and more workable' (sub 28, p.2). The Mental Illness Fellowship Victoria also favours the Scottish model, arguing it is 'a clearer test than the legalistic 'capacity' test, and in effect goes to the heart of the purpose of the provisions in the Act' (sub 167, p.10).

Some submissions, including from the Rethinking Mental Health Laws project at Monash University, suggest that the Scottish criteria should be adopted in full (sub 90, p.16) The Scottish criteria include: the person has a mental illness; the person's ability to make decisions about treatment is 'significantly impaired' by their mental illness (rather than the current Victorian 'refusal or inability to consent' criterion); treatment is available and will benefit the person by preventing the illness from worsening or by alleviating symptoms; if treatment is not provided there will be a 'significant' risk to the health or safety of the person or the safety of any other person; and the order is necessary.

In contrast, a small number of service providers favour maintaining the current criteria that allow a person who has refused to consent to be placed on an order. For example, St Vincent's Hospital states, 'where a patient has the capacity to consent, is refusing treatment and is a significant risk to themselves or others, the Act should permit an involuntary order to be placed on this patient' (sub 119, p.4). The Metropolitan CEO Group is concerned about a requirement for a process of consent and consultation with acutely psychotic patients and/or their carers in the context of emergency departments. It believes this is unlikely to be practical (sub 204, p.1).

Community views about reform of the risk criteria

The majority of submissions and forum participants commenting on this issue submit that the criteria should include a test for serious, imminent or significant risk to the person or others. A number of submissions also suggest the Scottish model of risk criteria should be adopted in Victoria. The Scottish model states: if treatment is not provided there will be a 'significant' risk to the health or safety of the person or the safety of any other person.

Victoria Legal Aid 'would support amendments such that the risk, either to self or others, must be serious and imminent, and not just a possibility, or what could otherwise be seen as 'crystal ball gazing' on the part of a clinician' (sub 145, p.8).

Austin Health, among others, suggests that the current risk criteria should remain, linked to a requirement that there be evidence of effective treatments.

In our view it is very appropriate to link the use of the involuntary treatment with the availability of effective treatments for the illness. These treatments should not only involve detention in a secure place, but also require evidence of effective treatments for the medical illness similar to the grounds in the Scottish Act.

(Sub 63, p.3)

A small number of service providers support the current risk criteria. For example, Forensicare believes that 'adding a requirement that risk to others be 'imminent' or 'serious' would impose a further judgment on clinicians which can be difficult to make' (sub 198, p.7).

It is also suggested that distinct criteria should be established for CTOs. This is discussed later in the report.

Panel's commentary

The community views outlined above support:

- requiring a diagnosis of mental illness rather than the appearance of mental illness
- greater specificity in relation to the risk criterion (such as requiring a serious, imminent and/or significant risk)
- the adoption of the significant impairment test used in Scotland in place of the current criterion regarding inability and refusal of treatment
- the adoption of the criteria used in Scotland in relation to the effectiveness of treatment
- specific criteria for CTOs (this is discussed later in this report).



We support the general concept that involuntary orders should only be used as a last resort. This could be achieved through a range of reforms discussed in this report. These include: guiding principles reflecting a presumption of capacity for people with a mental illness; advance statements; a staged order scheme involving orders of shorter duration with a fixed expiry date; and requiring that orders can only be used where reasonably justified and in a manner least restrictive of a person's human rights.

We note that Justice Bell in the Kracke decision discusses the principle of 'least restrictive' at paragraph 762:

Under the Mental Health Act, the limitations are connected, indeed inherently proportionate, to their purpose. The content and manner of involuntary treatment is mediated by the principles of medical necessity and least restriction and intrusion. The limitations vary according to the treatment needed by the patient and the options available for giving it least restrictively and intrusively. That means treatment is given in the community if possible.

We support reform of the current criteria that permit a person who has capacity and refuses treatment to be placed on an order. We see merit in the 'significant impairment' test, outlined below.

We note that a small number of submissions suggest retention of the current criteria, particularly in terms of risk. However, it would be inconsistent with the principle that involuntary orders should be used only as a last resort, not to place some qualifier on the presence of risk.

The criteria could be similar to those in the Scottish mental health legislation, which in summary are that: the person has a mental illness; the person's ability to make decisions about treatment is 'significantly impaired' by their mental illness (rather than the current Victorian 'refusal or inability to consent' criterion); treatment is available and will benefit the person by preventing the illness from worsening or by alleviating symptoms; if treatment is not provided there will be a 'significant' risk to the health or safety of the person or the safety of any other person; and the order is necessary.

2.3 Staged orders and external review

The Act allows for involuntary treatment orders of indefinite duration and CTOs of a 12-month maximum duration. The Act requires the board to conduct reviews of involuntary treatment orders within eight weeks of their making, and annually thereafter. The Act does not state the consequences if external reviews are not conducted within the required timelines.

A number of other jurisdictions have staged orders. Generally, a staged orders scheme includes orders of a shorter duration with a fixed expiry date. This results in more frequent external reviews to enable further orders to be made if necessary.

Challenges identified by the community

Key issues identified by the community are outlined below.

- Allowing up to eight weeks for external review of the making of an order is in breach of the Charter because the period is too long.
- Many orders are not independently reviewed by the board because discharge occurs before a hearing is held.
- Hearings are often not heard within the eight week timeframe with no consequence.
- The duration of orders is unacceptably long.
- Attendance and representation rates at board hearings are unacceptably low.

A range of people and organisations are particularly critical of the period of eight weeks between initial detention and external review.

It is astonishing that the great majority of recommended patients receive acute involuntary treatment without ever having any independent scrutiny by the [board], because the Act only requires an initial hearing within eight weeks of admission to involuntary status, and so many patients are discharged off section before this time. Even worse, the transfer of initial hearing between services commonly results in initial hearings being held three months or sometimes longer after recommendation. This is a travesty of the spirit of the Act.

(Sub 102, Shields, R, p.1)

Given that it is a person's liberty that is in question, we submit strongly that a wait of almost two months before compulsory review is far too long.

(Sub 163, Liberty Victoria, p.6)

The Public Interest Law Clearing House suggests that the current external review requirements are not compatible with the Charter and contrary to international jurisprudence on the right to a fair hearing (sub 158, p.22).

The imposition of an Involuntary Treatment Order (ITO) is a serious interference with human dignity and bodily integrity and such interferences should occur only in exceptional and justifiable cases. Therefore, timely review of ITOs by an independent and impartial body is a critical element of any mental health system...

In light of the right to a fair hearing in section 24 of the Charter, and the need for a very high level of scrutiny of decisions to involuntarily detain and treat individuals, PILCH considers that the following aspects of the external review mechanism under the [Act] requires review and reform:

- (1) time periods for reviews;*
- (2) constitution of the review body;*
- (3) legal representation before the review body; and*
- (4) access to information and ability to prepare for review hearings.*

(Sub 158, pp. 19-20)

There is concern that the current way in which external review hearings are conducted means they are ineffective in providing an appropriate safeguard for orders. For example, the Office of the Public Advocate states 'Victoria lags well behind other comparative jurisdictions with regard to the time allocated to hearings. The right to a fair hearing is a human rights principle enshrined in the Charter' (sub 192, p.32). Others commented on procedures:

... Board procedure is overly formal, legalistic resembling a court hearing. Decisions are routine and pre-determined with little opportunity or possibility of a mediated or probational outcome. Attending a community treatment order review by the Board is an isolating experience. Patients do not know how to vouch for themselves, nor the criteria for having the order lifted.

(Sub 14, Titcher, J, p.5)



The main problem is the [board] hearings which are generally not a therapeutic experience for the patient/client. From my observation (particularly of the psychotic patients) they find them very distressing and upsetting. They return from the hearings frequently angry with the medical staff, nursing staff, case managers and family. It stirs up all their righteous anger that they don't have a psychiatric illness, they shouldn't be in hospital and they should not take medication. The hearings frequently destroy the therapeutic relationship/alliance.

(Sub 84, confidential)

A confidential submission cites instances where people attending board hearings have received ECT on the same day. Clearly this 'impacts on the rights of patients who are placed in a situation where they are unable to effectively participate in the hearing process' (sub 193, confidential).

There are serious concerns about the low level of representation at board hearings. The Human Rights Law Resource Centre submits that 'the very low level of representation in matters before the Board is particularly concerning given the extreme consequences of Board decisions on the liberty and security of persons who may be subjected to involuntary orders' (sub 155, p.66). According to Liberty Victoria:

... given the particular disability and vulnerability of people with mental illness, effective advocacy on their behalf is critical. Apart from the system of criminal law, there is no other area in which a person may forfeit their liberty in the manner applicable to people with mental illness. The seriousness of that consequence and the particular vulnerability of the group in question, in our view necessitates a system in which legal advice, assistance and representation is made available to every person facing a Tribunal review, if they request it and after being fully informed of their rights.

(Sub 163, p.6)

Other issues raised in relation to board hearings include the practical problems people experience in accessing medical files prior to hearings (see, for example: sub 158, Public Interest Law Clearing House, p.25-26).

Community views about staged orders

Many jurisdictions in Australia and internationally achieve earlier and more frequent review through a staged orders scheme. There is broad support for a staged orders scheme with orders of limited duration and frequent external reviews. The Mental Illness Fellowship Victoria believes that the 'staged model for involuntary orders has merit, and may provide a framework for a more precise approach to intervention which is less likely to infringe on a person's rights' (sub 167, p.9).

Submissions to the review provide varying levels of detail on how a staged orders scheme could operate. A range of timeframes for external review are proposed, including that a review should be required at the earliest possible opportunity. For example, Mental Illness Fellowship Victoria believes that assessment orders should be acted upon 'as soon as practicable' and no later than 48 hours after the making of an order (sub 167, p.10).

In contrast, some clinicians do not agree with the introduction of a staged orders scheme.

I restate my concern that creating more stages produces a situation where there is a perception of greater protection for patients, but in reality a series of bureaucratic and administrative processes which are burdensome for clinicians and which ultimately lead to the same outcome for the patient, but which can potentially delay helpful interventions in the meantime. I make these comments having worked for several years in the UK using this very system.

(Sub 164, Tune, P, p.3)

Community views about external review hearings

Some submissions suggest that the court system should conduct external reviews, arguing that only a judge should be able to involuntarily detain a person (see, for example: sub 47, Bernard, D, p.1; sub 57, Stewart, I, p.1). Other submissions suggest that external reviews should be conducted by a tribunal responsible to another government department, such as VCAT (sub 195, Mental Health Legal Centre, p.76).

The Public Interest Law Clearing House supports greater use of single legal member boards with multidisciplinary input. It argues that, 'the legal member is likely to be perceived as having greater independence from the treating team' (sub 158, p.24). However, not all submissions agree with this position, instead preferring multidisciplinary three member panels (sub 131, Harper, T, pp.4–5). Others believe the board should include a representative from a consumer organisation to ensure the majority of cases do not simply confirm the position of the clinician (sub 147, confidential).

Many submissions suggest less formal, less legalistic hearings (for example, sub 84, confidential). The Southwest Advocacy Association supports review hearings being conducted in person at a neutral, non-threatening, non-clinical venue (sub 39, p.5).

A significant number of submissions argue that the new Act should require free representation at external review hearings as this would help to safeguard rights (see, for example: sub 137, Consumer and Carer Directorate, Southern Health, p.6; sub 12, Caulfield Aged Persons Mental Health Service, p.2; sub 141, Citizens Commission on Human Rights, p.29).

Some submissions support a funded scheme that would ensure legal representation is provided for all people subject to orders (sub 51, Australian Nursing Federation Victorian Branch, p.12). Other submissions support automatic access to legal representation, rather than it occurring by request (sub 95, Psych Action and Training Group, p.3).

The Victorian Mental Health Carer's Network suggests that carers should be represented at hearings (sub 105, p.9).

Community consultations also identified several changes to hearings that could be of benefit to people subject to orders, including: video recordings to be made available on request; notifying people several days in advance of hearings; and establishing a process for amendment of inaccurate medical records.



Panel's commentary

There is broad community support for a staged orders scheme. The community has identified the need for reform in this area to overcome deficiencies in the current system of external review for people subject to involuntary orders. Such a scheme could greatly strengthen the review safeguard. As Justice Bell states in the Kracke decision at paragraph 524:

The review safeguard is one of fundamental importance to the statutory scheme for the involuntary treatment of mentally ill people.

In our view it is unacceptable at present that, pursuant to the Act, a person can currently be treated involuntarily for a period of eight weeks before external review occurs. Given the restrictions on liberty and freedom inherent in involuntary orders, it is important that some form of external scrutiny should occur as soon as practicable after a person is made subject to an involuntary order.

It is equally unacceptable that in practice many external reviews are not conducted within the timeframes specified in the Act. In the Kracke decision, Justice Bell found that the board breached a person's human right to a fair hearing under the Charter by failing to conduct the reviews of involuntary orders within a reasonable time. Justice Bell states at paragraph 699:

Must means must. The time limits are not guidelines or aspirational. Conducting these reviews within the specified time is not optional. Doing so is mandatory and what the legislation expects to happen. Parliament could hardly have made its expectation any clearer.

While the right to appeal is an important safeguard, mandatory, board-initiated reviews are critical. Justice Bell states at paragraph 703 that:

... the legislation does not rely on [appeals] for good reason. It is dealing with people who are or may be mentally ill. It is no disrespect to them to say that sometimes they may not be able to act in their own best interests. There could be many reasons, including their illness, social isolation, other illnesses, lack of resources, advice and assistance, not knowing what to do or where to go for help and making poor judgments. Therefore the legislation has not made patient-initiated appeals the only safeguard. It has included mandatory, board-initiated reviews as an important safeguard.

We consider that delays in conducting reviews are unacceptable. However, we acknowledge the board is confronted with practical problems in meeting statutory deadlines, for example, adjournments may be sought, including by the person themselves. It is important that the new Act requires reviews to proceed within time in any event. In practice, this might mean offering a further more substantial hearing at a later date within a short period of time.

A staged orders scheme could include shorter orders with a fixed expiry date and more frequent external reviews. The following illustrates how the scheme might operate in respect of people subject to detention:

- an initial order made by the authorised psychiatrist with a maximum duration of 28 days
- a check on the legality of detention within seven days
- the need for a board review before the orders expire
- the making of further orders by the board (any further orders made by the board would have a maximum duration of six months)
- allowing the authorised psychiatrist to vary the order to a less restrictive option (discharge from involuntary status or a CTO) at any time
- a special review by the board within two years (at this review a second psychiatric opinion must be provided to the board).

One way to achieve a check on the legality of detention within seven days could be via an official visitor. The check on the legality would involve talking to the person, checking the paperwork and, if necessary, initiating an appeal to the board. Official visitors could be a practical, workable solution, placing a minimal burden on the workload of clinicians. Official visitors could offer a range of other integrated functions. These include assisting people subject to orders to understand and exercise their rights as discussed later in this report.

Staged orders in relation to CTOs are discussed later in this report.

Community consultations and submissions raised issues about the process and the way that board hearings are conducted, arguing that the system does not adequately respond to the needs of those involved. Some submissions make suggestions about the configuration of the board. We note that some changes, including membership of the board, will need to be legislative, while other improvements such as case management may be made administratively. As noted by Justice Bell in the Kracke decision at paragraph 702:

The board is constituted by statute as an independent, expert tribunal with substantial powers, including procedural powers. The legislation expects the board to carry out its review (and appeal) functions with positive vigour. That is the assumption underlying the time limits, which the legislation expects the board to drive. The board must be inquisitorial, proactive and oriented towards effective and timely case-management. It should arrange its administration accordingly.

Some submissions favour moving the review process to the court system or to VCAT. However, we have not received any persuasive evidence that the board's functions should be transferred to VCAT or the court system.

The community also supports the provision of accessible representation at external review hearings.



2.4 Use of community treatment orders

A CTO requires a person to obtain involuntary treatment for their mental illness in the community. Under the Act a person made subject to an involuntary order must be placed on a CTO unless they cannot obtain their treatment in the community.

Currently the Act contains the same criteria for involuntary orders, whether a person is to receive treatment in detention or in the community. The Act allows for CTOs of a 12-month maximum duration. Other safeguards applicable to CTOs (such as a treatment plan and clinical review requirements) are discussed elsewhere in this report.

Challenges identified by the community

Key issues identified in submissions and consultations in relation to CTOs are that they:

- are used too often and the duration of CTOs is too long
- are reviewed too infrequently
- can be extended on multiple occasions and can therefore last for many years
- may not be adequately addressing the mental health needs of many people.

A number of submissions state that CTOs are overused in Victoria.

OPA is concerned about comparatively high rates of CTOs in Victoria compared to other jurisdictions. This concern is based on whether the benefits outweigh the cost to the individual. CTOs are experienced by many consumers as a highly restrictive intervention.

(Sub 192, Office of the Public Advocate, p.32)

For Victoria to have such a disproportionate number of its citizens on this type of order strongly reflects that we are doing something seriously wrong with the medical treatment of these people.

(Sub 18, confidential)

The Australian College of Mental Health Nurses cites instances where people are placed on CTOs following the first episode of illness without allowing the person the chance to manage the illness for themselves.

(Sub 214, p.6)

The Gippsland Community Legal Service raises concerns in relation to a lack of monitoring of people subject to CTOs, particularly in country areas where there are limited outreach visits by psychiatrists (sub 166, p.2).

Further, submissions also raise the issue that CTOs are too long and too infrequently reviewed. The Doutta Galla Community Health Service submits that the 'duration of CTO's in Victoria is longer than the national average' (sub 191, p.10).

There are concerns that CTOs may not be addressing the mental health needs of many people in the community (sub 69, Royal Australian and New Zealand College of Psychiatrists, p. 16). The Office of the Public Advocate believes it is important that CTOs are not used as a substitute for a properly resourced service system (sub 192, p.33).

Community views about reform

It is suggested that CTOs should be used for people who have a long-term mental illness and history of noncompliance.

[CTOs] should be used for people with long term mental illness and where there is a consistent demonstration of inability to self-care/self-manage. Remission relapse is high in this group so inherent in this is the requirement that services need to operate in conjunction with each other so as not to leave person isolated but be actively involved.

(Sub 135, Mental Health at Work, p.4)

The Royal Australian and New Zealand College of Psychiatrists supports checks and balances signed off by a psychiatrist to determine if a person is receiving appropriate treatment and overall benefit via a CTO (sub 69, p.17).

There is support for specific criteria for CTOs. Some participants at the Warrnambool forum were of the view there should be a distinction in the legislation between orders for detention and treatment and orders for community treatment, including different definitions and criteria (workbook comment). Mercy Mental Health submits 'there is strong support for separate, more rigid criteria to be applied as grounds for a CTO' (sub 41, p.3).

A number of submissions suggest 'the duration of [CTOs] needs to be limited and the frequency of review increased' (sub 192, Office of the Public Advocate, p.33).

In contrast, a minority of submissions do not support limiting the duration of CTOs, or requiring more frequent external review. They are concerned this may add to the work burden of mental health professionals and could be problematic for people subject to orders (workbook comment, Keysborough forum). Zimmerman believes shorter CTO durations may cause stress by increasing the frequency of review hearings and by raising unrealistic expectations (sub 28, p.4).

Panel's commentary

We note the community concerns about the criteria for CTOs, their overuse in Victoria, and their duration (including extensions) and infrequent review.

Some of the concerns raised in relation to the duration of CTOs could be addressed by establishing a staged orders scheme, as discussed above. It is likely that a staged orders scheme would mean shorter CTOs with a fixed expiry date and more frequent external review.

The following illustrates how staged orders for CTOs could operate:

- CTOs of a maximum six months' duration made by the authorised psychiatrist or the board
- the need for a board review before CTOs expire
- special review within two years by the board (at this review a second psychiatric opinion could be required to be provided to the board).

If consideration were to be given to the introduction of specific criteria for CTOs, the aim should be to encourage voluntary treatment as far as possible. The criteria could include a different level of risk and a clear benefit for the person being made subject to the CTO.



2.5 Restraint and seclusion

Currently the Act regulates the use of mechanical restraint and seclusion. It also regulates the use of physical restraint for the purpose of transporting a person safely to a public mental health service. Physical restraint is otherwise governed by common law.

Challenges identified by the community

Several issues were raised during community consultations about the regulation of restraint and seclusion including:

- the compatibility of these interventions with the Charter and Disabilities Convention
- the harmful effects of these interventions on the people who are subject to them
- a lack of compliance with the Act's requirements
- the use of these interventions by unqualified staff.

Some submissions believe restraint and seclusion may be inconsistent with the Charter and Disabilities Convention.

Restraint or seclusion may disproportionately limit the right to protection from torture, cruel, inhumane or degrading treatment if the restraint or seclusion was found to cause mental suffering or physical pain that is not necessary or does not further the medical treatment of the patient... The right to freedom of movement may also be unreasonably limited if the restraint or seclusion imposed is not the least restrictive method of treating the patient.

(Sub 5, Human Rights Law Resource Centre, p.30)

Several submissions note the harmful effects that restraint and seclusion can have on people. Jacomb states 'restraint is an extremely scary and humiliating process for the patient' (sub 44, p.41).

Mechanical restraint and prolonged cell-like seclusion in an inpatient setting exacerbate fear, anger, strangeness, isolation and paranoid emotions in patients. They heighten hostility, provoke aggression, physical resistance and an urgency to 'escape'. They foster neither cooperation nor comfort for distressed patients, and can rarely be justified when anti-psychotics and calming drugs are as effective. Above all patients suffer the indignity of being observed in this incarceration. It hinders the person in regaining, as quickly as possible, normal interaction with others, especially family who are likewise traumatised by the apparent barbarity of such measures.

(Sub 14, Titcher, J, p.4)

A number of submissions identify failures to comply with the Act's requirements that people in seclusion be provided with adequate toilet breaks and adequate clothing, heating, blankets and bedding (sub 167, Mental Illness Fellowship Victoria, p.15). Similarly, the Victorian Women and Mental Health Network, among others, raises concerns about the practice of stripping a person naked during restraint or seclusion (sub 37, p.2. See also, sub 216, Eclectic Consumers Collective, p.15).

A number of people including workers in the service system expressed concern that physical restraint is used by unqualified staff members (see, for example: sub 139, Lacey, M, p.12). Concerns have also been raised that restraint can be used roughly and disrespectfully and that, in particular, unqualified staff members abuse physical restraint (sub 139, Lacey, M, p.12).

Community views about reform

Several reforms have been suggested in relation to the regulation of restraint and seclusion, including:

- limiting use as a last resort
- requiring an imminent and significant risk of harm to self or others
- enabling use of seclusion to prevent absconding, only where there is also a significant risk to the person or another person
- enabling use of mechanical restraint to prevent property destruction, only where there is also a significant risk to the person or another person
- limiting the duration of restraint and seclusion use
- requiring continuous observation of people in seclusion
- regulating physical and chemical restraint.

There is widespread support for limiting the use of restraint and seclusion and employing such interventions only as a last resort (see, for example: sub 214, Australian College of Mental Health Nurses, p.10).

The use of restraint is a significant intrusion on the person's right to liberty, freedom of movement and security. If the Act is to provide for circumstances in which restraint may be permissible, whether it be chemical, physical or mechanical restraint, the Act must narrow the grounds in which it may be used and provide for rigorous protective measures to ensure it is used as a last resort in very limited circumstances. The use of restraint should never be punitive.

(Sub 195, Mental Health Legal Centre, p.70)

The State Coroner Victoria acknowledges the potential consequences of the use of restraint and seclusion and strongly encourages the development of practices, which reduce 'the need for restraint and seclusion where these put people at risk of harm or death' (sub 202, p.2).

It is suggested that the grounds for seclusion should not include risk of absconding alone. The Alfred Psychiatry, Alfred Health submits that this is particularly the case where there is capacity to secure the building by locking exit doors or placing people under continuous observation (sub 194, p.8).

Some support the use of imminent and significant risk criteria to limit situations where restraint and seclusion may be applied (for example, sub 145, Victoria Legal Aid, p.18).

We acknowledge the potential inherent tension between a rights based approach and a zero tolerance approach to occupational violence and aggression. However, it is a critical issue, and one which impacts directly on the capacity of the current and future workforce in mental health settings. With this in mind, we support the concept that restraint should only be used as a last resort when other less restrictive options have been tried, or considered and excluded, and where it is necessary to protect the person or others from immediate or imminent risk to health or safety [footnote omitted].

(Sub 51, Australian Nursing Federation, Victorian Branch, p.10)

Some submissions point to the need to further limit the duration of restraint and seclusion. There is support for restraint and seclusion to end immediately once the grounds for the intervention are no longer met.

Restraint and seclusion may be necessary when a person is wielding or believed to be wielding a weapon; is behaving violently or destructively, in a siege situation, and perhaps to administer sedating medication in the interests of preventing harm and to enable transport to a safe setting. But these measures should be for emergencies and of very limited duration.

(Sub 14, Titcher, J, p.4)

Mental health services ought to work towards a restraint-free environment, there is emerging but substantial research evidence against the practice of restraints and seclusion.

(Sub 177, Victorian Disability Advisory Council, p.8)

The Victorian Equal Opportunity & Human Rights Commission believes the new Act should require seclusion to end as soon as the clinical grounds for seclusion have ceased. The commission argues that this approach would be consistent with the right to liberty and security of person in section 21 of the Charter and Article 14 of the Disabilities Convention (sub 115, p.10).

There is support for continuous observation of any person in seclusion and it has been noted that this accords with the Charter.

Consistent with the section 9 right to life in the Charter (and Article 10 of the [Disabilities Convention]), the section 82 criteria governing seclusion in the Act must include a requirement for continuous observation of the secluded person by a medical practitioner or registered nurse.

(Sub 115, Victorian Equal Opportunity & Human Rights Commission, p.10)

However, some submissions argue against continuous observation of persons in seclusion. The Royal Children's Hospital notes that 'isolation increases opportunities for reflection, reviewing interpersonal transactions, and learning.' It also states that continuous observation may undermine this, especially when a client gains a sense of power from controlling the time and attention of others (sub 168, p.4). Similarly, several submissions do not support continuous observation as the default option, as it 'may cause further distress and agitation' (for example, sub 50, Ennis, G, p.2).

The Victorian Mental Illness Awareness Council states that while the Act currently does not regulate chemical restraint, anecdotal evidence suggests that it occurs. The council recommends that the new Act make it clear that chemical restraint is unacceptable under any circumstances (sub 35, p.8).

The Australian Consumer Patient Rights Group suggests seclusion and restraint should be prohibited (sub 59, p.4).

The Victorian Faculty of the Australasian College for Emergency Medicine is concerned about the situation where people in acute conditions present at emergency departments. The faculty submits that 'delay in ED staff being able to restrain or control patients in appropriate circumstances may lead to harm to the patient, staff or the public or the prolonged detention of acutely ill patients in non-ideal circumstances (eg Police vehicles)' (sub, 128, p.1).

There is support for the regulation of physical restraint, with submissions identifying the need for better training, guidance, monitoring and review in relation to the intervention (sub 192, Office of the Public Advocate, p.53). Some submissions seek clarification about who may undertake physical restraint, as well as the circumstances in which it may occur (sub 211, Oseckas, T, p.1).

A number of service providers also see the need to regulate physical restraint across the wider health system to ensure consistency. For example, Austin Health states 'physical restraint across the whole of the hospital, not just for people detained under the Mental Health Act, should be regulated under a formal Act' (sub 63, p.8).

There is also support to bring physical restraint in line with provisions for mechanical restraint, particularly in relation to reporting (see sub 214, Australian College of Mental Health Nurses, p.10; workbook comment, Ringwood forum).

While indeed it may be onerous to implement, the Act needs to make mention of physical restraint and the need for its regulation. It has been 'the elephant in the room' for long enough and a rights based approach must tackle the less pleasant aspects of our mental health system.

(Sub 51, Australian Nursing Federation, p.11)

Participants at forums queried the necessity of using physical or mechanical restraint in relation to children and young people (for example, workbook comment, Benalla forum). However, a consultant child and adolescent psychiatrist indicated that physically holding 'out-of-control disturbed' children can be containing and therapeutic (sub 152, Youren, S, p.1).

A small number of service providers argue against the greater statutory regulation of physical restraint. The Alfred Psychiatry, Alfred Health submits that 'the new Act should not attempt to regulate physical restraint except when this is implemented routinely as part of a treatment plan' (sub 194, p.8).

Panel's commentary

There is widespread support to ensure that restraint and seclusion are used only as a last resort. There is also concern about the harmful effects these interventions can have on people. We recognise the important work already underway within the sector to limit the use of restraint and seclusion in Victoria. However, the new Act could assist in driving further reduction in their use.

There is a strong view that the new Act should allow restraint and seclusion only in situations of imminent and significant risk to a person. The new Act could reflect this by changing the grounds for use, for example, seclusion should not be used for the sole purpose of preventing absconding and mechanical restraint should not be used to prevent property destruction alone. The new Act could also require restraint and seclusion to end immediately once the grounds for the intervention are no longer met.



As suggested by the community, one strategy to further enhance the safety of people placed in seclusion is to require continuous observation of the person.

A number of submissions seek regulation of physical restraint in the new Act, including when it can be used and by whom. Similarly, there are calls for the regulation of chemical restraint. If there are practical ways of regulating these forms of restraint to ensure they are not used improperly, we are of the view that these should be adopted.

Overall there is a clear desire for increased regulation in relation to the use of seclusion and restraint and the panel supports such reform. We are concerned at reports that clinicians and service providers are not encouraged to comply with the Act's requirements, such as the provision of adequate bedding, clothing and toilet facilities. Noncompliance with these requirements can have an extremely negative impact on people who are subjected to these restrictive interventions. It is essential that there be stringent monitoring of the use of restraint and seclusion.



3 Supporting patient participation and carer involvement



3. Supporting patient participation and carer involvement

This section will outline the community's views and the panel's commentary on proposed reforms to support people to participate in decisions about their treatment and care, and proposed reforms to improve carer involvement. Issues addressed include:

- informed consent to treatment
- advance statements
- recovery planning
- co-ordinated care
- nominated person
- rights advice
- advocacy.

The Act is largely based on a substitute decision-making model where psychiatrists make treatment decisions for people subject to orders. However, the Act does contain some requirements designed to assist people to participate in decision making about their treatment and care, and to promote carer involvement. These include requirements that people subject to involuntary orders: receive a statement and explanation of rights; are involved in the preparation of a treatment plan; and receive information such as a copy of the treatment plan. The wishes of carers must also be taken into account in the preparation of a person's treatment plan, unless the person objects.

People subject to involuntary orders also have a right to a second psychiatric opinion and to appeal to the board against the order.

Feedback during community consultations highlighted that these requirements are insufficient to support people to participate meaningfully in decisions about their treatment and care.

Many submissions outline the benefit of involving people in decision making about their treatment and care. It is also asserted that the negative impacts of ignoring a person's views about treatment can be profound.

There is support for the new Act to enable people to make their own decisions and maximise their autonomy as far as possible. This would be consistent with the principles of the Disabilities Convention that include in Article 3(a): 'Respect for inherent dignity, individual autonomy including the freedom to make one's own choices, and independence of persons'.

The new Act could also better promote and recognise the involvement of carers.

The Act allows the disclosure of identified information about a person without their consent, to a guardian, family member or carer if the information is reasonably required for the ongoing care of the person. Views expressed during community consultations revealed dilemmas regarding the provision of information, with some submissions arguing the Act does not sufficiently protect people's privacy.

Others believe that the information sharing provisions in the Act are often not complied with and, as a result, carers can be unnecessarily excluded. This means that carers may not have information that is necessary to provide care and to avoid potential risks. A number of submissions argue that this can have an adverse impact on treatment and recovery. Mental health professionals report that they often do not provide carers with information because they are unsure what is permitted by law.

There is community support for improving carer involvement through specific initiatives within the legislative framework.



3.1 Informed consent to treatment

Currently the Act allows the authorised psychiatrist to consent to treatment for people who are subject to orders, irrespective of the person's capacity. However, the Act requires the authorised psychiatrist to seek informed consent before performing ECT on a person. Unless urgently needed, the Act does not permit ECT to be given to a person who has capacity to consent but refuses. ECT is discussed later in this report.

Challenges identified by the community

Key issues raised in relation to informed consent to treatment are set out below.

- Allowing the authorised psychiatrist to consent to treatment regardless of a person's capacity is not compatible with the Charter and the Disabilities Convention.
- The current requirements do not enable people to assess the risks and benefits of treatment options, including the side effects of treatment.
- There is a lack of consistency with other areas of non-emergency health care.

Many believe the current system of decision making is based on an outdated approach. Further, it is not consistent with current human rights law requirements, such as those set out in the Charter and the Disabilities Convention.

In this context, a number of submissions raise the issue of inadequate information about the side effects of proposed treatments. According to the Vanaheim Group 'doctors are not required to explain treatment effects to involuntary patients' and 'genuinely informed consent would allow a patient or the patient's legal guardian to assess the real potential risks and benefits of all treatment options' (sub 20, pp.4–5). The Dousta Galla Community Health Service reports one person's experience: 'I asked what the side affects were and they wouldn't tell me, they said I just had to take them' (sub 191, p.6). The Maine Connection is concerned that there is no legislative requirement for clinicians to report side effects, increasing the likelihood that the number and incidence of side effects is considerably understated (sub 34, pp.4–5).

The following are just a sample of the potential side effects that can be suffered from common anti-depressants, anti-psychotics and other psychiatric drugs involuntary patients are forced to ingest: mania; anxiety; delusions; suicidal thoughts and tendencies; akathisia (severe restlessness); aggression; birth defects; liver damage; depression; drowsiness; dizziness; blurred vision; sedation; and seizures.

(Sub 106, International Commission of Jurists Western Australia Branch, p.3)

Many submissions note that in other areas of non-emergency health care, treatment cannot generally be given without consent, even in urgent situations. As Brien points out: 'if I can decide to refuse chemotherapy and thus lose my life to cancer, why cannot I decide to endure whatever psychiatric symptoms to avoid the effects of strong psychotropic drugs, even if there is "risk" to myself' (sub 3, p.3). The Gippsland Community Legal Service is concerned that unlike other areas of medical treatment, a 'request for consent is not offered to those under involuntary orders' (sub 166, p.3).

Community views about reform

There is broad support for the new Act to provide greater opportunity for people to consent to decisions about treatment, irrespective of whether they are subject to an involuntary order or receiving treatment on a voluntary basis.

... there should be a presumption of capacity, until it is established, by taking all practicable steps to assist that person to make the decision, that he or she cannot [consent] [footnote omitted].

(Sub 155, Human Rights Law Resource Centre, pp.40-41)

A number of submissions note the high rate of orders that are made in Victoria compared with other jurisdictions. They seek a shift to a supported decision making model as this would ensure people have their legal capacity recognised. It would also enable people to provide informed consent to treatment as far as possible. A number of submissions argue that this would ensure consistency with the Charter and the Disabilities Convention (see, for example: sub 90, Monash University, p.8; sub 177, Victorian Disability Advisory Council, p.7).

A participant at the Ballarat forum submitted that a change between voluntary or involuntary status should not affect a person's rights. These rights include the ability to make informed decisions and to be actively involved in treatment plans (workbook comment).

Submissions note that there is no right to refuse treatment in the Act, and that 'the administration of medication by force - usually by intramuscular injection - is not adequately controlled by the Act' (sub 142, Hamilton, Dr B, p.2). According to Hamilton, the 'experience of enforced medication is at least as distressing, humiliating and traumatising as being detained...[and] far greater opportunity must be created for the person to consent or refuse, before commencing medical psychiatric treatment' (sub 142, p.2).

Several submissions suggest that a more comprehensive explanation of medication is required (see, for example: sub 46, Horvath, N, p.2; sub 198, Forensicare, p.12).

All and any known side effects of any proposed treatment must be given to the parent, guardian or patient in written format in their own language or clearly explained to the person by their next of kin, nominated person or lawyer in their own language.

(Sub 57, Stewart, I, p.3)

Various submissions argue that people must have the right to refuse treatments such as ECT and long-acting medications. ECT is discussed later in this report.

Some submissions raise concerns about increased workload if there is a requirement to seek informed consent to treatment for people who are subject to involuntary orders (sub 146, Health and Community Services Union, p.11). The Royal Children's Hospital supports providing relevant parties with available information and involving them in treatment decisions. However, it notes that the process may be time consuming and increase costs, especially with people who have neuro-developmental difficulties and educational and social disadvantage (sub 168, p.3).



One submission suggests that it is illogical that a person subject to an order may be able to provide informed consent to treatment.

The notion of informed consent by involuntary patients for psychiatric treatments contains an inherent paradox which I can't get my head around. Either the patient is unable or unwilling to consent, for which reason they are involuntary, and because of which – by definition – they can't give informed consent (at least in relation to their psychiatric condition), or they have capacity, in which case they should not be under an involuntary status.

(Sub 164, Tune, P, p.4)

It is recognised that in some circumstances substitute consent may be necessary. Oehm submits that 'in all circumstances there should be an attempt to obtain consent, but compulsory administration would remain an option ... where the client is a danger to themselves or others' (sub 134, p.3).

Some suggest that, rather than a psychiatrist, a person's carer, family or other support person could more appropriately provide consent for a person who is unable to provide consent (sub 90, Monash University, p.12).

When a person is clearly unable to make decisions for themselves, I believe spouses, parents or next of kin should be consulted in place of the patient, where they are available. These people are likely to know the life goals and acceptability level of risks posed by different courses of treatment.

(Sub 175, confidential)

Panel's commentary

We note the community view that the new Act should more positively enable the participation of people in their treatment and care and that the Act's reliance on the authorised psychiatrist for treatment decisions is outdated. There are benefits of increased participation in decisions about treatment and care. One way the new Act could promote autonomy is by overturning the presumption that all people subject to orders do not have capacity to make their own decisions. Instead, the new Act could be based on the presumption that all people with a mental illness have capacity to make their own decisions, including people subject to orders.

In this context we note that capacity is a decision-specific concept and the presumption of capacity can be displaced in relation to any given decision (therefore the presumption is rebuttable). The rebuttable presumption of capacity is consistent with the principles in the Disabilities Convention, including Article 3(a): 'Respect for inherent dignity, individual autonomy including the freedom to make one's own choices, and independence of persons'.

The Charter provides that a person must not be subjected to treatment without giving full, free and informed consent. It would therefore seem reasonable that the new Act requires clinicians to seek informed consent to treatment decisions. Seeking informed consent requires clinicians to test whether the person has capacity to consent to the treatment and provide information about the proposed treatment, including any risks, side effects and alternatives. The aim would be to improve engagement and to facilitate consent to treatment wherever possible. However, we note that substitute consent would still apply where a person is unable to make an informed decision.

3.2 Advance statements

Currently the Act does not make any reference to advance statements (which are also known as advance directives or living wills). The term ‘advance statement’ is used in this report. It is a written statement setting out a person’s wishes and preferences for future treatment and care in the event that person becomes unable to make such decisions. It may also contain a person’s lifestyle preferences or emergency arrangements to ensure that practical measures are addressed while the person is unable to make those arrangements.

Challenges identified by the community

Key issues identified by the community in relation to advance statements are:

- currently a statement of a person’s wishes and preferences has no legal status
- the Act does not adequately respond to the episodic nature of mental illness in terms of fluctuating capacity.

The Victorian Mental Health Carer’s Network believes advance statements ‘may circumvent some of the more complex problems associated with autonomy and consent’ (sub 105, p.10).

Citizens’ right to bodily integrity should be foremost among the objectives of reform. The provision of legally binding advance directive rights is essential.

(Sub 24, Odowd, B, p.1)

The Mental Health Legal Centre is currently researching the use of advance directives in Victoria. It supports their introduction and believes clinicians should recognise a person’s advance directive and give effect to it as far as possible. The centre prefers the term advance directives.

The episodic nature of mental illness means that people with mental illness may, at some time, have impaired capacity to make particular decisions. This is precisely where the use of advance directives is so compelling – an advance directive is drafted primarily by reference to the fact that the person has in the past experienced becoming unwell and has reflected on the experience, their treatment and how they felt at the time.

(Sub 195, Mental Health Legal Centre, pp.60–61)

Community views about reform

At public forums and in submissions the community expressed widespread support for the inclusion of advance statements in the new Act. There was also recognition that in order to be effective advance statements would need to be supported by a robust enforcement framework.

Some submissions identify advance statements as a way to recognise human rights. The Victorian Equal Opportunity & Human Rights Commission submits that ‘it is timely and appropriate for advanced directives to be incorporated in a revised Act’ (sub 115, p.15).

A number of views highlight the benefits of advance statements in facilitating the involvement of carers and family members (see, for example: sub 197, Inner South Community Health Service, p.5; sub 195, Mental Health Legal Centre, p.61).



There are various views about whether it should be possible to override a person's wishes and preference as expressed in an advance statement. Some submissions state that advance statements should not be overridden in any circumstances. Odowd asserts: 'by its nature it is a statement made by a Victorian citizen containing deep felt, thoroughly thought through wishes as to his or her biological integrity' (sub 24, p.26).

The Mental Health Legal Centre suggests that where a person's advance directive prohibits ECT, this should not be overridden (sub 195, p.8).

Other submissions outline situations where it might be appropriate to override a person's advance statement. According to the Health and Community Services Union, this would be where the person's circumstances have clearly changed or where the person's capacity to make a statement is unclear, or where there is a serious and imminent risk to the person or others (sub 146, p.20). Austin Health believes an advance statement 'should only be overridden following a second opinion from a second authorised or delegated psychiatrist' (sub 63, p.7).

The Mental Health Legal Centre suggests that where an advance directive is not followed the person should be given the reasons for the decision, and they should also have a right to appeal the decision to an independent body (sub 195, p.8).

There can be uncertainties for clinical staff in determining whether to rely on an advance statement. In particular, deciding whether the person was capable when the statement was made and whether the statement is current.

Some submissions raise practical issues in relation to the introduction of advance statements, suggesting a range of issues that require further consideration, for example: how the information is created, recorded and communicated; the person or persons responsible for ensuring that prepared advance statements are available and recorded on the person's medical file; the test for capacity that will apply at the time the advance statement is made; the identity of people who may attest to capacity; the means by which the advance statement is drawn to the attention of relevant clinicians; the circumstances in which the advance statement may be overridden; and the body or person who has the authority to override the statement (sub 90, Monash University, p.10–11).

In terms of the content of advance statements the Inner South Community Health Service believes that advance statements should be very broad and could include information about treatments, information sharing and confidentiality, and a range of other information on issues affecting people, when unwell (sub 197, p.5).

Panel's commentary

During consultations and in written submissions there was widespread support for recognition of advance statements in the new Act. It was persuasively argued that advance statements have the potential to assist in achieving better health. This is achieved by enabling people, when they are well, to make a statement of their wishes and preferences for treatment and care. The statement can then be relied upon in the event that the person becomes unable to make such decisions.

Recognition of advance statements in the new Act would reinforce the presumption of competence, as well as recognise and maximise autonomy. The inclusion of advance statements in the Act may also facilitate the involvement of families and carers by allowing a person to specify in what circumstances their families and carers should be contacted or otherwise involved.

We note that some submissions argue that the Disabilities Convention has the effect of requiring a process of supported decision making, rather than substitute decision making, on the basis of a benefit test. Regardless of whether this interpretation is correct, the first step in any process of supported decision making should be to ascertain, as far as possible, the wishes of the person. Advance statements are a formal way to identify a person's wishes and enable those wishes to be taken into account.

The need to ensure compliance with advance statements was clearly and consistently raised during community consultations. To this end, any decision to override an advance statement could be subject to some external scrutiny, for example, people whose advance statement is not complied with could appeal to the board.

In order to avoid unnecessary deviation from existing laws relating to enduring powers of attorney and guardianship, where possible the new Act should build upon these laws.

There are many practical issues that need to be addressed to ensure the effectiveness of advance statements. These include ensuring clinicians are made aware of the existence and content of advance statements. It has been suggested that this could occur through the registration of advance statements on the shared electronic records system accessible by public mental health services.

To ensure they are effective, the requirements for making a valid advance statement would need to be specified in the new Act, including a test to determine whether a person has capacity to make an advance statement. Further, the new Act could require that people making decisions must comply with the wishes and preferences stated in a valid advance statement, unless this would not be for the person's benefit. This could arise where, for example, a person's advance statement is outdated and refers to redundant treatments, or circumstances that are no longer relevant.

3.3 Planning for recovery

Currently the Act requires a treatment plan to be prepared and provided to every person made subject to an order, but it does not specify what must be recorded on the treatment plan.

The Act requires a person's wishes to be taken into account during treatment planning and unless the person objects, the wishes of their guardian, family member or carer.

The Act also refers to a right to a second psychiatric opinion, but it is silent on the status or consequences of a second psychiatric opinion.

Challenges identified by the community

A number of key issues were identified in relation to treatment planning.

- Treatment plans are poorly executed and do not always reflect the person's preferences or carer and family involvement.
- The requirements in the Act in relation to treatment planning are often not complied with.
- The right to a second psychiatric opinion is unclear because accessing a second psychiatric opinion can be extremely difficult. The status and effect of a second psychiatric opinion is also unclear.

Views expressed during community consultations indicated widespread criticism of treatment plans. It is reported that treatment plans often lack any expression of the goals of treatment and the outcomes that are being sought.



Part of the problem with current treatment plans is that they are rather wordy documents with lofty goals which may not fit reality. I think staff feel the treatment plans have to look good rather than documenting what good treatment actually is. This is why it becomes a paper exercise. If we could VALUE more some of the basics such as meeting regularly with patients and family, providing an opportunity to talk about concerns, plus a few specifics then the treatment plans might be more a working document instead of an extra piece of paper. Often the task is to develop a good treating relationship but this doesn't always translate into documentable actions.

(Sub 28, Zimmerman, Dr N, p.5)

The Act refers to a right to a second psychiatric opinion. However, in practice, people subject to orders are often unable to exercise this right because accessing an independent psychiatrist is difficult and reports are costly. As outlined in the consultation paper, access to a second psychiatric opinion is an important safeguard to challenge treatment decisions made by the authorised psychiatrist, or when a person cannot consent to ECT. ECT is discussed later in this report.

Community consultations identified a significant amount of criticism about the current arrangements for second psychiatric opinions. The Victorian Mental Illness Awareness Council claims the current Act has allowed for poor habits of clinical practice with some psychiatrists carrying out an independent second psychiatric opinion within a 5–10 minute period having never met the person before the opinion. The Council believes it is highly unusual for a second opinion to differ from the initial diagnosis (sub 35, pp.10–11).

Another major issue in relation to second psychiatric opinions is access.

HACSU received strong feedback that there should be more access to obtaining a second psychiatric opinion. A number of problems in accessing a second opinion were noted, including:

- *Difficulty in accessing a second opinion in rural and regional Victoria*
- *Time delay in obtaining a second opinion*
- *The cost of obtaining a second opinion can be prohibitive*
- *Both the perception and the reality of obtaining an independent opinion from that of the primary treater, particularly within the public system.*

(Sub 146, Health and Community Services Union, p.12)

A further issue is the status and effect of a second opinion. St Vincent's Hospital believes 'there should be a requirement that the second opinion is from a practitioner external to the treating service and it is given due consideration by the treating team' (sub 119, p.5).

Community views about reform of treatment plans

There is general support for holistic treatment, care and recovery plans 'which encompass a broader concern with consumer wellbeing and recovery' (sub 105, Victorian Mental Health Carer's Network, p.10). Hanover Welfare Services notes if a person sees 'their treatment in the context of what they want to do with their lives in the longer term rather than just recovering from a specific episode of illness, they are more likely [to] respond positively' (sub 122, pp.2–3). Norwood Association Inc believes plans should document all aspects of care, including 'referrals, medications (including side effects), medical, physical and psychosocial needs and proposed strategies and timeframes' (sub 149, p.4).

Submissions emphasise that plans should refer to the person's wishes (see, for example: sub 68, Dwyer, J, p.3; sub 149, Norwood Association Inc, p.4).

Many submissions note that to achieve holistic treatment plans greater involvement from carers, families, PDRS service workers, GPs and the treatment team is required. The Victorian Mental Health Carer's Network points out that, 'the circumstances of a person's life are often inextricably bound with, and reliant on, that person's carers.' It is therefore 'vital that carers are included in the construction of treatment plans whenever possible' (sub 105, p.10).

Some submissions highlight the need for minimum requirements for the content and format of plans, including living arrangements, community engagement, income arrangements, and a GP contact (see for example, sub 105, Victorian Mental Health Carer's Network, p.10; sub 191, Dousta Goulla Community Health Service, p.6).

... a treatment plan that incorporates work with the person's family as allies in the recovery process, that allows that the central goal setting in the process be done by the consumer, that incorporates psycho-social therapies, insight-building, problem-solving and development of an understanding of early warning signs for relapse provides a much better chance of recovery than a more basic individual service plan that addresses very few of these issues.

(Sub 139, Lacey, M, pp.9-10)

One criticism of the current system is that service providers are not held accountable for poor treatment planning and service delivery, leading to poor quality service. In order to address this, the Mental Health Legal Centre suggests that the board's powers to review treatment plans should be significantly enhanced (sub 195, p.15).

Community views about reform of second psychiatric opinions

There is broad support for large-scale reform in this area. It is suggested that independent second opinion psychiatrists should be made available to safeguard the rights of people subject to orders. Submissions emphasise the need for access to independent and timely second opinions (see, for example: sub 182, North Western Mental Health, p.3). In addition, the Office of the Health Services Commissioner believes 'patients and their carers should be involved in the choice of clinicians wherever practicable' (sub 205, p.6).

Health decisions affect all of us and getting a second opinion is seen as a legitimate way to ensure that the treatment received is the most effective and efficacious. Without the ability to obtain an independent second psychiatric opinion about realistic, safe and less restrictive treatment alternatives, consumers cannot fully participate in their treatment and recovery.

(Sub 197, Inner South Community Health Centre, p.8)

South West Healthcare Psychiatric Services Division highlights concerns about the availability of another psychiatrist independent from their service (sub 153, South West Healthcare Psychiatric Services Division, p.3).

A number of submissions believe second psychiatric opinions should be required after a few months of involuntary treatment, as is the case in Scotland (see, for example: sub 149, Norwood Association Inc, p.3).

There is a view that second psychiatric opinions should be available for all treatment decisions upon request.



Where there is a concern about the medical treatment, a second opinion should be [sought] and encouraged.

(Workbook comment, received by mail)

Perspectives from both public forums and submissions highlight the need for a mechanism to resolve differences of psychiatric opinion in order to determine which treatment is ultimately pursued. For example, participants at the Keysborough forum suggested a third party could be used to mediate between conflicting views about treatment and care (workbook comment, Keysborough forum; see also: sub 146, Health and Community Services Union, p.12).

Panel's commentary

Community consultations indicated that clinicians and service providers routinely fail to comply with the current treatment plan requirements in the Act. Although the Act requires a person's wishes to be taken into account as far as they can be ascertained, we are concerned that people subject to orders are infrequently involved in the development of their treatment plan. The same appears to be the case for carers and families.

There is support for the improvement of treatment planning to promote better health. In order to do this it will be critical to involve people in their own planning and include families and carers, where the person consents to their involvement. This could be achieved in a number of ways. At a minimum, it would be desirable if the new Act required the wishes of the person to be recorded on their plan.

The introduction of a planning model that has a recovery focus, reflecting a more holistic approach to treatment and care, could also improve effectiveness and promote desirable practice developments. The new model could incorporate discharge and crisis relapse prevention planning. In addition, plans could be renamed 'treatment, care and recovery plans'. Other desirable components of plans could be outlined in codes of practice. The potential value of codes is discussed earlier in this report.

Second psychiatric opinions are regarded by various submissions as an important safeguard for people who are subject to orders. However, submissions raise concerns about the fact that they operate far from optimally. Issues include a lack of access, cost, and lack of clarity about the status and effect of a second opinion. These difficulties are acute in rural and regional areas of Victoria, where accessing a second psychiatric opinion is often not feasible.

The panel believes the new Act could require a second opinion in some circumstances, for example, before ECT is performed, for people who have been subject to an order for more than two years, and for decisions relating to children and young people.

If a person obtains a second psychiatric opinion that differs from their treatment plan, the Act does not require the opinion to be taken into account in any way by the service provider or the board. Preferably the new Act should require second psychiatric opinions to be taken into account. One of the ways this could be achieved is by requiring the service provider to have regard to the second psychiatric opinion and review and revise the person's treatment, care and recovery plan. To this end, the board could have powers to vary treatment plans.

A further issue that was consistently raised is the need for a process to resolve differences of psychiatric opinion. We are of the view that the most appropriate way to resolve conflicting psychiatric opinions is by referral to the board for a binding decision.

3.4 Co-ordinated care

For the purposes of co-ordinated care, currently the Act enables electronic information to be shared between public mental health services. Employees of public mental health services are required to enter information in a shared electronic records system and can collect and use identified information from the system if it is necessary to enable a person's treatment. The Act also allows the disclosure of information without the person's consent to assist another service provider or practitioner to treat a person, including to GPs and PDRS services. The Act allows the disclosure of information to drug and alcohol services only with a person's consent.

Challenges identified by the community

Key issues identified by the community include concerns about:

- the lack of privacy protections in the Act regarding information sharing between public mental health services and other service providers
- problems in relation to information sharing with PDRS services and the impact on co-ordinated care
- the need to clarify the role of PDRS services, drug and alcohol services and GPs to improve co-ordinated care.

Submissions and community consultations revealed dissatisfaction with the lack of privacy protections in the Act.

The HRLRC does not dispute the importance of information sharing as between health services for the legitimate aim of improving the quality of consumer care and treatment. However, when a consumer's confidential information is disclosed without his or her consent, it is questionable whether a careful balance has in fact been struck. It is questionable whether the limiting nature of [the Act] on a consumer's right to privacy is reasonable and proportionate, and in compliance with international human rights law and the Charter.

(Sub 155, Human Rights Law Resource Centre, p.75)

At the same time, concerns were raised that other service providers such as PDRS services often have little or no information about the specific needs of people who are referred to them.

Especially for those with chronic and complex conditions, and where a number of providers are involved in the treatment and care, it is in the interests of care coordination and continuity that there be good communication between providers.

(Sub 120, Western Region Health Centre, p.15)

A number of submissions also discuss the need to clarify the role of GPs in the Act, particularly in relation to information sharing, in order to enhance co-ordinated care.



Community views about reform of information sharing with other service providers

There is support for increased information sharing, with the person's consent (see, for example: sub 51, Australian Nursing Federation, pp.16–17; sub 49, Donegan, M, p.1; sub 139, Lacey, M, p.20).

Significant and/or relevant information should also be released to key service providers involved with a patient, such as other medical practitioners, drug and alcohol services, and disability services, where there is a practical need for such service providers to be provided with the information and it is in the best interests of the patient, however the patient should be informed and the patient's consent should be sought first.

(Sub 39, Southwest Advocacy Association, p.8)

Several submissions point to the right to privacy in the Charter and Disabilities Convention.

... the decision whether to disclose confidential information about a consumer to any other person, whether it be to another practitioner or the consumer's family or carer, should ultimately be with the consumer wherever possible. Requiring that a consumer's consent be obtained prior to disclosure of confidential information, recognises and respects the consumer's right to privacy, their autonomy and their inherent dignity and is compatible with the [Disabilities Convention]. Seeking the consumers' consent also empowers and encourages the consumer to become more involved in their own treatment and their path to recovery.

(Sub 155, Human Rights Law Resource Centre, p.78)

The Human Rights Law Resource Centre suggests that where a person does not have capacity, information should only be shared where the person's guardian, family member or carer provides consent to the disclosure (sub 155, p.76).

Several service providers suggest that information should be shared without a person's consent in some circumstances. For example, Western Region Health Centre believes this is particularly necessary for those with chronic and complex conditions where a number of providers are involved in treatment and care. This would include both primary care clinicians and other hospital based practitioners. 'Non-clinical providers should also be able to access information where this is necessary for the safety of the staff, identified patient or co-residents in residential settings' (sub 120, p.15).

Forensicare would welcome an amendment which enabled disclosure of information to drug and alcohol services, without the person's consent where it is required for treatment by those services. Given the 'high levels of comorbidity in this area, it is suggested that such information sharing would be of benefit in the broader treatment of mental illness and substance abuse' (sub 198, p.25).

In considering the delivery of co-ordinated care many submissions raise the issue of the role of the PDRS services given developments in this area over time.

A participant at the Ringwood forum thought the new Act should 'reflect the changes in the support landscape – community, PDRS services, etc' and that 'this may lead to greater recognition, acknowledgement and communication with these services by clinical services' (workbook comment).

Other submissions seek greater clarity about each agency's responsibility and role (see, for example: sub 181, Mind, p.6). VICSERV suggests designating a role for the PDRS services sector in areas such as the development of treatment and discharge plans (sub 188, p.5). Dousta Galla Community Health Service believes discharge plans should be mandated for every person (both voluntary and involuntary) leaving an acute psychiatric ward. This process would include an explanation of PDRS services and other follow-up services available (sub 191, p.6).

A number of submissions see the need for increased liaison between clinical staff, including GPs, and the PDRS services sector (see, for example: sub 120, Western Region Health Centre, p.7).

Often the PDRS worker has more of a complete picture of a client in their service. They may also be able to facilitate the inclusion of carers in the treatment of their loved one where the consumer agrees to this.

(Sub 70, confidential)

Various submissions emphasise the important role of GPs in this process. AMA Victoria sees the need for a more structured framework for GPs to undertake early intervention, assessment and management of people with mental disorders. AMA believes 'the new Act needs to facilitate a clearer pathway for GP-psychiatrist communication' (sub 201, p.5). Chamley believes progress reviews should be conducted in the presence of the person and carer with communication sent to the GP (sub 17, p.5).

A number of submissions believe a full physical examination by a GP should occur to ensure whether an underlying and untreated physical condition is causing the mental state or emotional symptoms and that this should take place prior to any orders being made in respect of the person (see, for example: sub 82, Jekel, G, p.6).

At a consultation with the panel, General Practice Victoria noted that there is no reference in the Act to the role of GPs in providing treatment. Although they are sometimes mentioned in CTOs, the GP is usually not given a copy of the order. According to General Practice Victoria GPs are also not informed when a person is discharged from hospital.

One Patient - One Plan - a single mental health care plan that was accessible to all service providers would assist in continuity of care for patients. The GP is a key service provider and as such must be kept informed of any actions relating to the patients.

(Sub 156, North East Victorian Division of General Practice, p.2)

Panel's commentary

We note the community's support for increased information sharing for the purposes of co-ordinated care, including to PDRS services and drug and alcohol services. It would be preferable if the new Act defined the role of these service providers for the purposes of information sharing and to reflect their increasing involvement in the provision of treatment and care.

We are mindful both of the right to privacy in the Charter and that the community has raised concerns about privacy protections. As stated earlier in this report, we believe it is desirable for the new Act to be based on the presumption that all people with a mental illness have capacity to make their own decisions, including people subject to orders. Capacity is a decision-specific concept and the presumption of capacity can be displaced in relation to any given decision.



We are of the view that, where a person has capacity to consent to the disclosure of information, the information should be disclosed based on the person's wishes. Where it is determined that a person does not have capacity to consent to the disclosure of information, we believe the new Act should facilitate information sharing for the purposes of co-ordinated care. However, as far as possible the information sharing scheme in the new Act should be broadly consistent with laws applicable to health services.

3.5 Rights advice

The Act imposes a duty on the authorised psychiatrist to provide each person subject to an order with a statement and explanation of their rights. A treatment-specific statement must also be made prior to certain treatments such as ECT and psychosurgery. If the person does not appear to understand the explanation, the authorised psychiatrist is under a further duty to arrange for the information to be conveyed in a language or manner the person can understand. In practice, the treating team often performs these obligations.

Challenges identified by the community

Key issues in relation to rights advice include:

- the inadequacy of requiring rights advice to be given only on admission
- the conflict in requiring rights advice from the service provider responsible for limiting the person's rights.

Neami, a Psychiatric Disability Rehabilitation Support Service, notes the difficulties in expecting people to understand and retain information provided on admission at a time when a person may be acutely unwell. Neami believes assertive follow-up should be considered to ensure people understand any rights that have been removed, and how to exercise those rights (sub 52, p.4).

The Office of the Public Advocate reports that 'people calling from acute mental health units claim not to have been advised of their rights at the appropriate time of their admission' (sub 192, p.5). At one public forum, a consumer consultant reported on a small survey of people who overwhelmingly said that they had not been told of their rights. This was despite the provision of a rights statement on admission and a few days later, and despite the consumer consultant offering rights advice (workbook comment, Mildura forum).

The Health and Community Services Union notes the conflict in requiring service providers to provide rights advice. On the one hand service providers try to fulfil their role as mental health professionals operating under clinical guidelines and on the other they are required to inform a person of his or her rights in relation to that treatment and care (sub 146, pp.15-16).

Community views about reform

A significant number of submissions argue for continuous rights explanations throughout a person's order, to ensure that the person can digest this information (see, for example: sub 52, Neami, p.4; sub 192, Office of the Public Advocate, p.6).

The Homeless Persons' Legal Clinic believes the new Act should take into consideration the fact that a mental illness may pose an obstacle to understanding or recalling any explanation of rights (sub 169, p.23).

The Act should also require that a patient's rights are regularly revisited throughout treatment; there is no currently clear accountability for documenting and monitoring whether these rights are understood by patients or families.

(Sub 167, Mental Illness Fellowship Victoria, p.13)

Rights advice for people receiving treatment on a voluntary basis is discussed later in this report.

Panel's commentary

We received many submissions in relation to this issue. There is a significant level of dissatisfaction with current rights advice requirements among people subject to orders, families, carers and clinicians. As described above, there are reports of many people who, despite being provided with a rights statement, are unaware of their rights while subject to orders. It is clear that provision of a rights statement upon admission is not sufficient to ensure people can understand and exercise their rights. Ideally, rights advice should be ongoing throughout a person's involuntary order. Rights advice should also be provided independently from the service provider.

Currently, clinicians and mental health service staff provide advice about rights to people, while at the same time making or enforcing decisions to detain and involuntarily treat them. For this reason, people subject to orders may not accept the independence and importance of the advice provided. Rights advice models in other jurisdictions appear to overcome these difficulties. The new Act could require the provision of independent rights advice and support to people subject to orders. This could occur through the use of official visitors as described elsewhere in this report.

3.6 Carers, families and information sharing

Currently the Act allows for the disclosure of identified information about a person without their consent, to a guardian, family member or carer in some circumstances. These include if the information is reasonably required for the ongoing care of the person or where disclosure is necessary to prevent a serious and imminent threat to a person. This applies whether the person is subject to an order or is receiving treatment on a voluntary basis. In both circumstances, the Act *allows* but *does not require* disclosure of the information. The Act *requires* that information be disclosed without the person's consent in limited circumstances. A guardian must be notified when a person has been placed on an involuntary order, including reasons. Further, reasonable efforts must be made to notify a guardian or carer where a person is to have ECT based on the consent of the authorised psychiatrist.

Challenges identified by the community

Key issues identified by the community include:

- the lack of privacy protections in the Act in relation to the disclosure of information to carers and families
- the need to improve compliance with the Act
- the need to ensure that relevant and necessary information is disclosed to carers and families.



Views expressed during community consultations highlighted a high level of dissatisfaction with the current legislative framework for two reasons. First, given that the person's consent is not required, many argue the Act contains insufficient privacy protections. Second, carers report that the Act is often not complied with. As a result they infrequently receive sufficient information to assist them to provide necessary support.

Accordingly there is a clear tension between the right to privacy and the provision of information to carers and families. The Victorian Equal Opportunity & Human Rights Commission believes that an appropriate balance needs to be struck between the right to privacy of the person who is receiving treatment for mental illness and the needs of the family (or carer) to access adequate information about treatment in order to properly fulfil the role of caregiver (sub 115, p.26).

Some submissions note the complexity of the various health privacy laws. Hostettler believes the *Health Records Act 2001* is misused as a 'firewall' to avoid sharing information with families and carers and to cover up care quality problems (sub 104, p.5).

Services continue to display an unwillingness to involve carers in the treatment process or to provide them with appropriate information that would assist them in their caring role. Research indicates that the failure to include carers because of confidentiality concerns is a major barrier to effective family participation, and that low levels of collaboration with clinicians can have a substantial negative impact on 'carers' levels of well-being, knowledge and care-giving skills [footnote omitted].

(Sub 105, Victorian Mental Health Carer's Network, p.2-3)

A further issue is the need to recognise the role of carers formally in the new Act. This issue was dealt with earlier in this report, in relation to the objects and principles of the new Act.

Community views about information sharing with a nominated person

Many other jurisdictions require service providers to disclose information about key events to a nominated person. There is broad support among the community for a similar scheme in Victoria.

The Victorian Equal Opportunity & Human Rights Commission believes the new Act, underpinned by principles of autonomy, should permit a person who is receiving involuntary treatment to stipulate a nominated person who can access information relevant to treatment and care and who can be notified at all stages of the treatment process (sub 115, p.26).

Similarly, the Eating Disorders Foundation of Victoria believes that people should be allowed to decide who their nominated person is (sub 148, p.6). The Australian Nursing Federation submits that 'such a nomination should be respected unless there are grounds for believing this person's involvement may be harmful to the patient and/or others' (sub 51, p.6).

A number of submissions believe that there are complex issues to resolve in introducing a nominated person into the new Act (see, for example: sub 177, Victorian Disability Advisory Council, p.9).

In principle, we support the opportunity for consumers to appoint a nominated person, who will help to safeguard consumers' rights. However, we believe that more thought needs to be given to the questions of how the interplay of the roles of advance directives, supported decision making, powers of attorney, guardianship, family members and carers, and nominated persons will operate.

(Sub 137, Consumer and Carer Relations Directorate, Southern Health, p.5)

A large number of submissions raise the importance of protecting privacy, particularly in the context of section 13 of the Charter.

Requiring that a consumer's consent be obtained prior to disclosure of confidential information recognises and respects the consumer's right to privacy, their autonomy and their inherent dignity and is compatible with the [Disabilities Convention]. Seeking the consumers' consent also empowers and encourages the consumer to become more involved in their own treatment and their path to recovery.

(Sub 155, Human Rights Law Resource Centre, p.78)

The Victorian Equal Opportunity & Human Rights Commission believes, in determining where the balance lies between the right to privacy of the person, and the needs of unnamed carers or family members to access information that will help them to care for the person the new Act 'should limit any infringement on privacy rights only to the extent permissible in accordance with section 7 of the Charter' (sub 115, p.11).

A number of submissions argue that identified information should only be disclosed with the person's consent (see, for example: sub 14, Titcher, J, p.1). AMA Victoria 'recommends that in no circumstances should the Act mandate the disclosure of information to families, carers, guardians, and nominated persons without patient consent unless there is an overwhelming risk of harm to the patient or others by failing to do so' (sub 201, p.3).

Other submissions propose that information should be disclosed irrespective of a person's consent. A confidential submission argues that information should be unreservedly shared with those who care for people with a mental illness, particularly if carers could be endangered without this knowledge (sub 98, confidential).

Some submissions support disclosure 'in contravention of the consumers' wishes only when the information directly relates to the carer's role and when all relevant aspects of the case have been considered' (sub 137, Consumer and Carer Relations Directorate, Southern Health, p.7).

Hostettler suggests: 'information should be shared with families and carers unless it is not in the best interest of the patient or hindering the patient's recovery' (sub 104, p.6).

Victoria Legal Aid points out that trust is an integral part of the patient/doctor relationship. As a result, disclosure of information to families and carers without a person's consent should only occur in limited circumstances, including to avoid significant risk (sub 145, p.26).

Some also cite the importance of increased community education in this area.

... one solution may well be to increase community awareness to assist parents and individuals in these situations to respond, even if it is not appropriate for release of confidential information to the carer. With a better community understanding of mental health, then it would be more likely for the person to be willing to consent to information about themselves being provided to their carer.

(Sub 9, Marshman, K, p.3)

The Act should include a clause that will help to educate the general public to eradicate the old taboo idea that families and friends were forbidden to discuss some diseases, including mental illness especially if the patient belonged to the family.

(Sub 75, confidential)



Similar comments have been made in relation to the need for training of mental health professionals. A participant at the statewide carer forum believed mental health workers should be trained to consult with carers and families and that this should be required by the new Act (workbook comment, statewide carer forum).

Panel's commentary

We note the concerns of carers about inadequate information sharing by clinicians. This is despite the current Act *allowing but not requiring* the disclosure of information to carers that is reasonably required for the provision of ongoing care or where disclosure is necessary to prevent a serious and imminent threat to a person. Further, we note the calls for improved privacy protections. It is acknowledged there is a need to strike an appropriate balance between the right to privacy and carers' need for information.

As stated earlier in this report, it would be desirable for the new Act to be based on the presumption that all people with a mental illness have capacity to make their own decisions, including people subject to orders. Capacity is a decision-specific concept and the presumption of capacity can be displaced in relation to any given decision.

Where a person has capacity to consent to the disclosure of information, preferably the information should be disclosed based on the person's wishes, for example, they could specify a nominated person or they may have already specified a nominated person in their advance statement.

Where it is determined that a person does not have capacity to consent to the disclosure of information, we believe the new Act could require (rather than allow) the disclosure of information as follows:

- to a person previously nominated
- if the person has previously made an advance statement, to a nominated person already specified in it
- to a recognised carer who requires the information to perform their caring role (It is therefore not sufficient simply to be a family member). Because this is potentially an intrusion on liberty, the clinician disclosing the information must be satisfied that the carer is clearly providing care and the information is required to provide that care.

The information disclosed in these circumstances could include information about key events such as admission and discharge, board hearings and treatments such as ECT. In addition carers should be provided with information about potential side effects of treatments and changes in medication. Enhanced treatment, care and recovery planning processes (discussed earlier in this report) may also assist in improving information sharing.

3.7 Advocacy

Currently, the Act provides a right for people subject to orders to authorise any person, including a lawyer or support person, to represent them at board hearings. This issue is dealt with elsewhere in this report. The Act is otherwise silent in relation to advocacy.

Challenges identified by the community

The community has identified a clear need for the inclusion of a right to personal advocacy in the new Act.

There are many reasons why a person with a mental illness may not take advantage of schemes such as a nominated person or an advance statement. They may have become ill for the first time and not expected to ever need this kind of assistance or, they may not trust anyone enough to nominate them as persons to give them assistance. Where this is the case ... the new Act should provide for an independent support person who is a trained advocate to represent that person's interest.

(Sub 197, Inner South Community Health Centre, p.6).

'Patients' often have limited capacity to express themselves. Many do not even know their rights, and they need assistance.

(Sub 29, BMC Ministries Inc, p.2).

Community views about reform

Views were expressed during community consultations about the importance of advocacy for people with a mental illness.

Jeshimon House Community Association sees the need for the formal appointment of a person or advocate who will oversee the recovery journey of a client and represent their best interests (sub 72, p.4). One participant at a community forum stated that 'an advocate would be someone who is there for the patient, listening to them, talking to them, advocating to them' (workbook comment, sent via mail).

Some submissions support the requirement in the Scottish mental health law for independent advocacy. In Scotland people with mental illnesses have a right of access to independent advocacy and the onus is placed on each service provider to ensure the person concerned has access to independent advocacy (sub 177, Victorian Disability Advisory Council, pp.9–10).

Community consultations identified several benefits of a personal advocacy role, including improved participation in treatment plans and enhanced treatment decisions, leading to better recovery outcomes (see, for example: sub 191, Doutta Galla Community Health Service, p.7–8; sub 188, VICSERV, p.4; sub 181, Mind, p.5).

Access to advocacy is seen as central to preventing discrimination. The Consumer and Carer Relations Directorate, Southern Health believes that a right of access to advocates is central to maintaining an anti-discriminatory environment (sub 137, p.5). NorthWestern Mental Health submits that personal advocates who represent a person's needs and best interests would ensure a more level 'playing field' (sub 182, p.3).



The critical role of advocates for people with specific needs has also been identified. The Human Rights Law Resource Centre sees advocates as being able to provide additional and tailored support for people, including women, children, Indigenous and culturally and linguistically diverse populations (sub 155, p.17).

Some submissions suggest particular functions for advocates, such as facilitating information sharing, and assisting in the preparation and implementation of advance statements. For example, an independent advocate could participate in the admission process, as well as discussions about treatment (workbook comment, Ringwood forum).

Submissions also address the issue of representation at external review hearings. This issue has been discussed earlier in this report.

Panel's commentary

There is support for advocacy for all people receiving treatment and care for a mental illness, whether on a voluntary or involuntary basis. The community has identified the following benefits of advocacy:

- improved participation in treatment planning
- enhanced treatment decisions leading to better recovery outcomes
- the prevention of discrimination against people with a mental illness
- improved information sharing
- assistance with the preparation and implementation of advance statements
- the provision of additional and tailored support for people with specific needs.

The panel agrees that advocacy can be very helpful for people with a mental illness, particularly during times of crisis, and increased access to advocacy would be desirable.



4 Monitoring and promoting patient care, wellbeing and rights



4. Monitoring and promoting patient care, wellbeing and rights

This section will outline the community's views and the panel's commentary on proposed reforms to monitor and promote patient care, wellbeing and rights. Issues addressed include:

- complaints handling
- death reviews
- visiting and auditing
- clinical leadership
- clinical monitoring
- safeguards for ECT and psychosurgery.

Currently, the Chief Psychiatrist and community visitors have legislative roles to monitor the treatment and care provided under the Act. The effectiveness of these roles was criticised during community consultations.

Enhanced monitoring and promotion of the care, wellbeing and rights of people receiving treatment and care under the Act through the establishment of an independent, specialist mental health commission received broad support.

In particular, it was suggested that a commission would promote transparency, accountability and service improvement. There is a call for legislative requirements to ensure information learned from complaints, deaths, visits and audits is used to improve services.

The need for a robust process to ensure second psychiatric opinions was also identified as a key reform, as was the introduction of safeguards for ECT.

4.1 Complaints handling

Currently the Act does not address how complaints should be resolved, nor does the Act establish any body for this purpose. In practice complaints are made to a range of organisations and people. These include mental health services, the Health Services Commissioner, the Chief Psychiatrist, the Office of the Public Advocate, community visitors, the Ombudsman and members of parliament. In recent years, the Office of the Chief Psychiatrist has assumed a greater role in receiving, referring and resolving complaints, as well as facilitating collaboration between public mental health services and providing clinical advice to the sector.

Challenges identified by the community

Community consultations indicated that the current complaints system is not operating effectively and is in need of significant reform. The key issues identified are set out below.

- It is difficult for complainants to navigate the current complaints system.
- Complaints are not acknowledged as justified.
- Responses to complaints are often inadequate and untimely.
- There is no objective investigation of complaints.
- There is no effective follow up or any action taken against mental health services.
- Complaints often do not lead to service improvement.
- The Chief Psychiatrist's role is not sufficiently independent from the department or from mental health services to respond effectively to complaints.



Some submissions point to problems with local complaints systems within mental health services.

We agree that the – ‘present complaint system is confusing and inadequate’. Many of the complaint systems of Area Mental Health Services (hospitals) have no checks or balances and fail to properly address the real issue of the complaint; consequently, a number of serious shortcomings in the system remain unaddressed and the patient’s human rights continue to be ignored.

(Sub 66, Barrier Breakers Inc, p.3)

The Office of the Public Advocate has identified the difficulties people face in making complaints about mental health services, and the impact on complainants. It submits that it can be extremely difficult to navigate the different complaint pathways. At the same time, a poor response to a complaint can be more damaging than the concern that gave rise to the complaint (sub 192, p.45).

Other difficulties identified include inadequate and delayed responses to complaints, and that complaints are not acknowledged as justified.

The Victorian Mental Illness Awareness Council notes the negative impact on complainants of the lack of objective investigations of complaints.

One of the most distressing issues for consumers is to experience a breach of the Act, Chief Psychiatrist guidelines, policy, professional standards, etc, make a complaint about it and experience a failure of those responsible under the Act to undertake an objective investigation. The loss of faith along with a sense of hopelessness and helplessness can be overwhelming for the individual.

(Sub 35, p.2)

Others point to the ineffectiveness of the Chief Psychiatrist’s complaints role due to its position within the department and lack of independence from mental health services. The Alfred Psychiatry, Alfred Health believes the Chief Psychiatrist is ‘not sufficiently distant from mental health services to offer credible advocacy for patients.’ In its experience, frequently complaints that are directed to the Chief Psychiatrist are then redirected to other bodies for further consideration (sub 194, p.11).

There is also concern that there are no apparent consequences where the Act is breached (for example, workbook comment, statewide carer forum). In relation to the Chief Psychiatrist, Jacomb states that ‘a watch dog afraid to watch is of no use to any one’ (sub 44, p.48).

Lack of clarity about the complaints function and process is also an issue.

At present, there is some confusion about the different powers and responses through the Chief Psychiatrist, Health Services Commissioner, and Community Visitors, although each offers different services and covers different areas of service concern. A review and clarity about these roles is necessary to assist in complaints processes.

(Sub 120, Western Region Health Centre, p.14)

Community views about reform

There are calls for regulation of local level complaints, centralisation of the complaint system, service improvement and an independent specialist mental health complaints body.

Many mental health and legal professionals are supportive of retaining and further regulating local complaints processes within mental health services (sub 164, Tune, P, p.9). Some submissions suggest the Northern Territory mental health law as a model for local level complaints regulation (sub 158, Public Interest Law Clearing House, p.36).

A small number of service providers pose a contrasting view, arguing that legislative requirements for local complaints handling and management are unnecessary (sub 114, Southern Health, p.10). St Vincent's Hospital points out that mental health services are already required to maintain effective complaints systems that comply with the Australian Standards for Healthcare Services guidelines for accreditation (sub 119, p.15).

In terms of external complaints handling, it is suggested that conciliation and recommendation powers are inadequate to protect people's rights. According to the Southwest Advocacy Association 'it is absolutely vital that external complaints bodies have the power to make binding decisions upon mental health services... SWAA does not want to see the creation of another "toothless tiger"' (sub 39, pp.6-7).

Further, many submissions identify the need for processes to ensure service improvement following complaints (for example, sub 210, confidential).

There are calls to centralise the complaints system. This would have the added benefit of ensuring that an accurate picture of problems is obtained (workbook comment, Ringwood forum). There is a significant amount of support for an independent, specialist and centralised body to address complaints.

Many people do not feel confident making a complaint directly to the organisation they wish to complain about. An independent body charged with handling complaints would help ensure that the service providers are subject to – and are seen to be subject to – appropriate oversight. The new Act must reflect an understanding of the importance of a complaints body: not only to address individual grievances, but as a means of improving service delivery and ensuring genuine accountability. In order to ensure efficacy, integrity and independence, the complaints body must be independent of both services and government, and must have decision-making authority.

(Sub 105, Victorian Mental Health Carer's Network, p.14)

The Disability Services Commissioner supports the creation of an independent specialist mental health complaints body. It submits, 'such a body needs to be independent of service providers and government and have broad ranging powers ... The body needs to be able to receive complaints from family, friends, carers and others in addition to the patient themselves in recognition of the difficulties some people may face making a complaint' (sub 209, p.2).

A minority contrasting view is that there is no need for an independent, specialist mental health complaints body. The Office of the Health Services Commissioner does not support the creation of a new specialist mental health commission or ombudsman. It submits that 'our experience is that the complaint system is working well and that good outcomes are achieved for people' (sub 205, p.8).



The Victorian Branch of the Australian Nursing Federation supports greater mental health expertise at the Office of the Health Services Commissioner, as well as some changes to processes. The federation is of the view that this would be 'a far more preferable option to establishing an entirely new and separate complaints body' (sub 51, p.15).

Panel's commentary

We acknowledge the confusion and frustration experienced by people in making complaints about mental health services. The community consultations highlighted concerns with current complaints arrangements. These include that: there is no clear complaints system; responses to complaints are too often delayed and ineffective; and the Office of the Chief Psychiatrist is not sufficiently independent from the department and the sector.

It is desirable that, wherever possible, complaints be promptly resolved in the first instance at a local level. To this end, the new Act could regulate local level complaint handling. Complaints that are unresolved at a local level should be addressed through a centralised system. In this context it is important that the body responsible for complaints about mental health services is independent from the department and from the mental health system.

An essential element of independent complaint handling is the ability to use the information learned from complaints to promote system improvement and enhance health care. There are a number of ways this could occur, for example, by requiring the complaints body to make rulings about complaints, including reasons and any action required to remedy complaints. Another method would be through the publication of service-specific information about complaints, including any action taken to remedy complaints. Currently these functions are not performed in relation to complaints about mental health services.

There appear to be two options for independent, centralised complaint handling: first, the establishment of an expert mental health commissioner; and second, that all complaints be handled by the Health Services Commissioner with added responsibilities and powers. Whichever body handles complaints we see merit in it having the powers currently provided under the *Health Records Act 2001* in relation to health privacy complaints. This would include the ability to issue legally enforceable compliance notices. We also agree that to maintain current arrangements would be undesirable. In particular, we do not believe there is sufficient transparency or accountability in a model where the department continues to receive most complaints about mental health services.

An additional way to improve the current complaints system would be to support people to make complaints, particularly people admitted to mental health services and people subject to involuntary orders. If an official visitor role is established, as outlined elsewhere in this report, its functions could include supporting people to make complaints.

4.2 Investigation of deaths and serious incidents

Currently the Act requires service providers to report the death of any person receiving treatment and care for a mental illness (as defined in the *Coroners Act 1985*) to the Chief Psychiatrist and the State Coroner. The Act does not state the purpose for which this information is collected by the Chief Psychiatrist. The role of the State Coroner is to determine the cause of death.

Challenges identified by the community

Community concerns about investigations into deaths and serious incidents include:

- investigations are not conducted in a timely manner
- recommendations arising from investigations are slow to reach service providers and their status can be unclear
- learnings from investigations into deaths and serious incidents are not used to improve treatment and care across the system.

The Australian College of Mental Health Nurses notes the limitations of coronial reviews. In the college's view, 'it takes many months before the Coroner's review and recommendations are released leading to the potential for further deaths to occur in the meantime should the death have been preventable' (sub 214, p.14).

Community views about reform

A confidential submission identifies the need to share learnings across the state to avoid preventable clinical incidents.

[monitoring functions are required] to ensure that services are compliant with the requirements of the Mental Health Act to review significant clinical incidents and to require the mental health service system as a whole across the state to change its processes or content to reduce the risk of further clinical incidents and to ensure that the content of the services provided contains safe, evidence-based and clinically effective interventions.

(Sub 143, confidential)

Victoria Police has identified the systemic benefits of a death review function to achieve service improvement and prevent future deaths. Victoria Police believe that while this function should not duplicate or usurp the role of coronial investigations, it would tie in with a broader, systemic monitoring function (sub 217, p.11).

The State Coroner Victoria supports the introduction of an independent expert panel or body to improve 'our understanding of mental illness and death' (sub 202, p.1-2). Similarly, several submissions point to the benefits of expert review of deaths. For example, Lacey submits that 'deaths are sometimes preventable, and all deaths of involuntary patients, if investigated, might give a good indicator of really poor services that would need reform' (sub 139, p.16).



Similarly, the Ministerial Advisory Committee for Mental Health argues that ‘the important matter of the avoidable death of a patient, either in the public or private mental health system, needs to be identified and addressed in the new Act’. The committee suggests that: ‘The death of any patient within 90 days of discharge should become notifiable; it should be independently investigated and the findings disseminated to the sector to promote awareness and service improvement’ (sub 218, p.2).

An opposing view held by a small number of mental health service providers is that there is no need for the inclusion of a death review function in the new Act. According to Austin Health, all sudden and unexpected deaths are subject to a coronial inquest or inquiry and the involvement of the Chief Psychiatrist in this process seems a duplication (sub 63, p.10).

Some submissions suggest amendments to the *Coroners Act 1985*. The Mental Illness Fellowship Victoria believes that ‘where a recommendation of the Coroner is rejected by mental health services an explanation for this rejection should be made publicly available.’ The Fellowship also believes ‘a review of this rejection should occur through the Mental Health Review Board’ (sub 167, p.17). Victoria Legal Aid submits that an independent commissioner should be able to seek leave to intervene at a coronial inquest, to ensure that deaths are properly examined (sub 145, p.24).

Some submissions support the retention of current arrangements with additional requirements that the Chief Psychiatrist make recommendations following deaths. The Royal Children’s Hospital suggests that ‘patient deaths should be analysed and reported in annual reports from the Chief Psychiatrist, with clear system recommendations’ (sub 168, p.5).

Tune believes ‘the Office of the Chief Psychiatrist is the appropriate body to perform this function, to review coronial findings, and to disseminate conclusions’ (sub 164, p.9). The Victorian Women and Mental Health Network submits the new Act should require clinical incidents or sentinel events to be reported to the Chief Psychiatrist. The Chief Psychiatrist would then be required to publish the outcomes of its reviews and investigations (sub 37, p.3).

Panel’s commentary

Community consultations identified the benefits of a death review function, including achieving service improvement and preventing future deaths. It is important to ensure that service providers take swift and effective action to protect rights. The new Act could require this, as well as requiring publication of de-identified information about deaths and serious incidents, to help improve services and benefit all people receiving treatment under the new Act. In this context, we believe there is merit in establishing a mental health commissioner with an integrated set of functions. These could include investigating serious incidents and reviewing deaths.

4.3 Visiting and auditing

Currently the Chief Psychiatrist and community visitors have legislative roles to monitor the treatment and care provided under the Act. The Chief Psychiatrist is a senior departmental officer appointed by the Secretary with the responsibility to oversee the care and welfare of people receiving treatment or care for a mental illness. Community visitors are volunteers who report to the Minister through the Public Advocate. Their primary function under the Act is to visit public mental health services regularly to monitor the adequacy, appropriateness and standard of facilities.

Challenges identified by the community

The roles of the Chief Psychiatrist and community visitors were criticised during community consultations. Criticisms include:

- current monitoring arrangements are inadequate in terms of transparency, accountability and service improvement
- the Chief Psychiatrist's role is not sufficiently independent from the department or mental health services to effectively perform monitoring functions.

The Human Rights Law Resource Centre notes that the importance of community visitors cannot be underestimated. However, it believes the monitoring functions of the Chief Psychiatrist and community visitors are ineffective and inadequate in terms of an optimal model of transparency, accountability and promotion of service improvement (sub 155, p.72).


The Law Institute of Victoria notes a lack of independence in relation to the functions performed by the Chief Psychiatrist, which include a clinical leadership role and informal monitoring of mental health service providers (sub 92, p.26).

Concerns have been expressed that there is no independent body with the function to safeguard the rights of people subject to orders (for examples, see sub 192, Office of the Public Advocate, pp.41–42).

Community views about reform

There is support from a range of groups for the establishment of a body to perform a range of functions to safeguard rights. According to the Psych Action and Training Group 'this is especially important because of the potential for human rights violations inherent in the exercising of powers under mental health legislation' (sub 95, p.4).

The Public Interest Law Clearing House supports the Scottish model where the Mental Welfare Commission carries out monitoring, inspection and complaint functions (sub 158, p.34). The Southwest Advocacy Association also supports the creation of such a body to 'provide advice and assistance to patients in regard to their rights and ensure that mental health standards and legislative requirements in relation to patients are being met' (sub 39, p.6).



A fundamental step is that a truly independent auditing body must be established to ensure the responsibility, accountability and transparency of the mental health system as a whole. Independence is important not only for consumer confidence but to ensure that the mental health budget is well spent. An independent auditing body would play a key role in changing the current practicing culture in hospitals and service providers, which in many consumers' experience involves staff control of patients and staff safeguarding their professions.

(Sub 183, Choo, J, p.1)

There is support for annual reporting detailing the findings of review visits by an independent commission (sub 16, Monash, D, p.4). Victoria Legal Aid believes monitoring functions and findings should be reported annually and the collated information used to improve care and wellbeing and to achieve service improvement (sub 145, p.24).

In contrast, a small number of submissions suggest retention of the broad monitoring functions and powers currently performed by the Chief Psychiatrist with additional responsibilities to provide timely responses (see, for example: sub 51, Australian Nurses Federation, Victorian Branch, p.13).

Panel's commentary

Monitoring functions, including proactive visits and audits are essential to ensure that clinicians and service providers are complying with legislative rights protections. As outlined throughout this report, we have heard of many instances where the requirements in the Act are routinely not met, for example, in relation to treatment plans, information sharing, the seeking of informed consent to ECT, restraint and seclusion, and external review timeframes. We are concerned at the lack of compliance with rights protections in these situations. The consequences of noncompliance in terms of wellbeing and recovery can be profound.

The roles currently performed by the Chief Psychiatrist and community visitors do not adequately meet monitoring requirements. In particular, we note that the Chief Psychiatrist is insufficiently independent to monitor and promote rights, and rarely visits people subject to orders. The Chief Psychiatrist's office previously visited services during statewide clinical reviews. However, this program has now been inactive for many years. Further, we note that community visitors, while valued, do not have sufficient powers or expertise to resolve issues. The community's lack of confidence in the system is exacerbated by the fact that there is no enforcement of breaches of the Act.

One option to improve monitoring functions could be through the introduction of official visitors, consistent with many other Australian jurisdictions. In addition to their role of conducting a check on the legality of an involuntary order within seven days, official visitors could be required to check on the wellbeing and rights of people subject to orders. They could also support people to understand and exercise their rights. Official visitors could also conduct compliance (as opposed to clinical) audits. Service specific reports containing information obtained during audits and visits could be published regularly to improve accountability and assist in systemic service improvement.

4.4 Clinical leadership

In addition to monitoring and complaints functions, the Chief Psychiatrist conducts various clinical leadership activities to facilitate practice and service development, including providing education, training and advice to the sector. However, there is no reference in the Act to the clinical leadership functions performed by the Chief Psychiatrist.

Challenges identified by the community

Many submissions voice concern about the conflict in the Chief Psychiatrist's functions, which include clinical leadership as well as monitoring and responding to complaints.

There is an important distinction between the role of a clinical leader and the role of a body authorised to undertake responsibilities such as monitoring and receiving of and responding to complaints. However, both of these should operate in close proximity allowing for a dissemination of information and a close working relationship between the two. A clinical leader should be free to provide that leadership and assist in the operationalisation of recommendations without being placed in a position of conflict within their leadership role.

(Sub 214, Australian College of Mental Health Nurses, p.14)

Community views about reform

Mental health and legal professionals suggest that the clinical leadership functions of the Chief Psychiatrist should be retained, and the complaints and monitoring functions transferred to a new commissioner (see, for example: sub 194, The Alfred Psychiatry, Alfred Health, p.11; sub 145, Victoria Legal Aid, p.24). In order to reflect this, clinicians suggest the new Act should reconfigure the Chief Psychiatrist's role so that it focuses primarily on clinical leadership.

... we would value the Office of the Chief Psychiatrist assuming a more prominent clinical leadership role, in particular one that mirrors the Senior Clinician role created in the Disability Act 2006 (Vic).

(Sub 194, Alfred Psychiatry, Alfred Health, p.11)

A recurring theme in community consultations was support for the reintroduction of clinical audits. A number of mental health professionals cited the benefits of the clinical audits conducted by the Chief Psychiatrist in the 1990s, arguing they were an important mechanism to enable peer review and service improvement across the sector.

Panel's commentary

Community consultations have revealed support to retain and clarify the Chief Psychiatrist's clinical leadership functions. As outlined above, we note the focus of the Chief Psychiatrist's role has moved away from clinical leadership to complaints handling and effective collaboration between public mental health services. The new Act could establish a departmental clinical leadership role, responsible for providing advice, training and education to the sector, conducting clinical audits as well as providing advice to the Minister and the department. It is important that this role not be involved in the receipt of complaints.

4.5 Clinical monitoring

Currently the Act requires people subject to CTOs to be assessed as to their mental health by a supervising medical practitioner at regular intervals. This is known as a clinical review. The purpose of the clinical review is to determine whether the criteria for an involuntary order continue to apply to the person. There is no equivalent requirement in relation to people detained in a mental health service.

In terms of mental and general health, the Act also requires people on CTOs and people detained for treatment in a mental health service to be examined annually. This is known as an annual examination.

Challenges identified by the community

Community consultations identified a number of issues.

- The Act does not require clinical reviews, other than for people on CTOs.
- Reviews for people admitted to mental health services and people subject to CTOs are too infrequent.
- In terms of annual examinations, there is a tension between mental health professionals who believe the requirements to be unnecessary and others who believe they are essential to the provision of holistic care.

Community views about reform of clinical reviews

Many submissions support the establishment of requirements for frequent clinical reviews for all people subject to orders by the authorised psychiatrist or treating team. The Health and Community Services Union believes ‘the authorised psychiatrist could be required to review patients more frequently than is currently required’ (sub 146, p.14). Victoria Legal Aid notes the ‘review should be frequent, mandatory and noted in files’ (sub 145, p.11).

Several submissions specify the optimal frequency of clinical reviews. Suggestions vary from weekly to three monthly (see, for example: sub 41, Mercy Mental Health, p.2; sub 113, Maroondah City Council, p.1).

Some service providers suggest that a clinical review requirement is undesirable due to inflexibility.

... mandating a certain frequency of clinical review via the imposition of a ‘one size fits all approach’ seems too inflexible. Clinical review of any patient should occur as is clinically appropriate.

(Sub 12, Caulfield Aged Persons’ Mental Health Service, p.3)

Community views about reform of annual examinations

Many mental health professionals suggest the annual examination requirement is largely unnecessary.

We are aware of findings that the physical health of people with mental illness is often neglected and/or poorly managed. There are complex reasons for this. The requirement that all involuntary patients receive an annual physical examination is an attempt to influence clinical practice and outcomes through legislation. It is doomed to fail ... We would submit that these matters are the concern of policy and clinical guidelines and should not be subject to statute or regulation.

(Sub 194, Alfred Psychiatry, Alfred Health, p.7)

Similarly, the Australian Nursing Federation questions the necessity of regulating the frequency of annual examinations (sub 51, pp.4–5).

Some suggest that the annual examination requirement is particularly unnecessary for people on a CTO.

Austin Health is of the view that the annual examination requirement should change to reflect the needs of a community-based service. The ‘requirement should be that all involuntary patients on long-term community treatment orders have their health needs managed by a suitably qualified community general practitioner’ (sub 63, p.5).

The Mental Illness Fellowship of Victoria believes the annual examination requirement should be maintained, and that the results should be published on a de-identified, aggregated basis.

The incidence of physical morbidity in people with mental illness is relatively higher than in the general population; Gold et al (2008) noted that ‘[i]n general, 50% to 90% of patients with serious mental illness have at least 1 chronic health problem, and the rate of illness is often double that of the general population’. The life expectancy of people who have a diagnosis of schizophrenia is 25 years less than the general population – medical illness accounts for two thirds of this difference (Parks et al 2006) ... MI Fellowship believes that annual examinations should be maintained ... MI Fellowship believes that this annual review should include consideration of the wider social and community situation of the person who is the subject of the order.

(Sub 167, p.12)

Some believe the examination should be retained and include a general examination of mental and physical health, as the physical health of the person is essential to their overall wellbeing (see sub 173, Rafferty, J, p.4). Similarly, according to Dimopoulos, ‘medication takes its toll on the physical aspect of the consumer. There should be a duty of care by clinicians on the physical wellbeing of consumers. A consumer should be accessed holistically’ (sub 200, p.1).

There is some support for the retention of the annual examination requirement, with added flexibility (see, for example: sub 149, Norwood Association Inc, p.3). Vij believes all people ‘detained or given forced treatments should receive comprehensive medical examinations at sufficiently regular intervals to manage or eliminate any physical conditions which are causing mental symptoms’ (sub 196, p.9).



A contentious issue is whether the authorised psychiatrist should be permitted to consent to the examination where the person refuses. A number of submissions suggest the authorised psychiatrist should be able to consent to the annual examination in some circumstances. These include, for example, if the person is deemed not to be able to consent to the annual examination (sub 145, Victoria Legal Aid, p.11).

According to Shields, ‘there is simply no legal means to compel an involuntary patient in the community to submit to a physical examination, or indeed to compel a doctor to physically examine a patient’. Shield also notes, ‘it is, of course, very important that involuntary patients receive good medical care, and are engaged with GPs and other health service providers in the community, but this should be achieved on a collaborative basis’ (sub 102, p.2).

Panel’s commentary

Generally, there is support for mandatory clinical reviews on a frequent and regular basis for people admitted to mental health services and people subject to CTOs. There are varying views about the appropriate frequency. It would seem preferable that the new Act continues to require clinical reviews for people on CTOs, and that the new Act should also require clinical reviews for people admitted to mental health services. Should a staged order scheme be adopted, as suggested earlier in this report, more frequent reviews will be necessary in any event for people subject to orders.

Community consultations have revealed differing views about the necessity of annual examinations. On the one hand, clinicians and service providers argue there is no need for the new Act to require annual examinations. In contrast, several submissions argue that, due to reports about the poor management of the physical health needs of people with a mental illness, the new Act should retain a requirement for annual physical examinations. On balance it would be desirable for the new Act to continue to require annual physical examinations. However, in light of views about the undesirability of compelling people to undergo physical examinations, it would appear preferable that the new Act permits physical examinations to be undertaken only where the person consents.

4.6 Safeguards for ECT and psychosurgery

The Act contains the following safeguards in relation to ECT and psychosurgery.

ECT: The Act allows the authorised psychiatrist to consent to treatment for people who are subject to an order, irrespective of the person’s capacity. However, the Act requires the authorised psychiatrist to seek informed consent before performing ECT on a person. Unless urgently needed, the Act does not permit ECT to be given to a person who has capacity to consent but refuses.

Psychosurgery: Currently the Psychosurgery Review Board must consent to psychosurgery and deep brain stimulation (Deep brain stimulation has been interpreted as being within the definition of psychosurgery).

Rights advice: The Act also imposes a duty on the authorised psychiatrist to provide each person with a statement and explanation of their rights prior to certain treatments such as ECT and psychosurgery.

Challenges identified by the community

Community concerns about the regulation of ECT in the Act include:

- there is no mandatory requirement for a safeguard such as a second psychiatric opinion or board review as exists in other Australian jurisdictions
- the requirement in the Act that clinicians seek informed consent to ECT is often not complied with.

There is a sharp divide between people who suggest that ECT is a damaging procedure that should either be prohibited or subject to strict safeguards, and others, largely mental health professionals, who support its use for certain mental illnesses.

I will never forget how awful the experience of being forced to undergo the ECT treatment was for her. She was terrified and this only increased as the treatments continued. She was at her worst after she had had 5 or 6 treatments. She couldn't remember herself how many treatments she had had and would have to ask me about it and other matters. Her memory seemed to have completely collapsed.

(Sub 147, confidential)

ECT is a safe and effective treatment for a variety of psychiatric illnesses. Its use is invaluable in public mental health services.

(Sub 12, Caulfield Aged Persons' Mental Health Service, p.1)

The Royal Australian and New Zealand College of Psychiatrists cites research that found ECT appeared to be an effective short-term treatment for depression that may be more effective than medication (sub 69, p.28).

Brien asserts that the fact an authorised psychiatrist may consent to ECT on a person's behalf is an abuse under the Act (sub 3, p.2). In addition, Mind suggests that administering ECT without full consent does not sit comfortably with human rights and recovery approaches (sub 181, p.8).

As outlined in the consultation paper, the Australian Nursing Federation notes that of the people subject to orders who were given ECT in 2007–08, only 5 per cent were able or deemed to be able to provide consent for ECT. The federation poses the question: 'how realistic is the requirement of informed consent of involuntary patients who are deemed to require ECT?' (sub 51, p.8).

Community views about reform of ECT

Many in the community believe further safeguards are required in the new Act for the use of ECT, including:

- a compulsory and independent second psychiatric opinion or board hearing before ECT can be performed
- prohibiting the performance of ECT on a person who has capacity but refuses the treatment
- prohibiting the performance of ECT on children.

However, a small number of mental health providers do not agree further safeguards for ECT are necessary (see, for example: sub 41, Mercy Mental Health, p.3).

In contrast others suggest that 'ECT should be banned from use on all persons' (for example, sub 48, Little, M, p.1).



The ARAFEMI Consumer Group Forum believes ‘there should be a compulsory second opinion from an independent psychiatrist when ECT is given where a patient cannot give consent to the procedure’ (sub 185, p.3; see also: sub 63, Austin Health, p.7).

This position was supported by a forum participant and in a number of submissions: ‘second psychiatric opinion may be mandated before ECT can be given so as to improve safeguards for ECT’ (workbook comment, Keysborough forum).

The Royal Australian and New Zealand College of Psychiatrists submits that, ‘except in emergencies, where a patient is unable to give consent it is advisable that a second opinion is sought from a practitioner with experience and knowledge of ECT’ (sub 69, p.29). However, other submissions note that ECT is not an emergency treatment.

Provision for emergency ECT without consent should be removed. It should follow the same legislative process as other ECT process.

(Sub 114, Southern Health, p.7)

Some people are of the strong view that ECT should never be permitted without the person’s consent.

The Victorian Mental Illness Awareness Council submits that ‘in instances where the psychiatrist regards ECT as the most effective mode of treatment and the consumer has capacity and does not agree, ECT should not be able to be provided’ (sub 35, p.12). Southern Health believes ‘patients must have the right to refuse certain treatments like ECT and long acting medications’ (sub 114, p.4).

... the Special Rapporteur states that ECT ‘may constitute torture or ill-treatment’ and, if it is to be used, ‘it is of vital importance that ECT be administered only with the free and informed consent of the person concerned, including on the basis of information on the secondary effects and related risks such as heart complications, confusion, loss of memory and even death’.

(Sub 90, Monash University, p.19)

Some professionals argue that the new Act should prohibit or limit the use of ECT on children.

St Vincent’s Hospital submits that ‘in general, ECT should not be used in children less than 16 years. In any event that it is considered, there should be a requirement to have a second and third opinion’ (sub 119, p.10).

Used on children, without their or their parents’ consent, and potentially causing brain damage just to modify external behaviour, ECT is a criminal treatment and cannot be justified under Victoria’s Charter of Human Rights, or the International [Convention] on the Rights of the Child to which Australia is signatory.

(Sub 162, confidential)

In terms of licensing ECT, there is a high level of community support for maintaining current arrangements. A number of submissions comment on the need to reflect practice developments in terms of the number of ECT treatments in a course. Some suggest changing the number from six to between six and 12.

It is suggested that increased education could help improve the community’s understanding of ECT (sub 67, Doolan, B, p.5).

Community views about reform of psychosurgery

The Alfred Psychiatry Research Centre has raised the issue that under the Act, people are unable to consent to deep brain stimulation, as consent can only be granted by the Psychosurgery Review Board.

... a patient who is completely able to give informed consent and is also completely able to evaluate the potential benefits and risks of the procedure, may be denied access to the procedure if the board is not satisfied that the patient meets [the] criteria.

(Sub 13, Alfred Psychiatry Research Centre, p.2)

The Alfred Psychiatry Research Centre also notes the inconsistency of this approach with the way deep brain stimulation is regulated for people with neurological disorders. This is because the treatment of people with Parkinson's disease or epilepsy is not subject to external review (sub 13, p.2).

A number of submissions do not support the practice of psychosurgery. The Citizen's Commission on Human Rights notes that psychosurgery 'has already been banned in New South Wales and the Northern Territory, yet this is a practice that continues in Victoria despite its acknowledged controversy [footnote omitted]' (sub 141, p.27).

Panel's commentary

There is a sharp divide in community views about ECT and its regulation. In line with other Australian jurisdictions, we are of the view that it would be desirable if the new Act required a mandatory safeguard before ECT can be performed. There are options for how this could be achieved, including via the board or through a second psychiatric opinion. Determining an appropriate safeguard is a particular issue in relation to rural and regional areas of Victoria where access to second psychiatric opinions is problematic, and board visits are infrequent.

As outlined above, the Act currently permits ECT to be performed on a person who has capacity to consent but refuses, where 'urgently needed'. The new Act should not permit the performance of ECT on a person who has capacity but refuses the treatment. It is also important that the new Act encourages compliance with informed consent requirements, and that there be increased scrutiny of this process.

Issues relating to ECT and children are discussed later in this report. However, in relation to young people and adolescents (as with adults) it would be desirable if the new Act required an additional mandatory safeguard. The new Act could also require the involvement of a child and adolescent psychiatrist where ECT is being considered. The child and adolescent psychiatrist could be involved as a second psychiatric opinion or as a member of the board.

In relation to psychosurgery, it would appear sensible, given the extremely low number of cases, to subsume the operations of the Psychosurgery Review Board as a division of the board, rather than retaining it as a separate body.

In relation to deep brain stimulation, we do not believe we have the expertise to meaningfully comment. We suggest that further clinical advice be sought in relation to this issue.





5 Improving responsiveness to specific needs



5. Improving responsiveness to specific needs

This section examines ways the new Act could improve responsiveness to people with specific needs, including:

- people receiving treatment on a voluntary basis
- children and young people
- Indigenous people
- women
- the aged
- people with co-occurring substance use and mental disorders
- people with dual disabilities
- refugees and other culturally and linguistically diverse groups.

The principles of treatment and care in the Act include consideration of age-related, gender-related, religious, cultural, language and other special needs. However, there are no particular protections in the Act that have regard to the specific needs of people receiving treatment on a voluntary basis, children and young people, Indigenous people, and other groups.

Community sentiment indicated that a variety of specific needs should be recognised in the new Act to aid the delivery of appropriately responsive mental health support for particular groups.

The Act currently lumps everyone in together – need for Act to recognise different circumstances – e.g. children.

(Workbook comment, Ringwood forum)

5.1 Needs of people receiving treatment on a voluntary basis

At present, some parts of the Act apply both to people receiving treatment on an involuntary and voluntary basis. These include: the principles of treatment and care; the safeguards that apply to ECT, psychosurgery, mechanical restraint and seclusion; and provisions relating to confidentiality and information sharing. The Act does not require that information about rights and treatment be provided to people receiving treatment on a voluntary basis.

Challenges identified by the community

A number of issues have been raised in relation to people receiving treatment on a voluntary basis.

- The Act contains insufficient rights protections applicable to people receiving treatment on a voluntary basis.
- There are concerns about the relationship between involuntary and voluntary status, particularly regarding treatment and the use of coercion.
- Concerns were raised about whether the new Act should continue to regulate the use of restraint and seclusion on people receiving treatment on a voluntary basis.
- People are often unaware of their rights.

A forum participant noted that ‘sometimes in the current system it’s better to be an involuntary patient than a voluntary one, because at least then there’s a chance of being told what the treatment options are, and what are the implications’ (workbook comment, Keysborough forum).



The Victorian Mental Illness Awareness Council is aware of numerous reports of ‘clinical staff threatening voluntary patients that if they do not do what they are told they will be made involuntary’ (sub 35, p.6).

A forum participant noted ‘if a psychiatrist ‘offers’ you treatment as a voluntary patient and you refuse it, it’s common then to be made an involuntary patient. That’s coercion and should be illegal’ (workbook comment, Keysborough forum).

Community views about reform

The majority of views support greater recognition of the rights of people receiving treatment on a voluntary basis. For example, the Office of the Health Services Commissioner notes that there could be recognition of the rights of all people receiving treatment for a mental illness not only those who are involuntary (sub 205, p.2).

The Rethinking Mental Health Laws project at Monash University suggests the establishment of procedures in the new Act to support all people with a mental illness to exercise their own choices wherever possible.

Article 12 of the Convention clearly recognises legal capacity as fundamental to ensuring that individuals with disabilities, including mental illnesses, are considered equals before the law. It recognises the right of individuals with disabilities both to possess and exercise legal capacity. This means that individuals with mental illnesses must have their legal capacity recognised and that procedures be developed to ensure the enjoyment and realisation of their own choices to the fullest degree of their capabilities.

(Sub 90, p.8)

The Rethinking Mental Health Laws project believes the new Act should contain provisions dealing with the admission and treatment of people receiving treatment on a voluntary basis along the lines of Part 5 of the *Mental Health and Related Services Act 1998* (NT). This would include a right to appeal a decision to refuse treatment (sub 90, p.8).

However, there is not universal support for greater recognition, for example: ‘voluntary patients have the same rights as all others in the community ... The Act does not need to go into this area’ (sub 16, Monash, D, p.3).

There have been many calls for the reinstatement of protections that were removed from the Act in 1995. These include the right to challenge refusal of admission, and the requirement that a statement of rights be provided to people receiving treatment on a voluntary basis.

Under the Act, the requirement to provide a statement of rights applies only to ‘patients’ (that is, people on involuntary treatment orders). OPA suggest that a statement of rights should also be provided to persons who voluntarily receive treatment.

(Sub 192, Office of the Public Advocate, p.5)

The Act should provide for every patient – voluntary and involuntary – to be given a statement of their rights.

(Workbook comment, Ringwood forum)

Some believe that the new Act should prohibit the use of restraint and seclusion on people receiving treatment on a voluntary basis. A participant at the Bendigo forum believes physical restraint opens opportunities for abuse, especially of people with dementia (workbook comment).

However, contrasting views have also been expressed. For example, Southern Health is of the view that the new Act should continue to allow restraint and seclusion in very rare clinical situations. 'The maximum duration of seclusions/restraints must not be more than one hour. This prescribed period is to ensure that the patient's voluntary status is reviewed' (sub 114, p.8).

Panel's commentary

There is a diversity of views regarding the need for greater regulation of treatment and care provided on a voluntary basis. It appears that the present provisions in the Act regarding voluntary treatment and care are inadequate to protect people's rights and interests sufficiently. While there are protections that exist for all patients of public health services, the vulnerability of people who are receiving mental health services arguably warrants greater regulation of their treatment and care.

As outlined earlier in this report, revised guiding principles for treatment and care in the new Act could continue to apply to all people admitted to public mental health services and all people subject to orders. Revised principles could provide decision makers with a framework for best practice. The principles could also assist people in understanding their rights and what to expect in treatment and care.

In the past, it was mandatory for a statement and explanation of rights to be given to people admitted to a public mental health service on a voluntary basis. It could be beneficial to re-introduce this requirement. This could ensure that all people receiving treatment and care for a mental illness within public mental health services are equally informed of their rights on admission.

Community consultations highlighted that the nature of treatment and care can change throughout the course of a person's treatment. For instance, a person who is initially treated on a voluntary basis may be subsequently assessed as requiring an involuntary order. In the event that all people admitted to a mental health service receive a statement of rights, these people and their families may have a greater understanding of their options as well as the fluid nature of treatment.

We also note there was support for individuals to have the ability to seek a review of a decision to refuse admission to a mental health service. This is consistent with the Disabilities Convention and its focus on respect for inherent dignity, individual autonomy and the independence of persons, by ensuring voluntary access to services wherever possible.



5.2 Needs of children and young people

The principles in the Act require that a person's age-related needs should be taken into consideration in the provision of treatment and care. However, the Act does not contain any particular protections that have regard to the specific needs of children and young people. In practice, it is common for a child's parent or guardian to consent to treatment on their behalf. Accordingly, a relatively small number of children receive treatment on involuntary orders.

Challenges identified by the community

Key issues raised by the community in relation to children and young people include:

- the Act is silent on the needs of children and young people and therefore it contains no specific protections for children and young people
- children and young people only receive protections if they are subject to an involuntary order
- issues in relation to capacity to consent are particularly complex in relation to children and young people
- a number of children and young people care for parents who have a mental illness and the Act is silent on this issue.

The Child Safety Commissioner is of the view that the present voluntary and involuntary dichotomy may not be in the best interests of children and young people.

The distinction between voluntary and involuntary patients is not well suited to identifying or meeting the needs of children. Of particular concern is that by classifying children as 'voluntary' even where they have not consented to treatment (but a parent or guardian has consented), children are denied access to some safeguards that are available to 'involuntary' patients. However, adopting an approach of labelling any child who lacks capacity as an 'involuntary' patient may not be in the best interests of the child and may be counterproductive to empowering parents who are acting in their child's best interests.

(Sub 97, Child Safety Commissioner, p.1)

Community views about reform

A number of reforms have been suggested to respond to the needs of children and young people.

- the inclusion of guiding best interests principles applicable to children and young people
- a requirement for a multidisciplinary approach in the assessment of children
- the establishment of specific protections for children and young people, including greater safeguards on the use of restraint, seclusion, medication and ECT, and possibly board reviews of all treatment decisions pertaining to children and young people
- the recognition of the needs of children and young people who care for parents who have a mental illness.

The Rethinking Mental Health Laws project at Monash University suggests that 'young people should be provided with maximum protection under the legislation' (sub 90, p.3).

There is a significant level of support for the inclusion of guiding best interests principles for children and young people.

... the guiding principles in the Act which inform clinical decision making in mental health should include the human rights principles in the [United Nations Convention on the Rights of the Child] which emphasise that the best interests of the child is the primary consideration in all actions in relation to the treatment and care of a child with mental illness.

(Sub 115, Victorian Equal Opportunity & Human Rights Commission, p.28)

There is also support for: the need to include children and young people as much as possible in decisions regarding their treatment and care; recognition of the specific developmental needs of children and young people; and the desirability for the separation of children and adults in mental health services.

The Royal Children's Hospital submits there are ambiguities in the law around consent to treatment for children and young people who are found not to have capacity, and difficulties in determining whose views are paramount.

Current ambiguity is unhelpful, and there is a need to determine who has final responsibility and authority to decide action. In general, health professionals, parents and adolescents, would prefer there to be greater clarity in the laws concerning the rights of 15–17 year olds and would like greater guidance.

(Sub 168, Royal Children's Hospital, p.2)

There is support for involving children and young people in making decisions about their treatment and care.

Article 7(3) of the United Nations Convention on the Rights of Persons with Disabilities stresses the independence and participation of children in medical decision making on an age appropriate basis [footnote omitted]. Decisions involving children should be subject to independent review in all instances.

(Sub 90, Monash University, p.3)

The Child Safety Commissioner suggests that consent should be sought from children found to have capacity (sub 97, p.2).

Some submissions suggest that the new Act should enable parents or guardians to consent to treatment for children and young people found not to have capacity due to their level of maturity.

The Shire of Yarra Ranges Youth Services believes the Act needs to specify criteria where families can consent to treatment (voluntary or otherwise) for people under the age of 18 (sub 203, p.1). Lehocz states: 'no children under 18 years should be detained and parental or guardian's consent should always be obtained for any mental treatment' (sub 123, p.1).



Where the young person cannot consent due to their level of maturity, consent to treatment by the carer/parent or guardian should be permitted. The determining factor as to whether a person requires treatment for a mental illness should not rest with their age, but with their ability to make the decision in their own 'best interest'.

(Sub 148, Eating Disorders Foundation of Victoria, p.5)

No child or adolescent under 18 years should be involuntarily detained and treated. Parental or legal guardian's consent should always be obtained for any psychiatric treatment. There should be no difference in parental rights with psychiatric treatment than there is with any other medical treatment. It is completely unacceptable to remove parental rights where those parents are not subject to legal orders preventing them access to their children.

(Sub 38, O'Regan, M, pp.1–2).

Austin Health is of the view that decision makers should be legally appointed for children and young people found not to have capacity due to their level of maturity (sub 63, p.4).

A number of consultations suggest that a specialty focus is needed in the assessment of children and young people. A participant at the Mildura forum noted that this should occur before a diagnosis is given (workbook comment).

There is community support for the inclusion of specific protections for children and young people, including greater safeguards regarding restraint and seclusion, medication, and ECT (for example, workbook comment, Ringwood forum; sub 51, Australian Nursing Federation Victorian Branch, p.4).

It is also suggested that the needs of children who care for parents with a mental illness should be addressed. This is seen as being of particular relevance in light of the Charter right to protection of families and children. Victorian Families where a Parent has a Mental Illness Coordinators believe that 'because of the unique circumstances surrounding families where a parent has a mental illness, there is an imperative to formally acknowledge these issues in the Act' (sub 43, p.3).

The Act should take into account the rights of other family members – e.g. children where parent has a mental illness. There needs to be sharing of information to protect these children.

(Workbook comment, Ringwood forum)

Panel's commentary

Community consultations highlighted that, irrespective of involuntary or voluntary status, currently there are no particular legal safeguards in the Act tailored to the specific needs of children and young people. We recognise that children and young people are a particularly vulnerable group in our community who require additional safeguards when engaged in the mental health system.

As outlined above, it is common for the parent or guardian of a child or young person to consent to treatment on their behalf. Additional safeguards could apply in these situations. One option is for the new Act to require a treatment, care and recovery plan for all children and young people. Other options include specific guiding principles, and greater regulation of physical restraint and ECT.

Specific guiding principles could require that decisions relating to children and young people be made in their best interests. This would ensure that the new Act reflects the protection principles in the Charter and international human rights instruments. ‘Best interests’ would need to be defined to ensure all relevant matters are considered in decision making, including the participation of the child or young person in decisions concerning their treatment, care and recovery.

To facilitate the involvement of young people in decision making it is important that there is a renewed emphasis on assessing their evolving capacity. This will also provide greater clarity for clinicians in making treatment and care decisions. A code of practice may assist in this process.

We also support greater regulation of restrictive interventions including physical restraint as they apply to children and young people. In addition, the impact on young brain development of treatments such as ECT requires further consideration. This could inform possible changes to legislation where, for certain age groups, one of the following applies:

- ECT is prohibited
- ECT is only permitted following a mandatory second opinion
- a decision about the necessity of ECT is made by an independent review body.

A further concern is the situation where children and young people care for a parent with a mental illness. This is an issue that may best be dealt with in codes of practice. It is important that decisions made regarding the treatment and care of a parent have regard to the best interests of the young carer.

5.3 Needs of Indigenous people

The principles in the Act require that a person’s cultural and language needs be taken into consideration in the provision of treatment and care. However, the Act does not provide any particular protections that have regard to the specific needs of Indigenous people.

Challenges identified by the community

Views expressed during community consultations indicated that the Act does not take a holistic approach to recovery, due to its focus on treatment rather than healing. This is of particular significance for Indigenous people who have a unique and broad concept of holistic healing, and an inclusive understanding of family.

Community views about reform

Reforms raised by the community to improve responsiveness to the needs of Indigenous people include:

- incorporating guiding principles and legal protections for Indigenous people
- recognising the unique conception of mental health held by Indigenous people
- a requirement for involving culturally appropriate people in decision making
- recognising connection to land.

In light of the Charter principles that recognise the special importance of human rights for Victoria’s Indigenous people, there is support for specific principles to guide the treatment and care of Indigenous people.



The Victorian Equal Opportunity & Human Rights Commission suggests that under the new Act powers should be ‘exercised in a way that respects and promotes the cultural rights of Indigenous Victorians and people of culturally and linguistically diverse backgrounds’ (sub 115, p.11). The commission submits that clinical guidelines could be one way to do this. Examples include:

- *guidance to treating teams during the diagnosis and assessment of mental illness which take into account cultural behaviours, attitudes and beliefs of the particular person;*
- *incorporating cultural and religious observances into treatment plans;*
- *recognising diverse family and kinship relations in treatment planning; and*
- *guiding treatment teams about the significance that a diagnosis of mental illness in different [culturally and linguistically diverse] communities and the impact this has on the person who is diagnosed with mental illness in the context of treatment planning and discharge.*

(Sub 115, pp.30–31)

Further, peak Indigenous organisations submit that Indigenous people require specific legal protections, such as in relation to external review.

The Indigenous Australian community in Victoria is unique, and therefore a person representing opinions of the Indigenous Australian community in hearings should be, where possible, a member of the Koori community when an Indigenous patient’s treatment decisions are being presided over. This could take the form of a Koori Mental Health Liaison Officer. The standing of such an Indigenous Australian may be similar to that of Elders in the Koori Court or those who appear before the Parole Board. This would be an example of Indigenous Australian self-determination.

(Sub 212, Victorian Aboriginal Legal Service Cooperative Ltd, p.19)

As hearings are currently held at mental health services throughout Victoria ... in order to provide for culturally appropriate and accessible mental health care services and utilisation, it should be considered a possibility to have hearings made readily available at Koori health service centres.

(Sub 212, Victorian Aboriginal Legal Service Cooperative Ltd, p.32)

The Victorian Aboriginal Legal Service Cooperative also suggests that legislation in the Northern Territory is a useful model for the new Act, particularly in relation to specific principles, and provisions establishing Aboriginal health workers and membership of its tribunal (sub 212, pp.20–21).

The unique approach to mental health by Indigenous people was identified during community consultations, with support for legislative recognition of this issue.

The unique conception of what Indigenous Australian communities consider constitutes mental health and wellbeing, as well as what is considered mental illness, must be recognised and incorporated into legislation that deals with decisions around the treatment of persons. Without this inclusion, the significantly disproportionate and tragic consequences ... will not improve for the Indigenous Australian population.

(Sub 212, Victorian Aboriginal Legal Service Cooperative Ltd, p.5)

The Victorian Aboriginal Legal Service Cooperative also advocates for culturally appropriate persons having key roles, particularly when treatment decisions are being made and reviewed (sub 212, p.19).

There is support for recognition of connection to land. In this context, concerns were raised about the long distances that Indigenous people may have to travel from their homes to mental health services. This was a matter particularly important to regional and rural public forum participants.

Panel's commentary

The community consultations identified the unique understanding of mental health held by Indigenous people. We note that the Charter specifically recognises the distinctive rights and spiritual, material and economic relationship of Indigenous people with the land and waters. In this context, and noting community sentiment, we acknowledge the need for legislative recognition of the specific needs of Indigenous people. This could include recognition of Indigenous concepts of cultural safety, and an understanding of cultural competence and healing ways in the new Act. Revised guiding principles would be of benefit and could be given greater specificity in codes of practice. Further, when developing the new Act it would also be appropriate to consider how each proposed change could be tailored to meet the needs of Indigenous people.

5.4 Other people with specific needs

The principles of treatment and care in the Act include consideration of age-related, gender-related, religious, cultural, language and other needs. However, there are no particular protections in the Act that have regard to specific needs.

Challenges identified by the community

During community consultations there was significant support for increased protections for the following people with specific needs:

- women
- people with coexisting disability and mental illness
- people with co-occurring substance use and mental illness
- refugees and other culturally and linguistically diverse groups
- aged people.

Community views about reforms

During community consultations there was significant support for increased protections for women. The Victorian Women and Mental Health Network submits:

- *Women are generally in the minority in inpatient units often comprising approximately 40% of patients*
- *Women are more at risk of harassment/assault in inpatient units*
- *More women (approx 70%) who have a serious mental illness have experienced past sexual trauma (compared with 40% of male patients) and the rate of women who have experienced physical abuse is even higher.*
- *Women are more likely to be dealing with issues relating to care of children.*

(Sub 37, p.1)



Several submissions seek reform in relation to mixed wards. The Dousta Galla Community Health Service believes all wards should have a mandated safety plan to protect women where the facility is unable to provide a separate ward for women (sub 191, p.4). One submission expressed the view that women should be accommodated in separate wards where they may suffer underlying trauma associated with male strangers, or where there are males behaving inappropriately (sub 25, Dean, M, p.19).

Some submissions indicate support for a multidisciplinary approach to assessment and planning, particularly in relation to people with coexisting disability and mental illness (see, for example: sub 181, Mind, pp.7–8).

The need for specific approaches to the treatment of co-occurring substance abuse and mental illness was also raised. The Victorian Alcohol and Drug Association submits that where a person is identified as having a co-occurring substance use disorder, their drug treatment needs must also be considered and respected alongside their mental health treatment needs (sub 121, p.2).

The Victorian Dual Diagnosis Leadership Group believes there is a need to bring together the principles in the new Act and the Alcoholic and Drug-dependent Persons Act 1968 to develop an approach that encompasses both disorders (sub 117, p.8).

The Royal Australian and New Zealand College of Psychiatrists emphasises the importance of promoting culturally safe service provision, particularly for refugees and other culturally and linguistically diverse groups.

Cultural background affects how people experience mental illness and how they understand and interpret the symptoms of mental illness. Cultural safety means an environment which is spiritually, socially and emotionally safe, as well as physically safe for people; where there is no assault, challenge or denial of their identity, of who they are and what they need. It is about shared respect, shared meaning, shared knowledge and experience, of learning together with dignity and truly listening. Unsafe cultural practice is any action that diminishes, demeans or disempowers the cultural identity and wellbeing of an individual or group. Cultural safety can be compromised by racial or cultural bias that may be subconscious and unacknowledged. Equalising power differentials is a critical factor in establishing culturally safe service provision for indigenous and new Australians/Victorians.

(Sub 69, Royal Australian and New Zealand College of Psychiatrists, p.6)

Stolk submits that training in culturally sensitive practices should be a requirement for mental health staff (sub 89, p.4).

Several submissions identify the need to protect the rights of aged people, and in particular the need to clarify the circumstances under which the new Act should be applicable.

The Victorian Equal Opportunity & Human Rights Commission supports the need for a clear framework for the care and treatment of older people with mental illness that protects their human rights (sub 115, p.11).

Aged and Community Care Victoria suggests that the mental health problems experienced by many older people are often 'subclinical' and as a result older people may 'fly under the radar' of mental health services (sub 207, p.3).

The Caulfield Aged Person's Mental Health Service notes that clarity on the circumstances under which persons with dementia should be managed as involuntary patients would be most useful in the new Act (sub 12, p.4).

Panel's commentary

We note the community's desire for greater recognition of specific needs. We recognise that there are people within the community who require particular attention in relation to their interaction with the mental health system, due to their specific needs. The Act currently recognises the age-related, gender-related religious, cultural, language and other specific needs of people with a mental illness. It is important that these specific needs continue to be clearly recognised in the new Act.

Wherever possible, the new Act should provide guiding principles to address specific needs. When developing the new Act, it would also be appropriate to consider how each proposed change could be tailored to meet specific needs. These include the needs of women, the aged, people with coexisting disability and mental illness, people with co-occurring substance use and mental illness, refugees, and other culturally and linguistically diverse groups.

Many specific needs, particularly in relation to safety, may be more effectively addressed by activities that are not covered by legislation, such as through departmental and other initiatives. In particular, we note the work that is already underway to increase gender sensitivity in the service system. While these initiatives are outside the scope of this review, we note the community's desire for greater practical measures to address specific needs.

5.5 Issues raised by Victoria Police and Ambulance Victoria

A number of discrete issues were raised during the review consultation process. These include the involvement of Victoria Police and Ambulance Victoria, particularly where a person is in the acute phase of their illness. The panel notes that some of these issues could be addressed either legislatively or administratively.

Ambulance Victoria raised issues in relation to the transportation of people with a severe mental illness. One issue is the inability of ambulance officers to administer sedation to highly distressed people during transportation because of restrictions in the Act. In rural areas, there can be ongoing distress for people and police involvement to assist with transport which can cause delays. A second issue for ambulance officers, particularly in rural areas, is where a person breaches a CTO and must be taken to an approved mental health service for the administration of psychiatric medication. This often involves large distances where local health services are not authorised to administer the medication.

Ambulance Victoria seeks changes to the Act; first, to permit paramedics to sedate patients with acute behavioural issues who are a risk to themselves or others; and second, to allow paramedics to administer medication as prescribed by a medical practitioner (sub 151, p.1).



Victoria Police also raised a number of specific issues including:

- authorising other personnel to accept custody of people referred by police so that there is no requirement for police to remain for the outcome of an assessment
- allowing police to search a person where they have reasonable grounds for suspecting the person may have a dangerous article that they may use as a weapon
- retaining the special warrant provision
- formalising case planning in the new Act to reduce demands on frontline services, move away from episodic interventions in response to crises, avoid repeated requests for information and improve patient outcomes
- specifying that police involvement is to be limited to the exercise of powers under the new Act and other legislation, and to the provision of operational policing services (sub 217, pp.13–14).

Given the specialised nature of these submissions, the panel did not receive input from the community on them. It cannot therefore report on the community's response but includes the submissions here to ensure they are not overlooked.



A Appendices



Appendix 1 – Consultation process

Communication	A telephone enquiry line was established to provide a central point of communication for all enquiries and submissions. A dedicated email address was also created. Approximately 280 emails were received.
	A webpage was developed to provide a central source of information regarding project information and updates. The website received 62,217 hits during the period from May 2008 to March 2009.
	Over 500 groups were invited by the Community Consultation Panel to make submissions or attend public forums.
	Information about the public forums was made available via advertisements placed in a number of local and statewide newspapers as well as posters placed in mental health services throughout Victoria.
	A total of 4000 copies of the <i>Review of Mental Health Act 1986 Consultation paper – December 2008</i> and the <i>Review of the Mental Health Act 1986 Some key questions – December 2008</i> were distributed. These two consultation papers are available on the internet and were downloaded a total of 23,517 times during the consultation process.
Events	Fourteen public forums were held in metropolitan Melbourne and rural areas throughout Victoria. Of the 14 public forums, two statewide forums were held for consumers and carers. In total, 742 people attended these forums, including consumers, carers, mental health professionals and other professionals. Refer to Appendix 2 for details of the forums.
	The Community Consultation Panel and department conducted 67 presentations and meetings throughout the consultation process. These sessions provided an opportunity for focussed discussion. Refer to Appendix 4 for a list of people and organisations that attended these events.
Submissions	A submission template was made available on the project webpage. This document was downloaded 832 times.
	A total of 219 written submissions were received in response to the consultation papers. Refer to Appendix 5 for a list of submissions received.



Appendix 2 – Details of Community consultations

The following forums were conducted in a workshop format, designed to assist in identifying core objectives to be included in the new Act.

Forum	Date	Attendees
Carer (statewide)	29 January 2009	65
Consumer (statewide)	29 January 2009	32
Preston (North & West)	30 January 2009	69
Benalla (Hume)	2 February 2009	55
Geelong (Barwon-South Western)	4 February 2009	59
Warrnambool (Barwon-South Western)	5 February 2009	36
Keysborough (Southern)	9 February 2009	95
Ballarat (Grampians)	10 February 2009	41
Ringwood (Eastern)	12 February 2009	105
Bendigo (Loddon Mallee)	16 February 2009	53
Traralgon (Gippsland)	19 February 2009	30
Bairnsdale (Gippsland)	20 February 2009	12
Sunshine (North & West)	23 February 2009	53
Mildura (Loddon Mallee)	24 February 2009	37

Appendix 3 – Facilitator’s report on the Community consultations

Community consultations

Review of the *Mental Health Act 1986*

Facilitation final report

Prepared by Ms Vanessa Lynne,
Workplace and Community Facilitation and Education,
www.vanessalynne.com.au

Process

The main aim of the community consultations was to provide a forum in which all voices and opinions about what changes need to be made to the new Mental Health Act could be heard in a way that maximised participation. This was especially important in light of the attendance at the forums of mental health consumers and carers who, in most cases, would be mixing with mental health professionals and service providers.

A small group process was selected as the main tool for the consultations, with two supplementary processes, workbooks and graffiti walls providing participants with a variety of inclusive and low-threat modes of input. Each small group meeting around a table during the forum was labelled a ‘workshop’ for this process.

A lead facilitator co-ordinated the forum processes and was assisted by a team of facilitators, each sitting with the small groups who were gathered around a circular table. ‘It was good to have a facilitator at each table’ (workbook comment, Keysborough forum). Most of the table facilitators, who were volunteers from the head and regional offices of DHS, had a great deal of experience but some needed support and reassurance. The lead facilitators provided briefing and debriefing sessions as well as briefing notes.

Each table appointed a scribe who often provided the feedback to the whole group. Less commonly, another member of the group would report back and occasionally the table facilitator was co-opted to provide the feedback. Notes from the tables were handed to the lead facilitators who extracted the key points from the different forums. Notes were of variable quality and legibility and, although of mostly reasonable quality, in future consultations a more structured feedback sheet may prove useful. DHS staff also took extensive notes during each forum, as did the Community Consultation Panel.

Participants were asked to select two workshops from six different themes:

1. rethinking involuntary orders
2. the Act’s role in promoting recovery
3. patient participation in decisions about treatment and care
4. a stronger human rights focus
5. effective and accessible mechanisms to oversee treatment and care
6. responsiveness to the needs of families and carers.



More tables were created if a particular theme was popular, ensuring that each participant could be part of the workshop of his/her choice. 'It was good to have more than one table working on the same topic as it generates more information' (workbook comment, Geelong forum).

Except at the initial consumer and carer forums, each of the two workshops conducted per session were 50 minutes long. Warnings were given at 40 minutes and 45 minutes to allow the table facilitators to channel the discussions into identifying common themes. 'Time allowances were very well planned' (workbook comment, Keysborough forum). The workshops in the consumer and carer forums were 30 minutes rather than 50. 'The Forum broke tasks into achievable segments' (workbook comment, Warrnambool forum).

The Community Consultation Panel members first introduced themselves and outlined the key issues for consideration during the forums. Once the discussions began, they 'floated' between the tables, sitting in and joining the discussions for up to 20 minutes per table. At the end of the forum, they fed back to the whole group what they had heard and what they believed the main points were. 'The Panel were terrifically informed and open in their discussions' (workbook comment, Keysborough forum).

The participants were told at the beginning of each forum that the aim was not to agree but to share ideas and listen to what others had to say. With no expectation of agreement, some of the pressure was taken off. 'It was great to just express rather than discuss towards consensus' (workbook comment, Geelong forum).

Reactions

Many participants commented that they felt heard and the feedback sheets confirmed this. One comment that summed up the feeling of many participants was the consumer from Warrnambool who said, 'My friend didn't want to come because he said these things are a waste of time and no-one ever listens, but I'm going to go and tell him that he was so wrong.'

Occasionally a participant would dominate the small group, wanting to tell or re-tell a story or repeat a point of view. The small group process meant that this seldom disrupted the whole group. The discussions were often deep and because people had been told that they didn't have to agree, they were able to put forward a variety of points of view during the discussions and through the feedback. 'No negatives - no negative attitudes' (workbook comment, Preston).

The forums

Carer forum

About 70 carers attended the first forum on the morning of 29 January. Mr Lei Ning gave an outline of consumer issues and this was followed by an outline of carers issues delivered by Ms Margaret Leggatt. The discussions were focussed and while at times a little difficult in some groups, the session concluded with some broad agreement across a number of key themes. The carers were very clear that they needed to be involved as soon as possible and be in receipt of information about the consumer that would assist them in their caring role. They also believed that there needed to be more education and training for health professionals in the delivery of a holistic and recovery focussed approach to mental illness.

Feedback indicated that it was a positive experience being able to discuss topics and be heard by the whole group in the plenary session. The carers stayed after the forum and shared lunch with the consumers who had their forum in the afternoon.

Consumer forum

The hot weather played a part in a smaller than expected attendance by consumers, with temperatures in the low 40s that day. Approximately 40 people attended. The introductions by Mr Ling and Ms Leggatt were the same as for the carer forum and afterwards people formed groups to discuss topics of interest.

Feelings were quite strong at some points during the discussions and the feedback, but interestingly the issues that were raised and discussed were very similar to those raised by the carers. So both groups were very clear that a more holistic and recovery-focussed approach to mental health was going to be beneficial not just to consumers but to their families and carers as well. Consumers also recommended a greater role for consumer advocates at all stages of the process.

Preston

Another very hot day failed to deter 70 people attending the forum held at the Darebin Community Arts Centre. The mixed group of consumers, carers, service providers and health professionals provided the first test of the chosen processes and was successful in involving all the participants.

The longer discussion times allowed participants to explore the workshop topics in some depth. Similar themes to the previous forums started to emerge quite quickly. For example, having an assessment period before a person became an involuntary patient was supported by participants. Apart from giving the patient time to be thoroughly assessed, it would remove the stigma of being made involuntary if during the assessment the patient was able to be treated outside the Act.

People commented positively on being able to work with a group of participants from diverse backgrounds. 'Group synergy = good output' (workbook comment, Preston).

Benalla

Approximately 50 people attended the Benalla forum, which was held at Rafferty's Restaurant. This was a useful session with a wide range of issues raised, but some consensus emerged among providers and consumers.

Key themes included the need for clearer definitions of many terms, a view that the Act can't do it all and there is therefore, a need for more guidelines and codes of practice. The value of advance directives was strongly recognised, as was a need to boost consumer rights and choice about treatment. The need for stronger and more independent review mechanisms was raised. Carers were clear stronger roles for families/carers should be included in the new Act, including clearer rights for carers to be provided with relevant information given their strong role in the consumer's recovery.

Last, although there was strong support for more of a recovery approach to care, it was noted that recovery may have different meanings to consumers and professionals. Many thought it needed to be based on a holistic paradigm and should include broad rehabilitation. The concept of 'one plan' for each consumer was also promoted.



Geelong

Nearly 60 participants attended the forum held in a Geelong icon – the Geelong Football Club. The atmosphere was positive and lively with comments suggesting that people were feeling heard. ‘I think it was a very valuable opportunity to at least have input into possible suggestions – it worked well’ (workbook comment, Geelong). Once again the discussions were focussed and positive and the feedback demonstrated the range of thoughtful ideas that had emerged from the groups. Among the many issues discussed patient rights were raised and participants agreed that the rights need to be presented to patients in a variety of formats until they are clearly understood. This was especially important for people for whom English is not their first language. Participants were also keen to see the Mental Health Review Board hearings made less intimidating.

Some participants took advantage of the opportunity to sit in the members’ seats to eat their lunch and were rewarded by seeing several players from the club training on the ground below.

Warrnambool

Overlooking the beautiful Hopkins River, nearly 40 people gathered at the historical Proudfoot’s Boathouse to participate in the Barwon-South Western region forum. One of the differences between this forum and many others was the degree of existing satisfaction in local services. The forum was well represented by consumers and carers, all of whom were positive in their comments about how local services are structured and operated. ‘I liked the mix of service providers, consumers, carers and advocates’ (workbook comment, Warrnambool).

In common with the Geelong participants, those in Warrnambool thought that carers and family members needed opportunities to find out more about mental illness and how they can be of most help. Because of the distance from larger population areas, participants believed that local panels could be used rather than videoconferencing and that other health professionals could provide back-up to a psychiatrist during times when one was not available.

Keysborough

Approximately 90 people attended this forum in what seemed like an oasis – the Great Southern Golf Club.

Information sharing and respect for others’ opinions worked well – ‘I think the round table discussion were good as you get a wide variety of opinions and views’. In reflecting on the day, one participant wrote ‘I felt sceptical coming to the conference, but feel now that the workshops were effective’ and another commented that ‘I have a feeling that something will get done’.

Key themes and solutions that were highlighted strongly included the need for a staged process for assessment orders with more regular and quicker reviews.

A new complaints process should be developed via a one-stop shop, independent of services and the department. Recovery again was the preferred underlying approach to care, but one table noted that it may be unrealistic for some clients – even a punitive expectation. The proposal was put that consumers should have access to legal advocacy upon hospitalisation, with the advocate appointed from an independent body ‘compassionately detached’, with consumer advocates or peer workers available as alternatives. Last, carers thought it should be mandated that the treatment/recovery plan involves the carer/family and include sign off by consumer and family. The plan should be ‘more of a process than a destination’.

Ballarat

Approximately 40 attended, including health workers, police officers, paramedics and a range of consumers and carers. One evaluation noted that 'breaking it down into different small groups [worked well] as a lot more ideas get put forward, and another thanked the panel member Dominique for her comment about 'the dignity of risk'. One participant thought it 'the best DHS consultation I've been to!'

A key insight was that services mirror the '*all or nothing*' nature of the system. So the Act should read 'consumer rights to treatment when needed', not merely 'patient obliged to receive treatment'.

One group of consumers felt that ECT is form of torture and degrading, and should only be given with the consumer's consent. A mandatory second opinion should also be required by an independent psychiatrist or other relevant clinician. Again the participants strongly advocated for the use of advance statements.

Ringwood

Even with many people unable to attend because of their commitment to the bush fire emergency, 105 people still turned up to the Karralyka Centre for the largest of the forums. The smell and sight of smoke in the vicinity was a sombre reminder of the situation facing neighbouring communities.

Ensuring participation with so many people present successfully tested the processes to their limits. Keeping people to the time limits can present challenges in a group of this size, but everyone cooperated with the group agreement and the workshops and feedback sessions ran to schedule. 'Brilliant time-keeping. This kept people focussed on the issues and got the maximum value out of the available time.'

Concern was expressed by some participants about how the physical health of the consumer can sometimes decline as part of their illness and they advocated that more attention be paid to this. They also raised the issue about safe transport for patients. The other themes that emerged mirrored those of other forums.

The panel divided their time between the many tables and were kept busy for the whole forum. 'Having the Panel members rove tables (worked well).' Their feedback and summaries were also widely appreciated. Participants seemed satisfied with the input of the group members but cautioned that 'hopefully some notice will be taken of the well considered and well thought out suggestions'.

Bendigo

The session at the Four Seasons Conference Centre involved nearly 40 people. Evaluation forms noted that there were a 'good cross section of agencies and consumers/carers' and that 'good ideas came forward and, even though there might have been disagreement, the ideas presented led to more consideration'.

By now the range of themes emerging was looking familiar and reinforced the common concerns of all the participants in all of the forums, no matter where they were held. The participants saw a need for better communication, especially around involuntary orders. 'Sometimes the consumer doesn't realise he/she is being assessed'. They saw the need for feedback to be provided to the consumer about the particular behaviours/indicators that met the required criteria.

Like other groups, this group noted that the Mental Health Act does not in fact deal with mental health – it deals with mental illness. Suggestions for the new Act included definitions of wellbeing and mandated preventative measures.

Traralgon

Some unique issues arose in this forum attended by about 30 people. Covering a big rural area, the lack of resources was a common theme as well as the time it takes to transport people who are unwell or who have to comply with orders. Discussion ranged around solutions to the issues that face rural communities including allowing other mental health professionals to step in when a psychiatrist is not available. Having two police officers present also gave another perspective that was appreciated. A more cooperative relationship between the police and case workers was discussed, especially in relation to the revocation of community treatment orders.

Bairnsdale

The Bairnsdale forum was the smallest with 15 people attending. Like the Traralgon forum, many key people were unable to attend because of their commitment to working with the fire-affected communities. Rather than breaking into small groups and working on the usual workshop themes, the group looked at the themes overall and discussed them in the light of living in a small rural community. The feedback produced a variety of issues and suggestions including the effect of long trips on people who are unwell; safety issues for ambulance drivers under these circumstances and the fact that the town's only ambulance can be tied up making the trips. More local treatment was suggested with other mental health professionals providing the care if psychiatrists are not available.

Sunshine

There was a full room at the last session at the Victoria University Conference Centre, including a good range of consumers and carers. One consumer had prepared a full submission and made it available to all tables. One participant noted that 'the material was challenging and not too basic'.

Again a shorter time for review of order decisions was called for and tightening up of processes including language which was seen as too loose, for example, 'unable to consent' was too subjective and allowed too much personal opinion by clinicians to influence it. A physical check for chronic conditions, allergies etc was also suggested before involuntary orders could proceed. Treatment plans were also raised and participants thought they should be more comprehensive, holistic and wellbeing-focussed in scope, with strong consumer and, if appropriate, carer input.

Mildura

A group of about 35 people attended the most northerly forum at the Mildura Golf Club. Participants noted that it was 'good to see the police here as they have an interest' and that the session was 'very worthwhile: we were able to air our thoughts and listen to the other side'. Someone noted that 'having an individual facilitator at each table was great for keeping on topic'.

A similar range of issues emerged as in previous workshops, but comments also reflected the particular aspects caused by a more remote geography and scattered service distribution.

The nominated person proposal was supported. Although this would be agreed by consumers in advance and often be a family member, in some situations having another party as nominated person could relieve carers of being in a difficult situation in involuntary order events. The nominated person would clearly need to act in a person's 'best interests'. There was little support for the default system though.

The notion of shared decision making between consumer and provider (and carer/family where appropriate) received strong support, as it had at previous sessions. However, some consumers will need advocates to assist them in this decision making and this should be mandatorily available.

Conclusions

Overwhelmingly, feedback affirmed the format of the forums – focussed small groups to discuss individual aspects of the Act; facilitators at each table; the opportunity to mix with people with different perspectives and from different backgrounds and the timing of the day. The workbook was also a valuable additional tool to collect data. The food and venues were commented upon positively as well.

There were some comments about people going off the topic but these were countered by others who expressed satisfaction that people had a chance to tell their stories. Overall the suggestions for improvement were few and a number of people requested more such events. As noted above, improving the feedback mechanism is one area of improvement.

Summary of issues

The following themes and ideas emerged at most, if not all, sessions.

- A stronger human rights focus, especially around the issues of involuntary treatment, ECT, more regulation of physical restraint, more consumer input into decision making, more rights to treatment when needed and more choice of treatment.
- Act should be focussed around health and wellbeing and prevention (currently ignored) as well as illness.
- A wide range of definitions used in the Act needed revision and tightening up, as they were too loose. For example, the term ‘unable to consent’ was too subjective and allowed too much personal opinion by clinicians to influence it.
- A more holistic and recovery-focussed approach to mental health was strongly supported, beneficial not just to consumers but to their families and carers as well.
- Recovery may have different meanings to consumers and professionals. Many thought it needed to be based on a holistic paradigm, and should address social wellbeing needs as well as clinical ones. However, a recovery approach was not always realistic, and should not be a punitive expectation.
- New staged process for creating treatment orders, with mandatory pre-order assessments over perhaps two days, as well as quicker initial (two days) and more frequent ongoing reviews (for example, two to three months).
- A physical check for chronic conditions, allergies etc was needed before involuntary orders could proceed.
- ECT should only be given with the consumer’s consent, and a mandatory second opinion should also be required by an independent clinician.
- Access to legal advocacy upon hospitalisation, with the advocate appointed from an independent body ‘compassionately detached’, with consumer advocates or peer workers.
- Patient rights need to be presented to patients in a variety of formats until they are clearly understood. This was especially important for people for whom English is not their first language.
- Treatment and care plans should be integrated into a single plan, have specified content including being more comprehensive, holistic and wellbeing focussed in scope, with strong consumer and if appropriate carer input, and be ‘more of a process than a destination’.
- Advance statements were strongly supported and should include information re relapse, prevention, medications.

- Nominated persons and the right to independent advocates were common proposals in order to support consumers in decision making.
- Constraints on transporting consumers to care, especially in emergencies, need to be amended to allow ambulance officers to offer medication rather than physical restraint measures.
- Stronger independence of review and complaints bodies. For example, a new complaints process should be developed via a one-stop shop, independent of services and the department.
- Mental Health Review Board needs reviewing and hearings made less intimidating.
- The role of carers needs to be recognised more strongly in the Act, especially around involvement in care plans and better access to information to assist them to play their role properly. Some thought such involvement should be mandated.

An additional point often made was that the Act can't do it all and there is therefore a need for more guidelines and codes of practice. Similarly, some of the good intent of both the existing Act and any future model is constrained if resources are limited, an issue especially raised in rural areas.

Appendix 4 – Key stakeholders that attended presentations and meetings

Presentations

- Aged psychiatric clinical managers and directors of area mental health services
- Australian and New Zealand Association of Psychiatry, Psychology and Law
- Inpatient unit managers of area mental health services
- Managers of area mental health services
- Mental Health Review Board
- Ministerial Advisory Committee for Mental Health
- Nurse inpatient managers of area mental health services
- Psychiatric Disability Services of Victoria (VICSERV)
- Regional directors, Department of Human Services
- Senior psychiatric nurses of area mental health services
- Victoria Police

Meetings

- ARAFEMI
- Australian College of Mental Health Nurses
- Australian Medical Association (Victorian branch)
- Australian Nursing Federation (Victorian branch)
- Authorised psychiatrists of area mental health services
- Chief Psychiatrist and staff
- Child and adolescent managers of area mental health services
- Deputy Ombudsman, John Taylor
- Emergency Management Clinical Network
- General Practice Victoria
- Health and Community Services Union
- Mental Health Foundation of Australia (Victoria)
- Mental Health Legal Centre
- Mental Health Review Board
- Mental Health Review Board, Victorian Mental Illness Awareness Council and the Victorian Mental Health Carer's Network joint consumer and carer forum
- Mental Illness Fellowship Victoria
- Office of the Child Safety Commissioner
- Office of the Health Services Commissioner
- Office of the Public Advocate
- President of the Victorian Civil & Administrative Tribunal, the Honourable Justice Bell
- Rees, Professor Neil
- Rethinking Mental Health Laws project, Monash University, Professor Bernadette McSherry, Dr Penny Weller and Annegret Kampf
- Royal Australian New Zealand College of Psychiatrists



- State Coroner, Her Honour Judge Coate
- Victoria Legal Aid
- Victorian Aboriginal Community Controlled Health Organisation
- Victorian Mental Health Carer's Network
- Victorian Mental Illness Awareness Council
- Victoria Police
- Webb, Dr David
- Young people from Gateway Connexions, Platform Group Orygen Youth Health and Child and Adolescent Mental Health Services

Appendix 5 – List of written submissions received

No	Date received	Name
1	12/07/2008	Confidential
2	23/07/2009	Haslam, A
3	11/08/2008	Brien, P
4	02/09/2008	Confidential
5	22/09/2008	Human Rights Law Resource Centre
6	07/11/2008	Victoria Police
7	10/11/2008	Moon, W
8	07/01/2009	Ames, D
9	16/01/2009	Marshman, K
10	15/01/2009	Confidential
11	16/01/2009	Cameron, D
12	16/01/2009	Caulfield Aged Persons' Mental Health Service
13	19/01/2009	Alfred Psychiatry Research Centre
14	24/01/2009	Titcher, J
15	01/02/2009	Confidential
16	01/02/2009	Monash, D
17	04/02/2009	Chamley, W
18	31/01/2009	Confidential
19	07/02/2009	Dean, C
20	08/02/2009	Vanaheim Group
21	09/02/2009	Confidential
22	10/02/2009	Jackel, G
23	11/02/2009	Mortimer, S
24	11/02/2009	Odowd, B
25	12/02/2009	Dean, M
26	16/02/2009	Adams, V
27	18/02/2009	Langford, J
28	18/02/2009	Zimmerman, Dr N
29	18/02/2009	BMC Ministries Inc
30	20/02/2009	Clark, I
31	21/02/2009	Confidential
32	21/02/2009	Catron, M
33	22/02/2009	Newton, N
34	23/02/2009	The Maine Connection
35	23/02/2009	Victorian Mental Illness Awareness Council
36	23/02/2009	Twomey, T
37	24/02/2009	Victorian Women and Mental Health Network
38	24/02/2009	O'Regan, M
39	24/02/2009	Southwest Advocacy Association
40	24/02/2009	Smith, T



No	Date received	Name
41	24/02/2009	Mercy Mental Health
42	24/02/2009	Schmidt, HM
43	24/02/2009	Victorian Families Where a Parent has a Mental Illness Coordinators
44	24/02/2009	Jacomb, J
45	25/02/2009	Frank, K
46	25/02/2009	Horvath, N
47	25/02/2009	Bernard, D
48	25/02/2009	Little, M
49	25/02/2009	Donegan, M
50	25/02/2009	Ennis, G
51	25/02/2009	Australian Nursing Federation, Victorian Branch
52	25/02/2009	Neami
53	25/02/2009	Davies, P
54	25/02/2009	Pearl, M
55	25/02/2009	MacDonald, R
56	25/02/2009	Conley, J
57	25/02/2009	Stewart, I
58	25/02/2009	Simpson, E
59	26/02/2009	Australian Consumer Patient Rights Group
60	26/02/2009	Hooper, M
61	26/02/2009	White, P
62	24/02/2009	Confidential
63	26/02/2009	Austin Health
64	26/02/2009	Confidential
65	26/02/2009	Gillard, G
66	26/02/2009	Barrier Breakers Inc
67	26/02/2009	Doolan, B
68	26/02/2009	Dwyer, J
69	27/02/2009	Royal Australian and New Zealand College of Psychiatrists
70	26/02/2009	Confidential
71	26/02/2009	The Peter James Centre
72	26/02/2009	Jeshimon House Community Association Inc
73	26/02/2009	Confidential
74	26/02/2009	Confidential
75	26/02/2009	Confidential
76	26/02/2009	Confidential
77	26/02/2009	Roberts, L
78	26/02/2009	Confidential
79	26/02/2009	Beck, M
80	26/02/2009	Lerk, J
81	26/02/2009	Law, R
82	26/02/2009	Jekel, G
83	26/02/2009	Confidential

No	Date received	Name
84	26/02/2009	Confidential
85	26/02/2009	Confidential
86	26/02/2009	McCormick, B
87	26/02/2009	Confidential
88	26/02/2009	O'Shea, A
89	26/02/2009	Stolk, Y
90	26/02/2009	Monash University
91	26/02/2009	Coraci, Z
92	26/02/2009	Law Institute of Victoria
93	26/02/2009	Confidential
94	26/02/2009	Tucker, A
95	26/02/2009	Psych Action and Training Group
96	26/02/2009	Confidential
97	26/02/2009	Child Safety Commissioner
98	26/02/2009	Confidential
99	26/02/2009	Vennell, N
100	26/02/2009	Confidential
101	26/02/2009	Nash, M
102	26/02/2009	Shields, R
103	26/02/2009	Turner, P
104	26/02/2009	Hostettler, C
105	26/02/2009	Victorian Mental Health Carer's Network
106	26/02/2009	International Commission of Jurists, Western Australian Branch
107	26/02/2009	Lowenstein, B
108	26/02/2009	Curnuck, A
109	26/02/2009	Pak, J
110	26/02/2009	Lester, J&R
111	27/02/2009	Confidential
112	27/02/2009	MacGregor-Scholes, G
113	27/02/2009	Maroondah City Council
114	27/02/2009	Southern Health
115	27/02/2009	Victorian Equal Opportunity & Human Rights Commission
116	27/02/2009	Hall-Bentick, F
117	27/02/2009	Victorian Dual Diagnosis Leadership Group
118	27/02/2009	Confidential
119	27/02/2009	St Vincent's Hospital
120	27/02/2009	Western Region Health Centre
121	27/02/2009	Victorian Alcohol and Drug Association
122	27/02/2009	Hanover Welfare Services
123	27/02/2009	Lehocz, S
124	27/02/2009	Confidential
125	27/02/2009	Garden, S
126	27/02/2009	Gofton, D



No	Date received	Name
127	27/02/2009	Santoro, A
128	27/02/2009	Victorian Faculty Australasian College for Emergency Medicine
129	27/02/2009	Kuusela, M
130	27/02/2009	Wilson, P
131	27/02/2009	Harper, T
132	27/02/2009	Wilson, D
133	27/02/2009	Confidential
134	27/02/2009	Oehm, D
135	27/02/2009	Mental Health at Work
136	27/02/2009	Wilson, A
137	27/02/2009	Consumer and Carer Relations Directorate, Southern Health
138	27/02/2009	Confidential
139	27/02/2009	Lacey, M
140	27/02/2009	Confidential
141	27/02/2009	Citizens Commission on Human Rights
142	27/02/2009	Hamilton, B
143	27/02/2009	Confidential
144	27/02/2009	Bagnato, P
145	02/03/2009	Victoria Legal Aid
146	27/02/2009	Health and Community Service Union
147	27/02/2009	Confidential
148	27/02/2009	Eating Disorders Foundation of Victoria
149	27/02/2009	Norwood Association Inc
150	27/02/2009	Minas, H and Minas, S
151	27/02/2009	Ambulance Victoria
152	27/02/2009	Youren, S
153	27/02/2009	South West Healthcare Psychiatric Services Division
154	27/02/2009	Toth, J
155	27/02/2009	Human Rights Law Resource Centre
156	04/03/2009	North East Victorian Division of General Practice
157	27/02/2009	McCrorey, J
158	27/02/2009	Public Interest Law Clearing House
159	27/02/2009	Toth, F
160	27/02/2009	Confidential
161	27/02/2009	Webb, Dr D
162	27/02/2009	Confidential
163	27/02/2009	Liberty Victoria
164	27/02/2009	Tune, P
165	27/02/2009	Burrell, R
166	27/02/2009	Gippsland Community Legal Service
167	27/02/2009	Mental Illness Fellowship Victoria
168	27/02/2009	Royal Children's Hospital
169	27/02/2009	Homeless Person's Legal Clinic (PILCH)

No	Date received	Name
170	27/02/2009	Gartlan, F
171	27/02/2009	Pete and Tan
172	27/02/2009	Bassett, H
173	27/02/2009	Rafferty, J
174	27/02/2009	Grogan, O
175	28/02/2009	Confidential
176	28/02/2009	Ryan, Large, Nielszen, Hayes
177	01/03/2009	Victorian Disability Advisory Council
178	01/03/2009	Confidential
179	02/03/2009	Confidential
180	02/03/2009	beyondblue: the national depression initiative
181	02/03/2009	Mind
182	02/03/2009	NorthWestern Mental Health
183	02/03/2009	Choo, J
184	03/03/2009	Smith, P
185	03/03/2009	ARAFEMI Consumer Group Forum
186	03/03/2009	ARAFEMI Victoria Inc
187	03/03/2009	Wilson, P
188	03/03/2009	Psychiatric Disability Services of Victoria (VICSERV)
189	03/03/2009	Nall, G
190	03/03/2009	Nall, D
191	03/03/2009	Doutta Galla Community Health Service
192	03/03/2009	Office of the Public Advocate
193	03/03/2009	Confidential
194	02/03/2009	Alfred Psychiatry, Alfred Health
195	02/03/2009	Mental Health Legal Centre Inc
196	03/03/2009	Vij, L
197	04/03/2009	Inner South Community Health Centre
198	04/03/2009	Forensicare Victorian Institute of Forensic Mental Health
199	04/03/2009	Dent, M
200	05/03/2009	Dimopoulos, M
201	05/03/2009	AMA Victoria
202	05/03/2009	State Coroner Victoria
203	06/03/2009	Shire of Yarra Ranges Youth Services
204	06/03/2009	Metropolitan CEO Group
205	06/03/2009	Office of the Health Services Commissioner
206	06/03/2009	Federation of Community Legal Centres Victoria
207	06/03/2009	Aged & Community Care Victoria
208	25/02/2009	Meadmore, S
209	06/03/2009	Disability Services Commissioner
210	07/03/2009	Confidential
211	12/03/2009	Oseckas, T
212	16/03/2009	Victorian Aboriginal Legal Service Cooperative Ltd



No	Date received	Name
213	16/03/2009	Phillips, M
214	22/03/2009	Australian College of Mental Health Nurses
215	01/02/2009	Confidential
216	27/03/2009	Eclectic Consumers Collective
217	07/04/2009	Victoria Police
218	03/04/2009	Ministerial Advisory Committee for Mental Health
219	27/02/2009	Tolhurst, H

Appendix 6 – Questions posed in consultation paper

The following questions posed in the consultation paper were not intended to be exhaustive and comments did not need to be limited to these questions.

2. Background and framework for reform

Q1. What, if any, additional reform objectives should be reflected in the new Act?

Q2. What principles, departmental objectives and functions should the new Act include?

3. Involuntary orders

Q3. How should mental illness be defined in the new Act?

Q4. What conditions should be excluded from the definition of mental illness in the new Act?

Q5. If separating the involuntary treatment process into three stages is supported:
(a) What should be the grounds for each order? (b) What should be the duration of each order? (c) Should there be any restrictions on the kinds of treatment that can be given under each order?

Q6. How should the new Act address the issue of a person's capacity to consent to treatment in the grounds for an involuntary order?

Q7. How, if at all, should the new Act define what constitutes capacity to consent to treatment?

Q8. What requirements, if any, should the new Act contain for deciding whether or not a person has capacity to consent to treatment?

Q9. In what circumstances, if any, should the new Act permit a person to be placed on an involuntary order where the person has capacity to consent and is refusing treatment?

Q10. How should the new Act address the issue of the seriousness and immediacy of risk in the grounds for an involuntary order as they apply to: (a) The person?
(b) Others?

Q11. How should the new Act address the issue of 'immediate treatment' in the grounds for an involuntary order?

Q12. How should the new Act address the issue of the 'least restrictive manner' in the grounds for an involuntary order?

- Q13. What requirements, if any, should the new Act contain to enable involuntary patients to provide informed consent to a wider range of psychiatric treatment?
- Q14. If a second psychiatric opinion scheme is considered necessary, in what circumstances should the new Act require a second opinion?
- Q15. What additional safeguards, if any, in relation to treatment decisions made by the authorised psychiatrist should the new Act include?
- Q16. Should the new Act include a best interests requirement in relation to treatment decisions made by the authorised psychiatrist?
- Q17. How should the new Act address the issue of children and young people who do not have capacity to consent to treatment due to their mental illness?

- Q18. What requirements, if any, should the new Act contain for clinical reviews of involuntary patients subject to: (a) An involuntary treatment order? (b) A community treatment order?
- Q19. In what circumstances, if any, should the authorised psychiatrist consent to the annual examination of an involuntary patient?
- Q20. What obligations, if any, should the new Act impose in relation to reporting results of annual examinations?

- Q21. If separate grounds for a community treatment order are considered necessary, how should they differ from the grounds for making an involuntary treatment order?
- Q22. What should be the duration of a community treatment order in the new Act?
- Q23. Should there be any restrictions on the type of treatment that can be given under a community treatment order in the new Act?

4. Patient participation in treatment and care

- Q24. What obligations, if any, should the new Act impose in relation to informing a patient's family, carer or nominated person of a patient's rights?
- Q25. If a nominated person scheme is considered necessary, how should the new Act address this?
- Q26. What requirements should the new Act contain to assist patients to understand and exercise their rights throughout the involuntary treatment process?

- Q27. What requirements, if any, should the new Act contain to assist voluntary patients to understand and exercise their rights?

- Q28. What requirements, if any, should the new Act contain to address issues of: (a) Patient involvement in treatment planning? (b) The content of treatment plans?
- Q29. What additional requirements, if any, should the new Act contain to ensure the effectiveness of treatment plans?

- Q30. If an advance statement scheme is considered necessary: (a) What requirements should the new Act contain to ensure their effectiveness? (b) In what circumstances, if any, should the new Act allow an advance statement to be overridden?

5. Electroconvulsive therapy

Q31. How should the new Act regulate and monitor: (a) Premises on which ECT is provided? (b) Persons who administer ECT?

Q32. How should the new Act address the issue of a person's capacity to consent to ECT?

Q33. If oversight of consent to ECT is considered necessary, what type of scheme should the new Act contain?

Q34. How, if at all, should the new Act regulate provision of ECT in an emergency?

Q35. How should the new Act address patient participation where ECT is proposed?

Q36. What additional safeguards, if any, should the new Act contain where ECT is proposed for a young person?

6. Restraint and seclusion

Q37. How, if at all, should the new Act regulate physical restraint?

Q38. How should the new Act address the grounds for mechanical restraint and seclusion?

Q39. What obligations should the new Act impose on the authorised psychiatrist in relation to authorisation of mechanical restraint and seclusion?

Q40. What obligations should the new Act impose in relation to the clinical monitoring of secluded or mechanically restrained patients?

Q41. Should the new Act require mechanical restraint or seclusion to end 'immediately' when the grounds for their use are no longer met?

Q42. If regulation of physical restraint is considered necessary, should the new Act: (a) Authorise persons to exercise these powers? (b) If so, who should be so authorised?

Q43. If the physical restraint, mechanical restraint and seclusion of voluntary patients is considered necessary in the new Act: (a) On what grounds? (b) For what duration? (c) Subject to what safeguards?

Q44. What additional safeguards should the new Act contain for the effective regulation of restraint and seclusion?

7. External review and appeals

Q45. (a) How soon after the making of an involuntary order should the new Act require external review? (b) How frequently thereafter should the new Act require external reviews of involuntary orders?

Q46. What type of external body, what kind of proceeding, and what powers should the new Act contain for: (a) External review soon after the making of an involuntary order? (b) Subsequent external reviews of involuntary orders?

Q47. How should the new Act address issues of patient participation in external review?

Q48. How should the new Act address issues of participation by families, carers or nominated persons in external review?

Q49. How should the new Act address issues of participation by members of the treating team in external review?

Q50. Should the new Act incorporate the functions of the existing Psychosurgery Review Board within the functions of the external body that reviews involuntary orders?

8. Monitoring patient wellbeing

Q51. (a) What monitoring functions and powers should the new Act contain?
(b) What type of body would be most effective in performing these monitoring functions and powers?

Q52. If publishing of information obtained through monitoring functions is considered necessary: (a) What publishing requirements should the new Act contain?
(b) In what other ways should the new Act require that information obtained through monitoring is used to improve patient wellbeing and achieve service improvement?

Q53. (a) What death review functions and powers should the new Act contain?
(b) What type of body would be most effective in performing these death review functions and powers?

Q54. If the establishment of a clinical leadership role is considered necessary, what functions should the clinical leader perform?

Q55. If giving legal force to clinical guidelines or codes of practice is considered necessary, what should be the implications of non-compliance?

9. Complaints

Q56. What requirements, if any, should the new Act contain in relation to local complaint systems?

Q57. (a) What complaints functions and powers should the new Act contain?
(b) What type of body would be most effective in performing these complaint functions and powers?

Q58. What requirements, if any, should the new Act contain to support patients to make complaints?

Q59. What requirements, if any, should the new Act contain to ensure that information learned from complaints is used to promote service improvement?

10. Confidentiality and information sharing

Q60. In what circumstances should the new Act *permit* disclosure of information to families and carers without patient consent?

Q61. What key events should the new Act *require* be disclosed to a patient's family, carer and any nominated person without patient consent?

Q62. In what additional circumstances, if any, should the new Act require disclosure of information to guardians?

Q63. In what circumstances, if any, should the new Act allow a guardian to consent to the disclosure of information about a patient?

Q64. (a) What service providers, if any, should receive identified information without a patient's consent? (b) If so, in what circumstances should they receive identified information without a patient's consent?

