

The Human Rights Roadmap: **40 ways to operationalise** **human rights in Victoria's** **mental health and** **wellbeing system**

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About the Castan Centre for Human Rights Law

The Castan Centre for Human Rights Law (the Centre) is a world-renowned academic centre using its human rights expertise to create a more just world where human rights are respected and protected, allowing people to pursue their lives in freedom and with dignity. The Centre's innovative approach to public engagement and passion for human rights are redefining how an academic institution can create important and lasting change. The Centre is named after the late Ron Castan AM QC, a passionate advocate of human rights.

The Centre aims to:

- influence government policy and legislation;
- provide accessible public education on human rights; and
- provide students with outstanding opportunities.

The Centre works to influence legislation and government policy, improve government officials' understanding of human rights in Australia and elsewhere, and nurture the next generation of human rights leaders through our outstanding student programs that include sending students each year to leading human rights organisations as part of our Global Intern program.

The Centre also helps educate the public on important and current human rights issues. It hosts numerous free events throughout the year, as well as Australia's only human rights conference.

About Mental Health Victoria

Mental Health Victoria (MHV) is the peak body for mental health and wellbeing in Victoria. Its members include consumer and carer groups, community health and mental health services, hospitals, medical associations and colleges, police and emergency services associations, unions, local governments, and other bodies across the health and related sectors.

MHV's aim is to ensure that people living with mental health issues can access the care they need, when and where they need it. Its view is that all Australians should have access to a core suite of services that they can choose from – be they delivered in the home, community, or hospital.

MHV's vision is for a mental health system that:

- involves people with lived experience, including unpaid family and friend carers, in decisions which affect their lives;
- provides tailored, high-quality supports to people with different care needs and at different life stages;
- wraps around a person, ensuring all of their needs can be met;
- is easily navigated, providing continuity of care;
- is outcomes-focused; and
- is adequately and sustainably resourced to meet current and future needs including demand.

Executive Summary

This report represents a timely and unique contribution to public discourse and public policy making. The report's focus is on mental health and wellbeing systems in the State of Victoria, but the principles and recommendations contained in this report can and should inform public and academic debate as well as public policy and legislative reform in other jurisdictions, both across Australia and internationally.

This report provides a suite of pragmatic recommendations that are intended to ensure that Victoria's current and future mental health and wellbeing systems are based on a commitment to promote and uphold human rights and to focus on the promotion of good mental health and wellbeing.

This report is structured around seven key action areas:

1. **Governance:** Part 1 demonstrates the need for strong governance to oversee Victoria's mental health and wellbeing system.
2. **System foundations:** Part 2 outlines system foundation reforms required to provide a basis for a human rights-based system to flourish.
3. **Legislative underpinnings:** Part 3 provides recommendations to strengthen the underpinnings of Victorian mental health legislation.
4. **Decision-making capacity:** Part 4 identifies the need for greater protections for the autonomy of consumers, especially those who can demonstrate the capacity to make their own decisions about their healthcare.
5. **Supported decision-making:** Part 5 suggests both legislative and practical reforms to strengthen and clarify a person's access to decision-making supports, including the right to make binding advance statements.
6. **Coercive practices:** Part 6 looks at options to reduce recourse to coercive practices, including compulsory treatment and restrictive practices.
7. **Data Sovereignty:** Part 7 explores ways to establish a foundation for a human rights-based approach to the collection, use and sharing of information.

The report concludes with three overarching recommendations for legislators and policy makers to consider in recognition of the imperative to establish:

1. the 'continuous reorientation' of Victoria's mental health and wellbeing systems towards human rights-based approaches;
2. practical implementation supports to ensure that reforms to law and policy translate into practice and culture;
3. robust strategic oversight of Victoria's mental health reform agenda.

Foreword

The Castan Centre for Human Rights Law and Mental Health Victoria (MHV) are proud to launch *The Human Rights Roadmap: 40 ways to operationalise human rights in Victoria's mental health and wellbeing system*. This report is the culmination of an important partnership between the Castan Centre and MHV, which is centred on advancing human rights in the context of mental health and wellbeing.

The Castan Centre is a world-renowned research, education and policy centre which uses its expertise to promote respect for and protection of human rights, to allow all people to flourish in freedom and with dignity. MHV is the peak body for mental health and wellbeing in Victoria, and works to ensure that people living with mental health issues can access the care they need, when and where they need it.

This joint project was conceived in light of the important work of the Royal Commission into Victoria's Mental Health System, which made clear the widespread risks to, and breaches of, human rights in the mental health sector. It was further driven by a recognition of this pivotal moment in Victorian mental health law reform, and the unique opportunity for Victoria to emerge from this as a global leader in human rights-based approaches to mental health and wellbeing.

As this report makes clear, human rights must be firmly embedded into the very foundations of our new mental health system. This includes building respect for human rights into the governance structures of the mental health system, reinforcing human rights in the work and culture of bodies that provide services to mental health consumers, and reforming legislation in Victoria to underpin a strong rights-based new system. It is only through such a system that Victoria can more appropriately balance traditional care objectives and consumers' fundamental right to autonomy.

This project would not have been possible without the valuable contributions of former Castan Centre Director, Professor the Honourable Kevin Bell AM QC. Professor Bell is well known for his important work as a Justice of the Supreme Court of Victoria for 15 years, during which he played an important role in the implementation and operation of the *Victorian Charter of Human Rights and Responsibilities Act 2006* within the Victorian legal system. Professor Bell's seminal judgements in *Patrick's Case*, *PBU and NJE* and *Kracke*, among others, cemented his position as one of the foremost experts in human rights and mental health law in Victoria.

Professor Bell continued to advocate for the advancement of human rights in mental health during his time at the Castan Centre. In 2021, in conjunction with former MHV CEO Angus Clelland, he established a secondment program which enabled MHV Senior Legal Policy Advisor Joshua Finn to join the Castan Centre to design, develop and deliver this project. With the support of new Castan Centre Director Melissa Castan, MHV CEO Marcelle Mogg, Castan Centre Policy Manager Andrea Olivares Jones, and under Professor Bell's supervision, the project was finalised in 2022, the result of which is a comprehensive and insightful report to guide Victoria's next steps in mental health reform.

The Castan Centre and MHV affirm their strong and ongoing commitment to pursuing the advancement of human rights in Victoria's mental health and wellbeing system, and look forward to collaborating with governments and other key organisations and individuals in the sector in the years to come.

Melissa Castan, Director

Castan Centre for Human Rights Law

Marcelle Mogg, CEO

Mental Health Victoria

Recommendations

1. Governance

Recommendation 1.1:

Clarify the Victorian Government's legal obligations to 'respect, protect, promote and fulfill' human rights, in line with existing obligations under Victorian and international law.

Recommendation 1.2:

Empower the Mental Health and Wellbeing Commission to monitor and report on government activities to respect, protect, fulfill and promote human rights, as well as the progress of the mental health and wellbeing system towards compliance with the *Convention on the Rights of Persons with Disabilities*.

Recommendation 1.3:

Develop and implement strategic government responses to advance and promote human rights in the mental health and wellbeing system.

Recommendation 1.4

Provide the Mental Health and Wellbeing Commission with a clear function to 'promote, support and enforce compliance with human rights obligations and the provisions of the *Mental Health and Wellbeing Act* through the strategic and transparent use of compliance and enforcement powers', supported by:

- broad 'carrot-and-stick' compliance

and enforcement powers;

- powers and resources to develop standards and guidance for services on all relevant matters;
- powers to lead the system on a journey of cultural change;
- public reporting obligations; and
- a review of the Commission's performance incorporated into the review of the *Mental Health and Wellbeing Act*.

Recommendation 1.5:

Provide the Mental Health and Wellbeing Commission with an express objective 'to reduce recourse to coercive practices'.

Recommendation 1.6:

Review the need to increase or maintain the mental health and wellbeing surcharge in 10 years.

Recommendation 1.7:

Build human rights considerations into guidance on best-practice clinical governance frameworks to support the development of rights-based models of care.

2. System foundations

Recommendation 2.1:

Fund a law reform implementation initiative for the new *Mental Health and Wellbeing Act*.

Recommendation 2.2:

Expand lived experience research studies and collaborative learning networks, enquiring into how consumers experience, understand and define mental wellness and its opposite, and their applications to system change.

Recommendation 2.3:

Strengthen supports for people with lived experience and from key population groups to gain and retain employment in the mental health and wellbeing system.

Recommendation 2.4:

Embed people with lived experience into all stages of service commissioning and procurement processes.

Recommendation 2.5:

Clarify and strengthen human rights obligations on service providers through mental health principles, service contracts, private hospital standards and the *Statement of Priorities*, and support service compliance through dedicated funding for human rights impact assessments and action plans.

Recommendation 2.6:

Implement a cross-departmental pooled funding model for Aboriginal Community-

Controlled Organisations to provide a genuine platform of self-determination.

Recommendation 2.7:

Investigate and prioritise approaches to integration that strengthen connections between the mental health and wellbeing,

and related, sectors, including through the expansion of Health Justice Partnerships, utilisation of Local Mental Health and Wellbeing Services, and leveraging of community collectives as alternative entry points into the broader social care system.

3. Legislative underpinnings

Recommendation 3.1:

Establish the primary purpose of the *Mental Health and Wellbeing Act* 'to promote good mental health and wellbeing in Victoria', supported by a subsidiary purpose 'to establish a mental health and wellbeing system underpinned by a strong human rights framework'.

Recommendation 3.2:

Include an objective in the *Mental Health and Wellbeing Act* to 'promote and drive the development of a rights-based mental health and wellbeing system by:

- ensuring that the experiences of people living with mental illness or psychological distress, and their carers, families and supporters, are at the centre of changes in practice and service delivery and the design and evaluation of systems;
- promoting the personal recovery of people experiencing mental health issues through the provision of holistic care that is centred on an individual person's needs, encompassing any known or potential past experiences of trauma;
- supporting consumers to exercise choice and control between services, treatments and models of care;
- promoting access to services that are voluntary, peer-led, community-delivered, self-determined, rights-based and delivered in community settings;
- ensuring services provide safe and therapeutic experiences for people from all cultural backgrounds, genders, sexual orientations, and other social groups;
- drawing on the strengths of people with lived experience, including ways of being, doing and knowing;
- respecting the rights, dignity, autonomy and self-determination of people and peoples; and
- promoting opportunities for carers,

families and supporters to be involved in a person's care.'

Recommendation 3.3:

Include an objective in the *Mental Health and Wellbeing Act* to 'promote supported decision-making, in recognition of the need to support persons to make, participate in and implement decisions that affect their lives, having regard to the *Convention on the Rights of Persons with Disabilities*'.

Recommendation 3.4:

Take a rights-based approach to the mental health principles in the *Mental Health and Wellbeing Act* by aligning human rights obligations with Victorian and international laws.

Recommendation 3.5:

Align the supported decision-making principle in the *Mental Health and Wellbeing Act* with approaches taken in other jurisdictions and Victorian statutes.

Recommendation 3.6:

Include a new principle in the *Mental Health and Wellbeing Act* on 'Holistic, integrated care'.

Recommendation 3.7:

Require and support services to demonstrate their compliance with the mental health and wellbeing principles through the strategic and ongoing development and implementation of action plans.

Recommendation 3.8:

Include the right to health, along with other economic, social and cultural rights, in the Victorian *Charter of Human Rights and Responsibilities Act*.

4. Decision-making capacity

Recommendation 4.1:

Ensure all functions of the system operate with respect for the treatment decisions of persons found to have decision-making capacity on treatment matters.

Recommendation 4.2:

Investigate alternative approaches to decision-making capacity tests, incorporating the concepts of will and preferences, relational capacity, and a spectrum of capacity.

Recommendation 4.3:

Expand practical implementation supports, including training and education, and practice and culture resources, for workers conducting decision-making capacity tests, with specific attention paid to the use of personal and cultural values, beliefs, emotions and relationships in decision-making.

5. Supported decision-making

Recommendation 5.1:

Provide adequate funding for decision-making supports, supported by an analysis of gaps, challenges and opportunities in available supports, drawing on the views of Victorian consumers and lessons from international models, with consideration of introducing new roles to complement existing supports.

Recommendation 5.2:

Provide legislative options for binding advance statements, with limited exceptions, and non-binding values statements.

Recommendation 5.3:

Strengthen obligations for substitute decision-makers to 'give effect to' the views and preferences of consumers 'as far as practicable'.

Recommendation 5.4:

Expand practical implementation supports, including training and education, and practice and culture resources, for consumers, carers and workers to identify, understand and implement decision-making supports.

6. Coercive practices

Recommendation 6.1:

Expand community-based voluntary services that provide genuine alternatives to coercion.

Recommendation 6.2:

Introduce a decision-making capacity criterion into the compulsory assessment and treatment criteria.

Recommendation 6.3:

Design a new framework for compulsory treatment to form the basis of further consultation and consideration, based on the following elements:

- a capacity threshold excluding consumers with relevant decision-making capacity;
- decision-making according to determination of a person's will and preferences, or where such cannot be determined, either a 'best interpretation of will and preferences' test or a 'best interests' test incorporating a broad range of considerations in a flexible and holistic assessment, with the ultimate purpose of 'promoting personal recovery';
- a fusion model applying to all settings

including mental health and wellbeing, disability and physical health;

- a participative approach involving a consumer and their support network; and
- decision-making through a multidisciplinary body of experts.

Recommendation 6.4:

Expand the decision-making obligations that apply to substitute decision-making.

Recommendation 6.5:

Drastically increase legal aid funding to ensure that every consumer seeking legal representation at the Mental Health Tribunal is able to access it.

Recommendation 6.6:

Draw on Australian and international models to develop a continuous and rigorous multi-pronged approach to achieve the Royal Commission's vision of eliminating seclusion and restraint, including an evaluation of efforts in 10 years' time.

7. Data sovereignty

Recommendation 7.1:

Ensure permissions for non-consensual disclosure align with human rights obligations and principles, including through improved specificity, inclusion of reasonableness and necessity qualifiers, and the incorporation of consent and decision-making capacity considerations.

Recommendation 7.2:

Align mental health privacy principles with the Health Privacy Principles in the *Health Records Act* insofar as is possible, with consideration of direct application subject to limited exceptions.

Recommendation 7.3:

Draw on Recommendation 62 of the Royal Commission and relevant work in other jurisdictions to ensure consumers have open access to their files, incorporating:

- allowances for the unilateral addition and collaborative amendment of information;

- a dynamic consent model allowing for the provision, variation and withdrawal of consent for relevant matters; and
- limited exceptions for consumer access where a person's health, safety or confidentiality may be compromised.

Recommendation 7.4:

Conduct further consultation to refine the legislative duty to provide specified information at defined points to carers, families and supporters of consumers, with the consumer's consent.

Recommendation 7.5:

Expand practical implementation supports, including training and education, and practice and culture resources, for services and workers to interpret information laws and develop and consolidate rights-based practices.

Introduction

Around the world, big questions are being asked about mental health and wellbeing systems: How can people be supported to make decisions about their lives when mental illness has compromised their decision-making capacity? How can carers, family members and supporters be assisted to support their loved ones in times of need? How can workers be kept safe without reliance on the use of restrictive practices? And what is the appropriate place, if any, for the compulsory treatment of people who refuse mental healthcare?

At the heart of these questions lies the tension between the ethical values of beneficence and autonomy, of doing ‘what is best’ for someone versus letting that someone make their own choices. These values often come into conflict when a person’s decisions about their healthcare diverge from a clinical assessment of ‘what is best’. The dilemma at the heart of modern mental health and wellbeing systems, then, is how to provide safe, effective and therapeutic care to people when these values conflict. That is, how does one determine the most appropriate course of action to take when ethical values point in opposing directions? What course of action provides the most proportionate balance between the at-times opposing goals of beneficence and autonomy? How do we, as a society, decide where to draw the line?

A human rights framework can help us find answers to some of these questions. This is because human rights law is based on a normative framework designed to balance human rights against one another, acknowledging that sometimes limitations on one right are necessary to protect another.

Proportionality assessments function in human rights law to settle the question of how to balance competing rights. Developed over centuries of jurisprudence, they aim to determine when a limitation on one human right is justified to protect another. Relevant considerations include:

- How would the right be limited, and what impact would the limitation have?
- How important is the purpose of limiting the right in the first place?


- Is the limitation reasonable and necessary to serve its intended purpose?
- Is there any less restrictive means reasonably available to achieve the purpose?

These are the same questions that mental health and wellbeing systems should ask every day. By embedding these considerations into all aspects of mental health and wellbeing decision-making, decision-makers can be supported strike a proportionate balance between the ethical values of beneficence and autonomy, and the human rights which encapsulate them.

For centuries, mental health systems around the world have been skewed towards the value of beneficence. But any approach that systematically privileges one value over another cannot be conducive to balance. As this paper will demonstrate, the value of beneficence, encapsulated within the right to health, can in fact be dangerous when not proportionately balanced with the value of autonomy.

The development of human rights-based mental health and wellbeing systems, cultures and practices, will ensure that decision-making processes are capable of balancing competing ethical values, to incorporate but not be subsumed by approaches that favour one value or right over another. This requires recognition of the risks and limitations to human rights which are intrinsic to contemporary mental health and wellbeing systems, most especially in laws which permit coercive practices including substitute decision-making. Only by ensuring all decision-makers recognise the inherent nature of these risks, and the appropriate extent of justifiable limitations, will they be supported to make the right decisions in each individual case.

Victoria’s mental health and wellbeing system provides a unique opportunity to take a human rights-based approach to reform. At this moment in time, Victoria stands at the precipice of mental health and wellbeing reform. The Royal Commission into Victoria’s Mental Health System has published two reports, with a total 74 recommendations for reform, and the Victorian Government has committed to implementing each and every one. Pursuant to these recommendations, the Parliament



of Victoria introduced the new *Mental Health and Wellbeing Act* (MHWA) in August 2022.

To support the development of human rights-based approaches to mental health and wellbeing reform, this paper explores and applies human rights laws and principles to the practical realities of Victoria's mental health and wellbeing system. In doing so, this paper presents 40 recommendations for systemic and legislative reform. Together, these recommendations set forth a vision of a system capable of providing safe, effective and therapeutic care based on a proportionate balance of the values of beneficence and autonomy, and the various human rights which embody these values.

To achieve this vision, human rights must be embedded into the foundations of the system to address the systematic privileging of beneficence over autonomy; they must be embedded into cultures and workforces to help workers make decisions that are proportionate in every case; and they must principally inform the way the system is governed to prevent, identify and respond to cases where disproportionate approaches have been, are being, or are at risk of being taken. These matters form the basis of the first three parts of this paper.

Part 1 outlines the need for strong governance to oversee Victoria's mental health and wellbeing system. This encompasses strategic oversight to support a long-term journey of transformation towards a human rights-based system, as well as adequate system funding and strong compliance functions from the Mental Health and Wellbeing Commission to address risks to, and breaches of, human rights.

Part 2 outlines reforms required to provide a basis for a human rights-based system to flourish. This includes, first and foremost, the deep embedding of lived experience¹ into all aspects of the system. It also includes efforts to ensure services and workers have appropriate obligations and supports to implement new laws and give effect to people's rights in practice, as well as efforts to ensure the mental health and wellbeing system is properly integrated

into the surrounding social care environment.

Part 3 identifies improvements required in the legislative underpinnings of the MHWA along with any future mental health and wellbeing legislation. This includes ensuring the legislative basis for Victoria's mental health and wellbeing system has human rights embedded into its core with human rights-based purposes, objectives and principles. Part 3 also addresses reforms to associated Victorian legislation including the *Charter of Human Rights and Responsibilities Act 2006*.


The remainder of this paper addresses discrete areas of law and practice that require adaptation to advance and promote human rights. The recommendations developed therein are designed to provide a greater scope for the balancing of beneficence and autonomy with regard to the direct provision of care and support.

Part 4 explores the use of decision-making capacity assessments. It demonstrates the need for greater protections for the autonomy of consumers who demonstrate the capacity to make their own decisions about their healthcare. Practical implementation mechanisms are also suggested to support the operation of decision-making capacity assessments in practice. Over time, further research on decision-making capacity is required to ensure that all consumers have their autonomy recognised and respected.

Part 5 acknowledges the fundamental importance of supported decision-making to help people exercise their autonomy in practice. This requires both legislative and practical reforms to strengthen and clarify a person's access to decision-making supports, including the right to make binding advance statements. Practical implementation supports are also required to support workers and services to discharge their roles in supporting consumers to make decisions about their health and wellbeing.

Part 6 addresses ways of reducing recourse to coercive practices. At a minimum, coercive practices should only be used when a person lacks the capacity to make relevant decisions for

¹ This paper uses the term 'lived experience' to refer to all persons with personal experiences of mental health issues, including consumers of mental health services and their family members, carers and supporters.



themselves. This requires the introduction of a capacity criterion into the compulsory treatment criteria, and an exploration of alternative legal frameworks that can ensure consumers are only subject to compulsory treatment when it is proportionate to do so. It also requires expanded legal representation at the Mental Health Tribunal and continuous and rigorous efforts to eliminate the use of restrictive practices.

Finally, Part 7 looks at data sovereignty. Amendments to the mental health privacy principles are required to establish a foundation for a human rights-based approach to the collection, use and sharing of information. Providing consumers with greater access to their own information, and strengthening duties on services to share information at defined points, with the consumer's consent, along with practical implementation supports, are also required to balance the health benefits of

information-sharing with the right of consumers to control their personal information.

Creating a human rights-based mental health and wellbeing system is a long-term goal, the achievement of which will require ongoing research, reform and recalibration as systems shape and evolve. The recommendations contained in this paper are not designed as a panacea, but they do provide a roadmap with practical and achievable next steps to begin work on this all-too-important journey. Across Victoria, and indeed further abroad, people will no doubt have many different and useful ideas for what the ultimate mental health and wellbeing system should look like. These conversations will be important to continue over time. But for now, the way forward is clear.

'A map of the world that does not include Utopia is not worth even glancing at, for it leaves out the one country at which Humanity is always landing. And when Humanity lands there, it looks out, and seeing a better country, sets sail. Progress is the realisation of Utopias.'
– Oscar Wilde²

² Oscar Wilde, *The Soul of Man under Socialism* (J.W. Luce & Co, 7th ed, 1910).

Background

The State of Victoria stands at the precipice of mental health and wellbeing reform. In February 2019, the Royal Commission into Victoria's Mental Health System (the Royal Commission) was formally established by the Victorian Governor.³ In March 2021, the Royal Commission handed down its Final Report,⁴ containing 65 recommendations in addition to the 9 made in its Interim Report.⁵

This once-in-a-generation reform follows from broad recognition that Victoria's mental health system is failing to support those it is intended to serve. Many individuals, including Victorian State Premier the Hon. Daniel Andrews MP, have described the system as 'broken'.⁶

There are historical antecedents to the failures of Victoria's mental health system. In the 19th and 20th centuries, institutional care was the norm for the provision of mental health treatments. This began to change in the 1980s when the deinstitutionalisation movement instigated a shift towards providing mental healthcare within community-based models.

In the 1990s, Victoria's mental health system stood at the forefront of the nation. Victoria had the highest per capita spend on specialist mental health services in Australia,⁷ with the 1994 *Victorian framework for mental health service funding* prioritising the delivery of community-based care.⁸ The 1990s were also a time of unprecedented national cooperation in the reform of mental health systems across the country.⁹

Since then, Victoria's mental health system has deteriorated significantly. By 2016–17, Victoria had the lowest per capita spend on specialist mental health services in Australia.¹⁰ Furthermore, successive reports and reviews, including system reviews by the Victorian Auditor-General,¹¹ evidenced an increasing distance between the goals of deinstitutionalisation and the delivery of mental health services in overwhelmingly clinical settings.¹²

As a result, while the Victorian mental health system is no longer dependent on the asylums of the past, it has nevertheless failed to realise the vision of a deinstitutionalised future. With demand having overtaken capacity,¹³ the system now functions in a perpetual state of crisis.¹⁴ Community-based services are undersupplied,¹⁵ and emergency services have become de facto entry points into an overburdened system.¹⁶ Access to mental healthcare is inequitable,¹⁷ and many people are unable to access mental health services at all.¹⁸ Even when people are able to access services, delivery is compromised by enduring power imbalances,¹⁹ stigma and discrimination,²⁰ the exclusion of lived experience insights and perspectives,²¹ complex and ineffective regulation and oversight,²² poor integration of mental health services with the surrounding social care system,²³ workforce under-resourcing,²⁴ and poor practices including deficits in recovery-oriented and trauma-informed care²⁵ and the disregarding of the rights and dignity of consumers.²⁶

Over this period of time, however, the system

3 Letter from Linda Dessau AC to Penelope Armytage, *Royal Commission Letters Patent*, 22 February 2019 <http://rcvmhs.archive.royalcommission.vic.gov.au/Terms_of_Reference_signed.pdf>.

4 Royal Commission into Victoria's Mental Health System (Final Report, Parliamentary Paper No 202, Session 2018–2021, February 2021) ('*Royal Commission Final Report*').

5 Royal Commission into Victoria's Mental Health System (Interim Report, Parliamentary Paper No 87, Session 2018–2019, November 2019) 11 ('*Royal Commission Interim Report*').

6 *Royal Commission Final Report* (n 4) exec summary, 3; Adam Carey, 'Commissioners Named in Bid to Fix State's "Broken" Mental Health System', *The Age* (Melbourne, 24 February 2019) 2.

7 *Royal Commission Interim Report* (n 5) 551; Australian Institute of Health and Welfare, 'Expenditure on mental health services 2019–20, Table EXP.4', *Mental health services in Australia* (Spreadsheet, 9 March 2022) <<https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/expenditure-on-mental-health-related-services>> ('Mental health expenditure table').

8 *Royal Commission Interim Report* (n 5) 89; Department of Human Services (Vic), *A funding framework for mental health services in Victoria* (Report, August 1994).

9 *Royal Commission Interim Report* (n 5) 87.

10 *Ibid* 551; Mental health expenditure table (n 7).

11 See, eg, Auditor-General's Office (Vic), *Access to Mental Health Services* (Report, March 2019) 7.

12 *Royal Commission Interim Report* (n 5) 568.

13 *Royal Commission Final Report* (n 4) exec summary, 8.

14 *Ibid* exec summary 10; *Royal Commission Interim Report* (n 5) 89.

15 *Royal Commission Final Report* (n 4) exec summary, 8.

16 *Ibid* 10.

17 *Ibid*.

18 *Ibid* 8.

19 *Ibid* 4.

20 *Ibid* 16.

21 *Ibid* 11, 16.

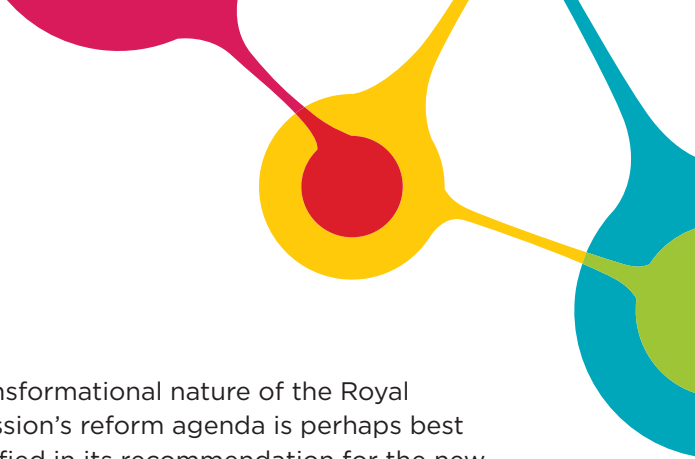
22 *Ibid* 17.

23 *Ibid* 11.

24 *Ibid* 18.

25 *Ibid* 12.

26 *Ibid* 18.



has also benefitted from the strengthening of human rights protections and the growth of the consumer movement.²⁷ The introduction of Victoria's *Charter of Human Rights and Responsibilities Act 2006* (the Charter) has established a legislative framework to ensure that Victorian laws, policies and services align with the human rights which all Victorians share with each other.²⁸ The Charter imposes a range of human rights obligations on lawmakers, Courts and public authorities when interpreting and applying Victorian laws, including that a public authority must act and make decisions compatibly with human rights.²⁹ The Charter therefore represents a singular strength to situate Victoria's mental health and wellbeing system within a human rights-based framework.

Underlying the Charter are international treaties which form the basis of Australia's international human rights obligations. These instruments include the *International Covenant on Civil and Political Rights* (ICCPR)³⁰ and the *International Covenant on Economic, Social and Cultural Rights* (ICESCR)³¹ as well as the *Convention on the Rights of Persons with Disabilities* (CRPD)³² which crucially sets out the human rights of persons with disabilities, including those relating to mental health. Australia has ratified each of these instruments and therefore bears obligations under international law to give effect to them domestically.

In light of the significant and enduring structural challenges besetting Victoria's mental health system, the Royal Commission recommended a 'transformational reform'.³³ It acknowledged the failures of earlier reforms, the enduring strength of the principles of deinstitutionalisation,³⁴ and the vital importance of a mental health and wellbeing system 'underpinned by a strong human rights framework' founded upon the Charter and the CRPD.³⁵

The transformational nature of the Royal Commission's reform agenda is perhaps best exemplified in its recommendation for the new *Mental Health and Wellbeing Act* to replace the *Mental Health Act 2014* (MHA)³⁶ with a 5-7-year review based on co-designed terms of reference.³⁷ This change in nomenclature reflects a broader movement within mental health service provision towards a focus on holistic care, taking into account all of a consumer's needs. As expressed by the Royal Commission:

Good mental health and wellbeing is not just the absence of mental illness; it is the ability to fully and effectively participate in society. This means attention must be paid to a range of factors related to poor mental health... Health is not the only priority in promoting good mental health and wellbeing.³⁸

With new legislation, a new Mental Health and Wellbeing Commission (the Commission), and a robust vision for further reform already laid out, the State of Victoria now has a unique opportunity to establish the foundations of a human rights-based mental health and wellbeing system. This transformation has the potential to achieve many things: to better support the mental health and wellbeing of all Victorians; to advance and promote the human rights of consumers within the system; to explore innovative approaches to system and service design and delivery; to capitalise on the strengths of the growing consumer movement; to incorporate developments in human rights law; and to finally realise the goals of the deinstitutionalisation movement.

Victoria's journey also has the potential to stand as a global example of how to create a human rights-based mental health and wellbeing system that is truly capable of supporting the mental health and wellbeing of those it is intended to serve.

27 *Royal Commission Interim Report* (n 5) 85.

28 *Ibid* 94.

29 *Charter of Human Rights and Responsibilities Act 2006* (Vic) s 38(1) ('Charter').

30 *International Covenant on Civil and Political Rights*, opened for signature 16 December 1966, 999 UNTS 171 (entered into force 23 March 1976) art 1 ('ICCPR').

31 *International Covenant on Economic, Social and Cultural Rights*, opened for signature 16 December 1966, 993 UNTS 3 (entered into force 3 January 1976) art 1 ('ICESCR').

32 *Convention on the Rights of Persons with Disabilities*, opened for signature 30 March 2007, 2515 UNTS 3 (entered into force 3 May 2008) ('CRPD').

33 See, eg, *Royal Commission Final Report* (n 4) exec summary, 18.

34 *Royal Commission Interim Report* (n 5) 89.

35 *Royal Commission Final Report* (n 4) vol 4, 228.

36 *Ibid* 11, Recommendation 42.

37 *Ibid* 12, Recommendation 43.

38 *Ibid* exec summary, 3.

Human rights in context

The tension between the values of beneficence and autonomy lies at the heart of modern controversies in mental health. Historically, mental health systems have been driven by a medical model which focusses on beneficence: which course of action is in the patient's best interests? But a mental health and wellbeing system that respects the value of autonomy must also ask the question, 'What does the person want?', and be able to determine the right course of action when the answers to these questions diverge.

Human rights provide an ideal framework to balance these competing considerations. This is because, like ethical values, human rights are intrinsically interrelated and interdependent.³⁹ On their own, particular rights may become meaningless or even oppressive if not balanced with other rights that are applicable in the circumstances.⁴⁰ A human rights-based system must provide for a holistic balance of all human rights, in the same way that mental health and wellbeing systems must holistically balance all ethical values.

By recasting the so-called 'intractable' debates of mental health into a human rights framework, value conflicts can be translated into concrete legal questions with corresponding solutions. In particular, incorporating the proportionality principle into mental health and wellbeing systems will facilitate rights-based decision-making, ensuring a proportionate balance is struck in each case where human rights, and the underlying values which they embody, come into conflict. To understand this first requires an understanding of how the values of beneficence and autonomy inform those human rights most relevant to the enduring dilemmas in mental health and wellbeing.

The right to health is foundational to mental health and wellbeing. Enshrined in the ICESCR⁴¹ and the CRPD,⁴² the right embodies the value of beneficence in its protection of 'timely and appropriate' healthcare⁴³ to ensure people have meaningful access to the benefits of health treatments. At the same time, the right to health also protects the right to make one's own medical decisions.⁴⁴ The relevance of autonomy to medical ethics was well-articulated by a clinician who once observed:

So, some things might not be in someone's best interest clinically, like they want leave so they can go and smoke. Smoking is bad for you. You shouldn't be advocating that, but at the same time you've got to balance that against their rights to do something that's a legal activity. I think if you give someone their rights, even though it might not technically be in their best interest in an ideal situation, then it gives them the strength to care a bit more about examining that for themselves.⁴⁵

Thus, the right to health requires consideration of both beneficence and autonomy, encompassing both the right to access health services and the right to refuse them.⁴⁶

Autonomy is also protected by other human rights, most especially the right to recognition as a person before the law. This right is contained in the Victorian Charter⁴⁷ as well as the ICCPR⁴⁸ and the CRPD.⁴⁹ It recognises the legal capacity of every person; that is, it protects a person's legal standing (their capacity to have rights) and their legal agency (their capacity to exercise those rights).⁵⁰ 'Legal capacity' should be properly distinguished from 'mental' or 'decision-making capacity'.⁵¹ Legal capacity refers to a person's capacity to hold and exercise legal rights,⁵² including the *right* to make decisions about medical treatment⁵³ while decision-making or mental capacity refers to

39 CRPD (n 32) preambular para (c).

40 Amita Dhanda, 'Legal Capacity in the Disability Rights Convention: Stranglehold of the Past or Lodestar for the Future' (2007) 34 *Syracuse Journal of International Law and Commerce* 429, 456-7; Penelope Weller, 'Health Law and Human Rights: Towards Equality and the Human Right to Health' in Ian Freckelton and Kerry Peterson (eds), *Tensions and Traumas in Health Law* (Federation Press, 2017) 21-2.

41 ICESCR (n 31) art 12.

42 CRPD (n 32) art 25.

43 UN Committee on Economic, Social and Cultural Rights, *ICESCR General Comment No. 14: The Right to the Highest Attainable Standard of Health* (Art. 12), 22nd session, UN Doc E/C.12/2000/4 (11 May 2000) [11], [12(b)], [17].

44 Ibid [8], endorsed in *PBU & NJE v Mental Health Tribunal and others* [2018] VSC 564 [79].

45 Chris Maylea et al, 'Consumers' experiences of rights-based mental health laws: Lessons from Victoria, Australia' (2021) 78 (September-October) *International Journal of Law and Psychiatry* 1, 6.

46 *PBU & NJE v Mental Health Tribunal and others* [2018] VSC 564 [97] ('PBU').

47 Charter (n 29) s 8(1).

48 ICCPR (n 30) art 16(1).

49 CRPD (n 32) art 22(1).

50 UN Committee on the Rights of Persons with Disabilities (CRPD), *General Comment No 1 Article 12: Equal recognition before the law*, 11th session, UN Doc CRPD/C/GC/1 (19 May 2014) [13] ('GCI').

51 GCI (n 50) [13].

52 *PBU* (n 46) [143]; GCI (n 50) [13].

53 *Re MB* [1997] 2 FLR 426, 436.

a person's *ability* to make those decisions.⁵⁴

Victorian jurisprudence interprets the right to recognition as a person before the law as grounding a presumption that every adult person has inherent legal capacity, a presumption that may be rebutted.⁵⁵ Personal attributes, including mental health status, do not justify denial of the right under Victorian law.⁵⁶ The CRPD goes one step further, stating that deficits in mental capacity never justify the denial of legal capacity.⁵⁷

Autonomy is also a fundamental element of the right to privacy⁵⁸ which is contained in the Victorian Charter⁵⁹ as well as the ICCPR⁶⁰ and the CRPD.⁶¹ This right protects the full sphere of a person's personal life, including their 'identity, self-determination, physical and moral integrity, maintenance of relationships with others and a settled and secure place in the community'.⁶² It enshrines the values of self-determination and personal inviolability.⁶³ The former protects the 'universal capacity of persons equally to determine who they are, how they will live their lives and what should be done to them'⁶⁴ while the latter protects a person from unjustified interferences with their physical and psychological integrity, their individual and social identity as well as their autonomy and inherent dignity.⁶⁵ The right to privacy is necessarily broad to protect all attributes that are private to individuals.⁶⁶ It includes medical treatment decision-making autonomy⁶⁷ because medical treatment decisions are an 'intensely personal' and 'fundamental expression' of one's individual identity, informed by personal

values, experiences and relationships.⁶⁸

Many other rights, including the rights to liberty, association and movement provide further protections for autonomy. In particular, medical decision-making autonomy is directly protected by the Victorian right to protection against medical treatment without full, free and informed consent.⁶⁹

Thus, the values of beneficence and autonomy underpin many of the human rights which are relevant to mental health and wellbeing systems. A human rights-based system therefore requires decisions to be made based on a proper consideration of both values, and an application of those values to the case at hand. Any parts of the system that exclusively privilege one value over another are fundamentally incompatible with human rights. It is these aspects of the system that require reform in order to establish a truly rights-based system.

Wherever the ethical values of beneficence and autonomy suggest different courses of action to take, both courses should be considered in light of the particular circumstances of each individual case. Application of a proportionality assessment in such situations will help to identify the most proportionate response, taking all rights and values into account. The recommendations in this paper all aim to facilitate rights-based decision-making, based on a proportionate balance of these values, and the human rights they embody.

54 *GC1* (n 50) [13].

55 *PBU* (n 46) [143]; *Re T (Adult: Refusal of Treatment)* [1992] EWCA Civ 18, 112.

56 *PBU* (n 46) [145].

57 *GC1* (n 50) [13].

58 *PBU* (n 46) [127].

59 *Charter* (n 29) s 13(1).

60 *ICCPR* (n 30) art 17.

61 *CRPD* (n 32) art 12(1).

62 See *Connors v United Kingdom* (2005) 40 EHRR 9 [82]; see also *PBU* (n 46) [128].

63 *PBU* (n 46) [109].

64 *Ibid* [127].

65 *Kracke v Mental Health Review Board* [2009] VCAT 646 [619]–[620] ('*Kracke*').

66 *Director of Housing v Sudi* (2011) 33 VR 559 [29].

67 *PBU* (n 46) [128].

68 *Ibid* [199].

69 *Charter* (n 29) s 10(c).

Part 1: Governance

Governance mechanisms form the bedrock of human rights guarantees. Without effective governance, risks to human rights may not be identified and prevented, and breaches may not be recognised and redressed.

The World Health Organization identified governance and leadership as one of the 'six building blocks' of an effective health system.⁷⁰ It defined governance as 'ensuring strategic policy frameworks exist and are combined with effective oversight, coalition-building, regulation, attention to system-design and accountability'.⁷¹ Health system governance also includes clinical governance to support quality assurance and system performance.⁷²

Effective governance is also recognised as an essential component of a human rights-based approach to system design and delivery.⁷³ Only through effective governance can human rights and legal instruments be turned into on-the-ground realities.⁷⁴ In particular, the prompt, thorough and effective investigations of allegations of violations is crucial to the satisfaction of Australia's international human rights obligations⁷⁵ which depend on systems based on the principles of accountability and legality.⁷⁶

The Royal Commission acknowledged poor governance, including deficits in oversight and accountability,⁷⁷ as a key barrier to providing safe, high-quality treatment, care and support in Victoria.⁷⁸ Indeed, poor governance is well-recognised as a key system barrier to mental health and wellbeing system delivery worldwide.⁷⁹ To address this, the Royal Commission recommended that new legislation clarify governance arrangements for the new mental health and wellbeing system,⁸⁰ strengthen accountability mechanisms and monitoring

arrangements,⁸¹ and establish a range of new governance bodies.⁸² These reforms are vital to the Royal Commission's vision of a foundational shift in system governance to support the development of rights-based system.⁸³

In addition to these Royal Commission reforms, the effective governance of a rights-based mental health and wellbeing system requires government accountabilities to respect, protect, promote and fulfill human rights, complemented by strong regulatory oversight and the development of a strategic approach to continuously advance and promote human rights. In addition, adequate system funding and guidance for the development of human rights-based clinical governance frameworks is required.

70 World Health Organization, *Everybody's Business: Strengthening Health Systems to Improve Health Outcomes: WHO's Framework for Action* (Report, 2007) vi.

71 Ibid.

72 Sameen Siddiqi et al, 'Framework for assessing governance of the health system in developing countries: gateway to good governance' (2009) 90(1) *Health Policy* 13.

73 Philip Alston, 'Ships Passing in the Night: The Current State of the Human Rights and Development Debate Seen Through the Lens of the Millennium Development Goals' (2005) 27(3) *Human Rights Quarterly* 755.

74 Australian Human Rights Commission, *Human Rights Based Approaches* (Web Page) <<https://humanrights.gov.au/our-work/rights-and-freedoms/human-rights-based-approaches>>.

75 GC1 (n 50) [15].

76 Scottish Human Rights Commission, *Human rights in health and social care – putting it into practice: Case studies from Scotland* (Report, 2019) 4.

77 *Royal Commission Final Report* (n 4) vol 4, 32, 407.

78 Ibid 227–229.

79 Benedetto Saraceno et al, 'Barriers to improvement of mental health services in low-income and middle-income countries' (2007) 370(9593) *The Lancet* 1164; Graham Thornicroft et al, 'WPA guidance on steps, obstacles and mistakes to avoid in the implementation of community mental health care' (2010) 9(2) *World Psychiatry* 67.

80 *Royal Commission Final Report* (n 4) vol 4, 11, Recommendation 42(2)(b).

81 Ibid 11, Recommendation 42(2)(d).

82 Ibid 11, Recommendation 42(2)(c).

83 Ibid 228.

1.1 Clarify government accountabilities

Recommendation 1.1

Clarify the Victorian Government's legal obligations to 'respect, protect, promote and fulfill' human rights, in line with existing obligations under Victorian and international law.

The Victorian Government's human rights obligations should reflect its obligations under Victorian and international law. This is consistent with the Royal Commission's vision for a rights-based system underpinned by 'strong system leadership and accountability'.⁸⁴

The MHWa empowers the Health Secretary and Chief Officer for Mental Health and Wellbeing with functions to 'promote human rights compliance'.⁸⁵ It does not impose any obligations on the Victorian Government to 'respect', 'protect' or 'fulfill' human rights, while promotion functions are limited to matters of 'compliance'.

These accountabilities are out of step with governmental obligations under both Victorian and international law. The Charter includes obligations to both 'protect' and 'promote' human rights,⁸⁶ while international human rights law includes obligations to 'respect', 'protect' and 'fulfill' human rights. Respecting human rights pertains to a government's obligation to not directly interfere with a person's rights; protecting human rights requires the prevention of violations by third parties, such as health services; while fulfilling human rights requires further positive measures to support the full enjoyment of rights.⁸⁷

A rights-based system underpinned by strong leadership and accountability requires at its outset appropriate government obligations. To achieve this, the obligation to 'respect' human rights should be included as required by the Victorian Charter. Truly rights-based legislation would include complete legal obligations to 'respect, protect, promote and fulfill' human rights imposed on all relevant government actors.

1.2 Regulatory oversight

Recommendation 1.2

Empower the Mental Health and Wellbeing Commission to monitor and report on government activities to respect, protect, fulfill and promote human rights, as well as the progress of the mental health and wellbeing system towards compliance with the *Convention on the Rights of Persons with Disabilities*.

As recommended by the Royal Commission,⁸⁸ the MHWa established the Mental Health and Wellbeing Commission to hold government accountable for system management⁸⁹ and to promote, support and protect the rights of consumers.⁹⁰ However, the MHWa does not provide the Commission with any express power vis-a-vis human rights.⁹¹

To ensure the Government is held accountable for discharging its human rights obligations, the Commission should be specifically empowered to monitor and report on the government's performance with regard to human rights. This would be consistent with the Commission's other monitoring and reporting obligations, as well as the Royal Commission's vision of strong regulatory oversight and a human rights-based system.

This would be best achieved through the development of successive reports, led by or co-produced with people with lived experience, and informed by research into the operation of mental health and human rights laws, and human rights-based approaches to safeguarding and service delivery. The reports should be complemented with concrete recommendations for improvement. The recommendations of this paper should be specifically considered in the inaugural report, with further recommendations developed as required in the spirit of continuous improvement.

⁸⁴ Ibid 77.

⁸⁵ *Mental Health and Wellbeing Act 2022* (Vic) ss 254(f), 261(e) ('MHWa').

⁸⁶ *Charter* (n 29) ss 1(2), 7(1).

⁸⁷ International Commission of Jurists, *Maastricht Guidelines on Violations of Economic, Social and Cultural Rights* (Guidelines, January 1997); UN Office of the High Commissioner for Human Rights, *International Human Rights Law* (Web Page) <<https://www.ohchr.org/en/instruments-and-mechanisms/international-human-rights-law>>.

⁸⁸ *Royal Commission Final Report* (n 4) vol 4, 59, Recommendation 44.

⁸⁹ *MHWa* (n 85) s 413(a).

⁹⁰ Ibid s 413(e).

⁹¹ Ibid s 415.

1.3 A strategic approach

Recommendation 1.3

Develop and implement strategic government responses to advance and promote human rights in the mental health and wellbeing system.

The Royal Commission set out a vision for a rights-based system, including a strong governance reform agenda. However, work still remains to identify the detailed actions required to achieve this goal in the long-term, including after the completion of the Royal Commission's 10-year reform journey. This requires the development of successive long-term strategies, the ultimate goal of which should be to monitor and promote compliance with the CRPD.

The Victorian Government should establish a strategic approach to advance and promote human rights within the mental health and wellbeing system. This should form an ongoing body of work, comprising successive strategies developed in response to findings of the Mental Health and Wellbeing Commission vis-à-vis

human rights. This work may be subsumed into existing strategic planning for the system or may form a stand-alone body of work.

While Victoria's previous *10-Year Mental Health Plan* acknowledged human rights,⁹² it was not accompanied by clear measures, milestones or accountability structures.⁹³ To effectively promote the development of a rights-based system in practice, strategic frameworks must include these mechanisms, along with human rights indicators and accountability tools, such as human rights impact assessments and action plans.⁹⁴ Legal scholars have added to these requirements the need for improved collection and dissemination of performance indicators, leadership roles for people with lived experience, and funding for research and evaluation into mental health and human rights laws.⁹⁵ To these may further be added clear actions and timeframes, capacity-building and other supports required for lived experience participation and leadership, and research into human rights-based approaches to mental health service delivery and safeguarding.

⁹² Department of Health and Human Services (Vic), *Victoria's 10-year mental health plan* (Report, November 2015).

⁹³ Victorian Auditor General's Office, *Child and Youth Mental Health* (Independent Assurance report to Parliament 2018-19 No 26, 5 June 2019).

⁹⁴ Victorian Equal Opportunity and Human Rights Commission, *The Human Rights Culture Indicator Framework* (October 2021); Commission for Gender Equality in the Public Sector, *Gender Impact Assessments* (Web Page, 2020) <<https://www.genderequalitycommission.vic.gov.au/gender-impact-assessments>>.

⁹⁵ Simon Katterl and Chris Maylea, 'Keeping human rights in mind: Embedding the Victorian *Charter of Human Rights* into the public mental health system' (2021) 27(1) *Australian Journal of Human Rights* 58, 70-71.

1.4 Compliance and enforcement regulatory functions

Recommendation 1.4

Provide the Mental Health and Wellbeing Commission with a clear function to 'promote, support and enforce compliance with human rights obligations and the provisions of the *Mental Health and Wellbeing Act* through the strategic and transparent use of compliance and enforcement powers', supported by:

- broad 'carrot-and-stick' compliance and enforcement powers;
- powers and resources to develop standards and guidance for services on all relevant matters;
- powers to lead the system on a journey of cultural change;
- public reporting obligations; and
- a review of the Commission's performance incorporated into the review of the *Mental Health and Wellbeing Act*.

Pursuant to the Royal Commission's recommendation,⁹⁶ it is vital that the Commission have strong regulatory powers to ensure it can hold services to account for repeated breaches of ethical and legal obligations. Currently, the Commission has a range of regulatory functions including using dispute resolution to resolve complaints,⁹⁷ serving compliance notices⁹⁸ and, where there is a risk of serious harm, reporting a matter to another regulatory or oversight body.⁹⁹ The Commission may also 'promote and support' compliance with the MHWa.¹⁰⁰ These powers should be supported with strong complementary regulatory functions. This is particularly important in light of evidence that the previous regulator, the Mental Health Complaints Commissioner, took no compliance actions in its seven years of operation, despite receiving more than 12,000 complaints.¹⁰¹

To establish strong regulatory oversight of the system, the new Commission requires a clear and broad function 'to ensure compliance with human rights obligations and the provisions of the *Mental Health and Wellbeing Act* through the strategic and transparent use of compliance and enforcement powers'. The clarity and breadth of this function so stated is necessary to empower the Commission to take a strategic and proactive approach to ensuring the letter of the law is realised in practice, without being constrained by legal technicalities or overburdened by strict obligations.

A clear and broad compliance function accords with the Royal Commission's strong vision of reform. The Royal Commission acknowledged the need for the Commission to have 'bold objectives and appropriate powers' to be achieve its objectives¹⁰² which include 'protect[ing] the rights of consumers'¹⁰³ and 'strengthen[ing] system leadership and accountability'.¹⁰⁴ Providing the Commission with a strong compliance mandate is crucial to achieve this broad vision for strong regulatory oversight of the mental health and wellbeing system.

Providing consumers of mental health services with comparatively weak regulatory protections is also in direct contradiction to the Australia's human rights obligations. Comparable regulatory bodies, such as the NDIS Quality and Safeguards Commission and the Aged Care Quality and Safety Commission, already have legislative functions which include clear and broad compliance functions.¹⁰⁵ The right to equality explicitly requires the 'equal protection of the law'¹⁰⁶ as well as the equal enjoyment of human rights without discrimination.¹⁰⁷ Regulatory protections for consumers of mental health and wellbeing services should therefore be equivalent to those provided for consumers of other social care services.

A clear and broad compliance mandate should be supported by strong powers and other mechanisms to strengthen system oversight including:

- a range of enforcement powers capable of supporting the Commission to ensure

⁹⁶ *Royal Commission Final Report* (n 4) vol 4, 59, Recommendation 44.

⁹⁷ *MHWa* (n 85) s 415(l).

⁹⁸ *Ibid* s 415(m).

⁹⁹ *Ibid* s 415(ze).

¹⁰⁰ *Ibid* s 415(zc).

¹⁰¹ Adeshola Ore and Melissa Davey, 'No action taken against Victorian mental health services despite more than 12,000 complaints', *The Guardian* (online, 26 May 2022) <<https://www.theguardian.com/society/2022/may/26/no-action-taken-against-victorian-mental-health-services-despite-more-than-12000-complaints>>.

¹⁰² *Royal Commission Final Report* (n 4) vol 4, 78.

¹⁰³ *Ibid* 5.

¹⁰⁴ *Ibid* 78.

¹⁰⁵ See, eg, *Aged Care Quality and Safety Commission Act 2018* (Cth) s 13(ac); *National Disability Insurance Scheme Act 2013* (Cth) ss 181E(a), (d).

¹⁰⁶ *Charter* (n 29) s 8(3).

¹⁰⁷ *Ibid* s 8(2).

services are complying with relevant laws,¹⁰⁸ including 'carrot-and-stick' powers to:

- intervene to prevent imminent breaches;
- work in partnerships to enable networked regulatory approaches¹⁰⁹ including data-sharing between oversight bodies;¹¹⁰
- address all levels of an organisation, from the Board-level down, through the roles of CEO, managers and supervisors, and frontline workers;
- necessary powers and resources to develop standards and guidance for services, not only on complaints management processes¹¹¹ and the application of the mental health principles,¹¹² but also on service reporting requirements and the application of human rights and other legal obligations to different settings and contexts within the mental health and wellbeing system,¹¹³ with particular regard to supported decision-making;
- powers to lead the system on a journey of cultural change, drawing on the *Gender Equality Act 2020 (Vic)*¹¹⁴ and the outcomes of a law reform implementation initiative¹¹⁵ encompassing powers to provide education and practical support for ongoing implementation and culture change;
- public reporting obligations, including service-level data to allow comparison and benchmarking;¹¹⁶
- a review of the Commission's performance as part of the next review of the MHW.

1.5 Reducing recourse to coercive practices

Recommendation 1.5

Provide the Mental Health and Wellbeing Commission with an express objective 'to reduce recourse to coercive practices'.

The Commission should have a clear mandate to reduce recourse to coercive strategies. Currently, the Commission's objectives contain no reference to coercive practices,¹¹⁷ while its functions in this regard are limited to monitoring and reporting on the use of coercive practices,¹¹⁸ with the use of restrictive practices reported against targets set by the Health Secretary.¹¹⁹

Considering the significant human rights risks associated with coercive practices,¹²⁰ a broad function to reduce recourse to coercive practices is important to support a long-term shift towards alternatives to coercion which can provide greater scope for consumer autonomy. It also directly supports the Royal Commission's recommendations to reduce the use of compulsory treatment¹²¹ and eliminate restrictive practices,¹²² including through strong regulatory oversight.¹²³

By providing an express goal to reduce recourse to coercive practices, the Commission will be clearly empowered to use its functions in this regard, including its investigative, enforcement and supportive functions. Otherwise, the Commission's activities in this space will be limited to its explicit role in monitoring and reporting on coercive practices. Monitoring and reporting is a crucial element of effective governance but cannot alone achieve the change envisioned by the Royal Commission.

¹⁰⁸ See also enforcement options available to the Gender Equality Commissioner: *Gender Equality Act 2020 (Vic)* ss 22, 26.

¹⁰⁹ Simon Katterl, 'Regulatory oversight, mental health and human rights' (2021) 46(2) *Alternative Law Journal* 149.

¹¹⁰ Victoria Legal Aid, *Roads to Recovery – Building a Better System for People Experiencing Mental Health Issues in Victoria* (Submission, May 2020) 47.

¹¹¹ *MHW* (n 85) ss 415(o), (r).

¹¹² *Ibid* s 415(g).

¹¹³ Simon Katterl, 'Regulatory oversight, mental health and human rights' (2021) 46(2) *Alternative Law Journal* 149; Victoria Legal Aid (n 110) 47.

¹¹⁴ See Victoria Legal Aid (n 110) 45–6.

¹¹⁵ See Part 2.1.

¹¹⁶ Victoria Legal Aid (n 110) 47.

¹¹⁷ *MHW* (n 85) s 413.

¹¹⁸ *Ibid* ss 415(h)(ii), (iii).

¹¹⁹ *Ibid* s 415(i).

¹²⁰ See Part 6.

¹²¹ *Royal Commission Final Report* (n 4) vol 4, 361, Recommendation 55(1).

¹²² *Ibid* 297, Recommendation 54(1).

¹²³ *Ibid* 226, Recommendation 53.

1.6 System funding

Recommendation 1.6

Review the need to increase or maintain the mental health and wellbeing surcharge in 10 years.

Adequate system funding is vital to securing human rights in practice, and should be ensured through a review of funding arrangements in 10 years. As the right to health includes the availability, accessibility, acceptability and quality of health services,¹²⁴ adequate funding for such is an essential precondition of a rights-based mental health and wellbeing system.

The Royal Commission recognised that historic underinvestment in Victoria's mental health system has compromised access to services and reduced their scope and effectiveness.¹²⁵ It therefore recommended the introduction of a new revenue mechanism to provide operational funding for the mental health and wellbeing system.¹²⁶ This has since been implemented in the form of a mental health and wellbeing surcharge.¹²⁷ Considering the fundamental importance of adequate system funding to realise human rights in practice, the adequacy of this surcharge should be reviewed once implementation of the Royal Commission's recommendations is complete.

It is inconceivable that the reduction or elimination of this revenue mechanism would promote the development of a rights-based system. As such, the terms of reference of this review should explicitly rule out the possibility of such. Rather, the review should be expressly purposed towards ascertaining the need to *increase or maintain* the surcharge to ensure the safe and effective ongoing operation of the new mental health and wellbeing system.

1.7 Clinical governance frameworks

Recommendation 1.7

Build human rights considerations into guidance on best-practice clinical governance frameworks to support the development of rights-based models of care.

Human rights considerations should be built into guidance on best-practice clinical governance frameworks to support the development of rights-based models of care. Currently, there are few rights-based models of care, and guidance provided on best-practice clinical governance frameworks rarely take human rights into consideration.¹²⁸

This must change to give effect to the Royal Commission's vision of a system built on 'a culture where human rights are understood, valued and applied in providing care'.¹²⁹ In particular, human rights-based clinical governance frameworks are critical to supporting workers to make clinical decisions based on a proportionate balance of the values of beneficence and autonomy which underlie many human rights.

Guidance on best-practice clinical governance frameworks should consider how human rights can be:

- recognised and embedded in service planning and oversight functions;
- promoted through staff training and guidance;
- maintained through staff empowerment and supervision;
- upheld by quality and safety frameworks;
- protected through efforts to recognise and respond to implementation enablers and barriers;
- assessed using consumer evaluations and outcomes data; and
- supported through lived experience participation and leadership.¹³⁰

¹²⁴ UN Committee on Economic, Social and Cultural Rights, *CESCR General Comment No. 14: The Right to the Highest Attainable Standard of Health* (Art. 12), 22nd session, UN Doc E/C.12/2000/4 (11 May 2000) [12].

¹²⁵ *Royal Commission Interim Report* (n 5) 544–6.

¹²⁶ *Ibid* 543, 560.

¹²⁷ State Revenue Office (Vic), *Mental health and wellbeing surcharge* (Web Page), <<https://www.sro.vic.gov.au/mentalhealthsurcharge>>.

¹²⁸ Katterl and Maylea (n 95) 71.

¹²⁹ *Royal Commission Final Report* (n 4) vol 4, 301.

¹³⁰ See Katterl and Maylea (n 95); Nick O'Connor and Michael Paton, 'Governance of' and 'Governance by': Implementing a Clinical Governance Framework in an Area Mental Health Service' (2008) 16(2) *Australasian Psychiatry* 69, 70; *Certain Children v Minister* (No 2) [2017] VSC 251 [525]–[526]; Equality and Human Rights Commission, *The impact of a human rights culture on public sector organisations: Lessons from practice* (Report, June 2009).

Part 2: System foundations

A rights-based system requires human rights to be embedded into the very foundations of the system. This is necessary to ensure a broad systemic capacity to facilitate rights-based approaches across all parts of the system. Only when human rights are considered at every relevant decision-making juncture will a system be capable of providing proportionate responses in all cases where human rights are at risk.

The embedding of human rights into a system requires a multi-pronged approach targeting all key levers and system foundations. Victorian caselaw recognises that an effective approach to implementing human rights will target every public power and function that connects public authorities to systems.¹³¹ At the same time, international law recognises that human rights obligations apply to all branches of government and all public authorities,¹³² and encompass all 'appropriate measures'.¹³³

Embedding human rights into the foundations of Victoria's mental health and wellbeing system means addressing matters of lived experience participation and leadership, workforce training and culture change, service commissioning and funding models, and other aspects of system

management¹³⁴ including service provider obligations and integration of the system in the broader social care environment. Other system foundations are discussed in Parts 1 and 3.

The embedding of lived experience across all functions of the system is especially important to provide greater scope for people to exercise their autonomy, both with regard to their own care and to broader system planning and functioning. This is because, as recognised by the Royal Commission,¹³⁵ the CRPD requires that persons with disabilities 'have the opportunity to be actively involved in decision-making processes about policies and programmes, including those directly concerning them'.¹³⁶ Historically, power imbalances have worked to systemically exclude people with lived experience from exercising their rights to participate in, and act as leaders and change-makers, in a system designed for their benefit. Deep system reform is therefore necessary to facilitate the inclusion of people with lived experience in all relevant decision-making processes as a critical component of a rights-based system capable of incorporating the value of autonomy.

¹³¹ *Certain Children v Minister for Families and Children* (2016) VSC 796 [185].

¹³² UN Human Rights Committee, *General comment no. 31* [80], *The nature of the general legal obligation imposed on States Parties to the Covenant*, 2187th meeting, UN Doc CCPR/C/21/Rev.1/Add.13 (26 May 2004) [4].

¹³³ *Ibid* [7]; UN Committee on Economic, Social and Cultural Rights, *General comment No. 3: The nature of States parties' obligations* (art. 2, para. 1, of the Covenant), 5th session, UN Doc E/1991/23 (14 December 1990) [4].

¹³⁴ Katterl and Maylea (n 95) 64–6.

¹³⁵ *Royal Commission Final Report* (n 4) vol 3, 13.

¹³⁶ *CRPD* (n 32) preambular para (o).

2.1 Law reform implementation initiative

Recommendation 2.1

Fund a law reform implementation initiative for the new *Mental Health and Wellbeing Act*.

A law reform implementation initiative will be critical to ensure legislative changes translate into practice. That is, law reform implementation efforts are necessary to ensure the mental health and wellbeing system has a workforce and system of service providers with the requisite knowledge and capability to deliver a rights-based system. This is particularly important to get right in light of observed deficits in the implementation of the MHA¹³⁷ as well as the Charter in the mental health sector.¹³⁸

A law reform implementation initiative should include the following three core elements:

- workforce education and development;
- organisational change and capacity-building; and
- policy advice for ongoing implementation needs.

It should also aim to provide consistent, clear and relevant communication from a centralised platform across a range of mediums and formats, led and/or co-produced with consumers and diverse communities to ensure the development of suitable advice and material for all audiences.

Workforce education development

The successful development of a rights-based system depends firstly on a workforce that understands and is supported to implement legal and human rights principles.¹³⁹ International human rights law recognises that educative measures are a core component of state obligations to implement human rights obligations.¹⁴⁰

The Charter already imposes obligations on Victorian public authorities to ‘give proper consideration’ to human rights when making

decisions.¹⁴¹ Mental health and wellbeing workers to whom this obligation applies cannot be expected to discharge this obligation without education and training on the content of human rights, and how they apply within the context of mental health and wellbeing laws.

The workforce development arm of the law reform implementation should align with the development of the Victorian Mental Health and Wellbeing Workforce Capability Framework. As recommended by the Royal Commission,¹⁴² this Framework will need to incorporate capabilities around understanding mental health law and human rights responsibilities.¹⁴³ A law reform implementation initiative can support this undertaking through the design and delivery of state-wide co-produced education and training programs targeted at the particular educative needs of individual workforce segments¹⁴⁴ including frontline workers, leaders of service provider bodies, Mental Health Tribunal members and workforces that intersect with the mental health and wellbeing system. These programs should cover:

- the value of human rights in service and system design and delivery;
- the risks to human rights inherent in the mental health and wellbeing system;
- approaches to balancing competing rights based on proportionality principles;
- the core philosophy and objectives of the MHWA and Charter;
- specific legal obligations under the MHWA and Charter;
- recent legislative changes as well as established legislative requirements;
- applications of legal obligations to different settings, cohorts, contexts and stages of treatment;
- the value of lived experience involvement in service and system design and delivery;
- the broad range of roles which people with lived experience may undertake, and appropriate supports and structures for consumers to discharge these roles;
- the value of cultural safety for both workers and people with lived experience, including appropriate processes,

¹³⁷ *Royal Commission Final Report* (n 4) vol 4, 26–8.

¹³⁸ Victorian Council of Social Services, Vicseiv, and Mental Health Legal Centre, *Submission to Scrutiny of Acts and Regulations Committee Review of the Charter of Human Rights and Responsibilities Act 2006* (Submission, 2010); Chris Maylea et al, ‘Consumers’ experiences of rights-based mental health laws: Lessons from Victoria, Australia’ (2021) 78 (September–October) *International Journal of Law and Psychiatry* 1, 5.

¹³⁹ Katterl and Maylea (n 95).


¹⁴⁰ UN Human Rights Committee, *General comment no. 31* [80], *The nature of the general legal obligation imposed on States Parties to the Covenant*, 2187th meeting, UN Doc CCPR/C/21/Rev.1/Add.13 (26 May 2004) [7]; UN Committee on Economic, Social and Cultural Rights, *General comment No. 3: The nature of States parties’ obligations* (art. 2, para. 1, of the Covenant), 5th session, UN Doc E/1991/23 (14 December 1990) [7].

¹⁴¹ *Charter* (n 29) s 38(1).

¹⁴² *Royal Commission Final Report* (n 4) vol 4, 452, Recommendation 58.

¹⁴³ *Ibid* 522.

¹⁴⁴ *Ibid* 35.



supports and structures for their treatment and employment, as well as the broader relevance of culture to mental health and wellbeing; and

- the role of governance and safeguarding mechanisms to protect and promote human rights.

Organisational change and capacity-building

A law reform implementation initiative must also include practical supports to assist services to play their roles in implementation and culture change. This should be driven by lived experience and should include:

- access to expert support and advice around assessing compliance, facilitating implementation efforts, supporting workers to assess and develop capabilities, driving organisational and cultural change, and measuring implementation success;
- the development of an organisational capabilities framework to provide direction, leadership and examples on how organisations can identify, prevent and respond to human rights risks and breaches;¹⁴⁵ and
- the identification, development and delivery of required resources such as statutory guidelines, templates, frameworks, and culture-specific assessment and screening tools, done in close connection with the development of guidance material from the Department of Health.¹⁴⁶

Policy advice for ongoing implementation needs

If the Commission is provided with a suitably strong compliance function,¹⁴⁷ it will be able to discharge the role of supporting implementation and ensuring compliance on an ongoing basis. The value of an implementation initiative such as this is to begin this work quickly, while the Commission is established, and to provide advice to the Commission on ongoing implementation needs. A specific outcome of the initiative should therefore include the development of policy guidance for the Commission regarding the ongoing education, practical supports and/or service obligations required to discharge its power to lead culture change.

¹⁴⁵ Cath Roper and Bridget Hamilton, *Organisational Capability Project: Report of the mental health consumer perspective component* (Report, August 2018).

¹⁴⁶ Department of Health (Vic), *Mental Health and Wellbeing Act: What we heard: Report on engagement process June–August 2021* (Report, November 2021) 25 ('What we heard').

¹⁴⁷ See Part 1.4.

2.2 Lived experience research and collaborative learning

Recommendation 2.2

Expand lived experience research studies and collaborative learning networks, enquiring into how consumers experience, understand and define mental wellness, and its opposite, and their applications to system change.

Lived experience¹⁴⁸ research studies and collaborative learning networks should be developed to enquire into the philosophical underpinnings of mental health and wellbeing. Understandings of mental health and mental illness have been contested for decades, and continue to be the source of considerable theoretical and philosophical debate.¹⁴⁹ This presents an existential threat to the proper functioning of the mental health and wellbeing system. That is, without a shared understanding of the problem being addressed, the system lacks a stable foundation upon which to operate.

Lived experience research projects should be developed to review the philosophical underpinnings of mental health and wellbeing by drawing on the expertise of those with lived experience. In so doing, these projects should ultimately aim to develop new and/or refined understandings of 'mental health' and 'wellbeing' that better align with the experiences and understandings of consumers. They may do so by asking fundamental questions such as:

- What is 'mental health'? What is 'wellbeing'? What is 'lived experience'? What is 'living experience'?
- What is it that differentiates consumers, or people with lived experience of mental health issues, from others?
- What do consumers, or people with lived experience of mental health issues, have in common with each another? What is it that unites and divides this group as a collective?
- What are the unique strengths and

challenges of people with lived experience?

- What do consumers, or people with lived experience of mental health issues, know by virtue of their experiences, and how do they know it?

Answering these questions will require drawing on the following philosophical traditions:

- Phenomenology has been described as the 'science of experience',¹⁵⁰ and with its focus on how a subjective viewpoint experiences and constructs meaning from phenomena,¹⁵¹ provides an ideal starting point for understanding the experience of 'mental health'.
- Ontology studies the nature of being,¹⁵² and so can enquire into what it means to *be* a consumer, or a person with experiences of mental health issues. It therefore provides a unique tool to understanding the existential nature of 'consumers' and 'mental health'.
- Epistemology is the study of knowledge, and incorporates broad and multifaceted enquiries including with regard to the formation of knowledge.¹⁵³ As such, it can provide insights into the ways in which consumers develop knowledge(s) from their experiences that are distinct from other epistemological cultures based on alternative evidentiary approaches.

Such projects will directly advance the right to health by solidifying the conceptual foundations upon which the mental health and wellbeing system operates. A rights-based mental health and wellbeing system must provide for substantive, not merely formal, equality. While formal equality counters direct discrimination by treating people the same, substantive equality acknowledges the differences between people, and attempts to provide a more fundamental equity by taking this 'dilemma of difference' into account.¹⁵⁴ To correctly distinguish between when consumers require the same treatment as others, and when they require differential treatment that caters to their differentiated needs, a level of ontological, epistemological and phenomenological certainty is required. That is, the mental health and wellbeing system must be based on a sufficiently robust understanding of the underlying nature of

148 In this section only, 'lived experience' refers exclusively to the experiences of consumers. It is used in this way to distinguish between the *experience* of mental ill-health and the *observation* of mental ill-health. This distinction is drawn in line with phenomenological approaches which focus on the direct experience of a phenomenon. All other sections of this paper use the term 'lived experience' more broadly to reflect the important experiences and knowledges that both consumers and their family members, carers and supporters bring to the mental health and wellbeing system.

149 Dirk Richter and Jeremy Dixon, 'Models of mental health problems: a quasi-systematic review of theoretical approaches' (2022) 11 *Journal of Mental Health* 1.

150 GWF Hegel, *Phenomenology of Spirit* (Oxford University Press, 1979).

151 Department of Philosophy, Stanford University, 'Phenomenology', *Stanford Encyclopedia of Philosophy* (Web Page, December 2013) <<https://plato.stanford.edu/entries/phenomenology>>.

152 Department of Philosophy, Stanford University, 'Logic and Ontology', *Stanford Encyclopedia of Philosophy* (Web Page, December 2013) <<https://plato.stanford.edu/entries/logic-ontology>>.

153 Department of Philosophy, Stanford University, 'Epistemology', *Stanford Encyclopedia of Philosophy* (Web Page, April 2020) <<https://plato.stanford.edu/entries/epistemology>>.

154 UN Committee on the Rights of Persons with Disabilities (CRPD), *General comment No. 6 (2018) on equality and nondiscrimination*, 19th session, UN Doc CRPD/C/GC/6 (26 April 2018) [10].

mental health, and the experiences, existences and knowledges of consumers, to be genuinely capable of catering to consumer needs without reducing them to categories based on assumptions and observed deficits. Only by asking these fundamental questions can the system capitalise on the insights from lived experience that have the potential to effect system change at its most basic foundation.

A number of bodies exist with the capabilities to support research projects of this nature. Abroad, academic institutions have established similar lived experience research programs¹⁵⁵ and collaborative networks.¹⁵⁶ In Victoria, the Collaborative Centre for Mental Health and Wellbeing has been established to bring people with lived experience together with researchers and care providers to drive practice change, educate the workforce, and research new treatments and models of care.¹⁵⁷ The Collaborative Centre may be an ideal body to conduct this research.

2.3 Lived experience work and participation

Recommendation 2.3

Strengthen supports for people with lived experience, including people from key population groups, to gain and retain employment in the mental health and wellbeing system.

People with lived experience should be supported to gain and retain employment within the mental health and wellbeing system. This will provide greater scope for an ethics of autonomy by supporting direct participation in system operations, in line with the CRPD's principle of 'full and effective participation and inclusion in society'¹⁵⁸ and Royal Commission's recommendations.¹⁵⁹ Strengthening lived experience participation in the system will also have flow-on benefits for the right to health by improving system operations through lived experience insights and knowledges.

A human rights-based approach requires lived experience participation to be both 'full and effective'¹⁶⁰ as well as active, free and meaningful.¹⁶¹ To meet these requirements, all efforts to support lived experience work and participation should adhere to the following principles:

- The participation of people with lived experience should extend across all parts of the system including governance and service design, planning, delivery and evaluation.
- People with lived experience should be employed in roles at all levels of an organisation, including leadership roles, so as to have meaningful opportunities to affect decision-making and adapt internal procedures, with more than a single person with lived experience required in oversight and governance structures.¹⁶²
- Wherever possible, co-production methodologies should be employed to promote meaningful collaboration in all aspects of system and service design and delivery.
- Particular attention should be paid to people with lived experience from diverse communities to address specific barriers to employment.
- People with lived experience should be supported to discharge their roles with appropriate remuneration, supportive organisational structures and other supports determined through consultation with lived experience groups.
- Development of a lived experience workforce should be supported through the provision of capacity-building programs and industrial protections, including codified career progression pathways and clear role delineation. The establishment of a peak body for lived experience workers would be of particular value.

¹⁵⁵ King's College London, *Service User Research Enterprise* (Web Page) <<https://www.kcl.ac.uk/research/sure>>.

¹⁵⁶ The Collaborating Centre for Values-based practice in Health and Social Care, St Catherine's College Oxford, *Phenomenology and Mental Health Network (PMH)* (Web Page) <<https://valuesbasedpractice.org/what-do-we-do/networks/phenomenology-and-mental-health-network-pmh>>.

¹⁵⁷ *Royal Commission Interim Report* (n 5) 391.

¹⁵⁸ *CRPD* (n 32) art 3(2); see also art 4(3).

¹⁵⁹ See, eg, *Royal Commission Final Report* (n 4) vol 3, 11, Recommendation 28; 67, Recommendation 30.

¹⁶⁰ *CRPD* (n 32) art 3(2).

¹⁶¹ Scottish Human Rights Commission, *What is a Human Rights Based Approach?* (Web Page), <<https://careaboutrights.scottishhumanrights.com/whatisahumanrightsbasedapproach.html>>; Scottish Human Rights Commission, *Human Rights Based Approach: A Self-Assessment Tool* (Report, December 2018) 3.

¹⁶² Victoria Legal Aid (n 110) 47; *What we heard* (n 146) 23.

2.4 Service commissioning and procurement

Recommendation 2.4

Embed people with lived experience into all stages of service commissioning and procurement processes.

All service commissioning and procurement processes should involve people with lived experience, whether through the direct employment of staff or the contracting of lived experience consultants. Lived experience participation must extend across all aspects of commissioning and procurement processes including the preparation of tender materials and the making of tender decisions.

Lived experience involvement in service commissioning and procuring will support greater accountability for services, governments and Regional Boards to the people they are intended to serve. It will also directly support the autonomy of consumers and the capacity of the system to deliver safe, effective and therapeutic care informed by the insights and knowledges of lived experience.

2.5 Service provider obligations

Recommendation 2.5

Clarify and strengthen human rights obligations on service providers through mental health principles, service contracts, private hospital standards and the *Statement of Priorities*, and support service compliance through dedicated funding for human rights impact assessments and action plans.

Service provider bodies should be legally required to adhere to human rights obligations. This is an important step to advance and promote human rights in an era where public

health services are generally not delivered by governments directly.¹⁶³ As such, direct obligations on services are required in addition to broad governmental accountabilities. Indeed, the Royal Commission explicitly recognised the utility of clarifying expectations on services with regard to human rights obligations.¹⁶⁴

Human rights obligations should be imposed on service providers through three key mechanisms to ensure they function consistently across the sector. Firstly, the principles of the MHW Act impose high-level obligations on service providers.¹⁶⁵ The Charter already imposes relevant obligations on public authorities which should be vested into these principles.¹⁶⁶

Human rights obligations should also be embedded into service standards, including service contracts and expectation-setting instruments. Public health services and integrated community health services have their expectations set and performance monitored through an annually published *Statement of Priorities*.¹⁶⁷ Registered community health services, on the other hand, operate subject to contractual arrangements.¹⁶⁸ Embedding human rights obligations into these mechanisms was recommended by the Royal Commission¹⁶⁹ and is an important shift given that the *Statement of Priorities* currently contains few rights-related performance indicators.¹⁷⁰

Finally, human rights obligations should be imported into the standards which apply to private hospitals. Australia's international obligations to protect human rights requires the protection of individuals against private actors¹⁷¹ so private hospitals must be subject to equivalent human rights obligations as their public counterparts. Private psychiatric hospitals are subject to standards set out in regulations under the *Health Services Act 1988*¹⁷² which require persons receiving care to be treated with 'dignity and respect'.¹⁷³ Additional provisions should be included to impose equivalent obligations between private and public mental health services with regard to human rights.

To support this shift towards rights-based service contracting, services should be provided

163 Katterl and Maylea (n 95).

164 Royal Commission Final Report (n 4) vol 4, 274.

165 MHW Act (n 85) pt 1.5-1.6.

166 See Part 3.5.

167 Royal Commission Final Report (n 4) vol 4, 66.

168 Ibid.

169 Ibid 102, Recommendation 48; see also 129.

170 Department of Health (Vic) 2019-20 *Statement of Priorities* (Web Page, October 2019) <<https://www.health.vic.gov.au/funding-performance-accountability/2019-20-statement-of-priorities>>.

171 UN Human Rights Committee, *General comment no. 31* [80], *The nature of the general legal obligation imposed on States Parties to the Covenant*, 2187; meeting, UN Doc CCPR/C/21/Rev.1/Add.13 (26 May 2004) [8].

172 *Health Services Act 1988* (Vic) s 158(1)(a).

173 *Health Services (Health Service Establishments) Regulations 2013* (Vic) r 25(A).

with additional funds to conduct, maintain and implement supervised human rights impact assessments and action plans. These or similar activities will be necessary to support the implementation of, and demonstrate compliance with, new standards.¹⁷⁴ Additional data disclosure obligations should also be considered.¹⁷⁵

2.6 Funding models for self-determination

Recommendation 2.6

Implement a cross-departmental pooled funding model for Aboriginal Community-Controlled Organisations to provide a genuine platform of self-determination.

A pooled funding model across all government departmental funding streams will provide a genuine platform of self-determination for Victorian Aboriginal communities. Such a model must be designed in close collaboration with Aboriginal Community-Controlled Organisations (ACCOs) to ensure the model is sustainable and promotes collaboration not competition.

The importance of self-determination was recognised by both the Victorian Government¹⁷⁶ and the Royal Commission,¹⁷⁷ although the latter was constrained in its recommendations by its terms of reference which limited its scope of work to the mental health and wellbeing system.¹⁷⁸ True self-determination requires a whole-of-government approach.¹⁷⁹

The right to self-determination is enshrined in international human rights law,¹⁸⁰ while cultural rights, including the distinct cultural rights of Aboriginal persons, are expressly recognised in the Charter.¹⁸¹ Self-determination encompasses the rights of Indigenous peoples to maintain traditional health and cultural practices¹⁸² and to

determine priorities for development vis-à-vis health, housing and other needs.¹⁸³ The right to self-determination is of paramount importance as its realisation is an essential precondition for the realisation of other human rights.¹⁸⁴

As recognised by the Royal Commission, adherence to an Aboriginal social and emotional wellbeing framework is required to advance Aboriginal rights to health and self-determination.¹⁸⁵ This framework defines social and emotional wellbeing as a multidimensional concept that includes, but is not limited to, 'mental health', as well as the domains of physical health, connection to land and country, culture, spirituality, ancestry, family and community.¹⁸⁶ As Aboriginal conceptualisations of social and emotional wellbeing extend beyond Western conceptualisations of mental health, so too must social and emotional wellbeing services extend beyond Western models of mental health service delivery.

Siloed funding streams provide a significant barrier to self-determination. They do so by constraining ACCOs from delivering services in line with culturally valid understandings of wellbeing, limiting service delivery to Western 'streams' of wellbeing that align with government departmental funding streams. More broadly, they also constrain Aboriginal communities from exercising genuine control over funding priorities, as required by international law.¹⁸⁷

A pooled funding model across government departmental fundings streams can therefore advance the health and wellbeing of Aboriginal communities, and provide a genuine platform of self-determination by empowering ACCOs to exercise choice and control over funding priorities, and deliver services in accordance with culturally valid understandings of health and wellbeing. It would also have the added benefit of streamlining Aboriginal service delivery.¹⁸⁸

¹⁷⁴ Katterl and Maylea (n 95).

¹⁷⁵ Victoria Legal Aid (n 110) 24–5.

¹⁷⁶ Department of Health and Human Services (Vic) *Korin Korin Balit-Djak: Aboriginal Health, Wellbeing and Safety Strategic Plan 2017–2027* (Report, August 2017) 7; Department of Health and Human Services (Vic) *Balit Murrup: Aboriginal Social and Emotional Wellbeing Framework 2017–2027* (Report, October 2017) 8.

¹⁷⁷ *Royal Commission Interim Report* (n 5) 472.

¹⁷⁸ Letter from Linda Dessau AC to Penelope Armytage, *Royal Commission Letters Patent*, 22 February 2019, 2 <http://rcvmhs.archive.royalcommission.vic.gov.au/Terms_of_Reference_signed.pdf>.

¹⁷⁹ Tom Calma, *Essentials for Social Justice: Reform* (Speech Transcript, February 2008) <<https://humanrights.gov.au/about/news/speeches/essentials-social-justice-reform>>.

¹⁸⁰ ICCPR (n 30) art 1; ICESCR (n 31) art 1; *United Nations Declaration on the Rights of Indigenous Peoples*, GA Res 61/95, UN Doc A/RES/61/295 (2 October 2007, adopted 13 September 2007) art 3 ('UNDRIP').

¹⁸¹ *Charter* (n 29) s 19.

¹⁸² UNDRIP (n 180) arts 11(1), 24(1).

¹⁸³ *Ibid* art 23.

¹⁸⁴ UN Human Rights Committee, CCPR General Comment No. 12: *Article 1 (Right to Self-determination)*, *The Right to Self-determination of Peoples*, 21st session, UN Doc CCPR/GEC/6626/E (13 March 1984) [1].

¹⁸⁵ *Royal Commission Interim Report* (n 5) 474–7.

¹⁸⁶ Victorian Aboriginal Community-Controlled Health Organisation, *Balit Durn Durn: Strong brain, mind, intellect and sense of self: Report to the Royal Commission into Victoria's Mental Health System* (Report, August 2020) 24.

¹⁸⁷ UNDRIP (n 180) art 23.

¹⁸⁸ Heather McRae et al, *Indigenous Legal Issues: Commentary and Materials* (Thomson Reuters, 4th ed, 2009) 165.

2.7 Holistic approaches to wellbeing

Recommendation 2.7

Investigate and prioritise approaches to integration that strengthen connections between the mental health and wellbeing, and related, sectors, including through the expansion of Health Justice Partnerships, utilisation of Local Mental Health and Wellbeing Services, and leveraging of community collectives as alternative entry points into the broader social care system.

There is an urgent need to investigate and implement approaches that better integrate mental health and wellbeing services within the broader social care environment. While the Royal Commission recognised the need for better integration of systems and services, its terms of reference restricted its work to the mental health and wellbeing system. There remains a pressing need to support integration beyond the mental health and wellbeing system so people can have all of their needs met regardless of departmental silos and funding streams.

People with mental health issues often have needs that extend across multiple domains of life and wellbeing. Supporting better integration of services across these domains therefore supports a broad range of economic, social and cultural rights, including the rights to housing,¹⁸⁹ social security,¹⁹⁰ education¹⁹¹ and work.¹⁹² Better integration is also intrinsically important for the right to health which encompasses the underlying determinants of health.¹⁹³

Structures including Health Justice Partnerships and Local Mental Health and Wellbeing Services (Local Services) provide useful blueprints for integration. Health Justice Partnerships are a

form of direct integration where consumers can access health and legal services concurrently, while Local Services will act as soft entry points into the mental health and wellbeing system with linkages to other parts of the social care system. These structures should be leveraged to support the intersectoral integration required to facilitate holistic approaches to the delivery of wellbeing services.

Analogous to the role of Local Services within the mental health and wellbeing system, the community collectives recommended by the Royal Commission¹⁹⁴ may be able to act as soft entry points into the broader social care sector. This approach is beneficial as it relies on a discrete part of the social care system to facilitate connections, rather than expecting every service in every system to perform this complex role. It also capitalises on the strengths of Local Governments in connecting citizens to local support services. Such an approach is also likely to provide particular benefits to those people with mental health issues who are hesitant to seek help from mental health services for reasons including the impacts of internalised stigma, past negative experiences and/or challenges in identifying their mental health needs.

Community collectives should be supported to discharge their connecting roles by the Regional Boards which will engage with local communities and undertake workforce, service and capital planning for local mental health and wellbeing services.¹⁹⁵ The functions of Regional Boards will be rolled out over several years,¹⁹⁶ and will include working with other agencies to support integration within and beyond the mental health and wellbeing system.¹⁹⁷ In so doing, they should connect with community collectives to develop additional avenues to help people find the services they need.

¹⁸⁹ *UNDRIP* (n 180) art 11.

¹⁹⁰ *ICESCR* (n 31) art 9.

¹⁹¹ *Ibid* art 13.

¹⁹² *Ibid* art 6.

¹⁹³ UN Committee on Economic, Social and Cultural Rights, *CESCR General Comment No. 14: The Right to the Highest Attainable Standard of Health* (Art. 12), 22nd session, UN Doc E/C.12/2000/4 (11 May 2000) [3], [11], [54].

¹⁹⁴ *Royal Commission Final Report* (n 4) vol 2, 9, Recommendation 15.

¹⁹⁵ *Ibid* vol 1, 192, Recommendation 4(2).

¹⁹⁶ Department of Health (Vic), *Mental Health and Wellbeing Act: Update and engagement paper* (Consultation Paper, June 2021) 38 ('Update and engagement paper').

¹⁹⁷ *Royal Commission Final Report* (n 4) vol 1, 270.

Part 3: Legislative underpinnings

Rights-based legislation is an essential precondition for rights-based practice. The underpinnings of mental health and wellbeing laws must therefore incorporate human rights principles to provide a foundation for a rights-based mental health and wellbeing system. Rights-based legislation is also necessary to satisfy Australia's international legal obligations to enact domestic laws that conform to ratified human rights instruments.¹⁹⁸

While legislation can provide discrete rights and protections, the underpinnings of legislation provide the foundational framework upon which these rights and protections operate. These underpinnings include the statutory purposes, objectives and principles which inform the interpretation of legislation. In Victoria, the Charter also operates to provide a human rights framework which underpins the interpretation and implementation of Victorian laws.

The fundamental importance of legislative underpinnings is well recognised at law. Statutory purposes and objectives both act to guide the interpretation of legislative provisions, including constraints on legislative powers.¹⁹⁹ In the MHW, furthermore, the mental health principles form the basis of direct obligations on service providers and decision-makers.²⁰⁰ As such, the purposes, objectives and principles of the MHW provide vital touchpoints for guiding how mental health and wellbeing laws are to be interpreted and implemented in practice.²⁰¹

As recommended by the Royal Commission,²⁰² the objectives of the MHW are laid out 'in pursuit of the highest attainable standard of mental health and wellbeing for the people of Victoria'.²⁰³ This language is consistent with the right to health enshrined in the ICESCR²⁰⁴ and the CRPD²⁰⁵ and provides the MHW with a solid foundation to ensure its provisions

are interpreted, and powers exercised, in accordance with the right to health.

However, it is important to recognise the inherent risks in prioritising a single human right over others. Human rights are indivisible, interrelated, and interdependent.²⁰⁶ On their own, particular rights may become meaningless or oppressive if not balanced with other rights that are applicable in the circumstances.²⁰⁷ This is particularly true within the mental health and wellbeing system where some of the most intractable problems require a careful balancing of competing human rights, and the values of beneficence and autonomy which underlie those rights. This risk is clearly demonstrated in situations where the right to health may be invoked to justify coercive treatments which impinge upon other rights.²⁰⁸

It is therefore imperative that the legislative foundation of the mental health and wellbeing system recognises all human rights, and the values which underpin them. An approach that privileges one right over all others is not conducive to balance. Only with legislative underpinnings that respect all human rights can the Royal Commission's vision of rights-based system be realised.

198 ICCPR (n 30) art 2(2); ICESCR (n 31) art 2(1); UN Human Rights Committee, *General comment no. 31 [80], The nature of the general legal obligation imposed on States Parties to the Covenant*, 2187th meeting, UN Doc CCPR/C/21/Rev.1/Add.13 (26 May 2004) [13]; UN Committee on Economic, Social and Cultural Rights, *General comment No. 3: The nature of States parties' obligations (art. 2, para. 1, of the Covenant)*, 5th session, UN Doc E/1991/23 (14 December 1990) [3].

199 *Project Blue Sky v Australian Broadcasting Authority* [1998] HCA 28; *Victims Compensation Fund v Brown* (2002) 54 NSWLR 668; *Interpretation of Legislation Act 1984* (Vic) s 35(a).

200 MHW (n 85) pts 1.5–1.6.

201 PBU (n 46) [67].

202 *Royal Commission Final Report* (n 4) vol 4, 11, Recommendation 42.

203 MHW (n 85) s 12.

204 ICESCR (n 31) art 12(1).

205 CRPD (n 32) art 25.

206 Ibid preambular para (c).

207 Amita Dhanda, 'Legal Capacity in the Disability Rights Convention: Stranglehold of the Past or Lodestar for the Future' (2007) 34 *Syracuse Journal of International Law and Commerce* 429, 456–7; Penelope Weller, 'Health Law and Human Rights: Towards Equality and the Human Right to Health' in Ian Freckelton and Kerry Peterson (eds), *Tensions and Traumas in Health Law* (Federation Press, 2017) 21–2.

208 See Part 6.



3.1 Legislative purpose

Recommendation 3.1

Establish the primary purpose of the *Mental Health and Wellbeing Act* ‘to promote good mental health and wellbeing in Victoria’, supported by a subsidiary purpose ‘to establish a mental health and wellbeing system underpinned by a strong human rights framework’.

The primary purpose of the MHWa should be to ‘promote good mental health and wellbeing in Victoria’. This phrasing was directly suggested by the Royal Commission²⁰⁹ and supports the reorientation towards a right-based system, away from the current legislative focus on coercive practices.²¹⁰ Despite the Royal Commission’s express advice on this matter, the MHWa’s purposes contain no reference to good mental health and wellbeing.²¹¹

A subsidiary purpose may be added as an additional provision to ‘establish a mental health and wellbeing system underpinned by a strong human rights framework’. This phrasing is also directly drawn from the Royal Commission,²¹² and would support the interpretation of the MHWa to incorporate all human rights, not just the right to health.

3.2 An objective to promote and drive system change

Recommendation 3.2

Include an objective in the *Mental Health and Wellbeing Act* to ‘promote and drive the development of a rights-based mental health and wellbeing system by:

- ensuring that the experiences of people living with mental illness or psychological distress, and their carers, families and supporters, are at the centre of changes in practice and service delivery and the design and evaluation of systems;
- promoting the personal recovery of people experiencing mental health issues through the provision of holistic care that is centred on an individual person’s needs, encompassing any known or potential past experiences of trauma;
- supporting consumers to exercise choice and control between services, treatments and models of care;
- promoting access to services that are voluntary, peer-led, community-delivered, self-determined, rights-based and delivered in community settings;
- ensuring services provide safe and therapeutic experiences for people from all cultural backgrounds, genders, sexual orientations, and other social groups;
- drawing on the strengths of people with lived experience, including ways of being, doing and knowing;
- respecting the rights, dignity, autonomy and self-determination of people and peoples; and
- promoting opportunities for carers, families and supporters to be involved in a person’s care.’

The objectives of the MHWa may be strengthened with explicit acknowledgement of the Royal Commission’s objective to promote and drive system change. This is important as our current reform journey will not produce a mental health and wellbeing system free from human rights risks and breaches. To maintain a focus on this ultimate goal, the MHWa should

²⁰⁹ *Royal Commission Final Report* (n 4) vol 4, 35.

²¹⁰ *Ibid* 21–2.

²¹¹ *MHWa* (n 85) s 12.

²¹² *Royal Commission Final Report* (n 4) vol 4, 228.

include an explicit objective to ‘continuously promote and drive the development of a rights-based mental health and wellbeing system’. Numerous elements of the MHWa, particularly governance arrangements, are already purposed to support this continuous improvement objective.²¹³

The MHWa’s objectives currently include the aim ‘to promote continuous improvement in the quality and safety of mental health and wellbeing services’.²¹⁴ This objective so stated is unnecessarily narrow, limiting improvements to matters of quality and safety. It is also further qualified in reference to lived experience participation, a critical but by no means exhaustive tool for continuous improvement. Finally, it is further restricted by its subordination to the right to health.²¹⁵ To ensure a suitably broad and balanced approach, system change must form a stand-alone objective, allowing for broader considerations to inform statutory interpretation, including other human rights that embody an ethics of autonomy.

Reflecting contemporary understandings of best-practice service delivery, an objective to ‘promote and drive the development of a rights-based mental health and wellbeing system’ should be achieved by:

- ensuring that the experiences of people living with mental illness or psychological distress, and the people receiving treatment, their carers, families and supporters, are at the centre of changes in practices and service delivery and the design and evaluation of systems;
- promoting the personal recovery of people experiencing mental health issues through the provision of holistic care that is centred on a person’s full array of needs, encompassing any known or potential past experiences of trauma;
- supporting consumers to exercise choice and control between services, treatments and models of care;
- promoting access to services that are voluntary, peer-led, community-delivered, self-determined, rights-based and based in the community;
- ensuring services provide safe and therapeutic experiences for people from all cultural backgrounds, genders, sexual orientations, and other social groups;
- drawing on the strengths of people

with lived experience, including ways of being, doing and knowing;

- respecting the rights, dignity, autonomy and self-determination of people and peoples; and
- promoting opportunities for carers, families and supporters to be involved in a person’s care.

3.3 An objective to promote supported decision-making

Recommendation 3.3

Include an objective in the *Mental Health and Wellbeing Act* to ‘promote supported decision-making, in recognition of the need to support persons to make, participate in and implement decisions that affect their lives, having regard to the *Convention on the Rights of Persons with Disabilities*’.

The MHWa should also contain an objective to:

promote supported decision-making, in recognition of the need to support persons to make, participate in and implement decisions that affect their lives, having regard to the *Convention on the Rights of Persons with Disabilities*.

Supported decision-making is a necessary element of a number of human rights,²¹⁶ and is formally recognised in the CRPD which requires states ‘to provide access by persons with disabilities to the support they may require’.

The MHWa currently include an objective ‘to recognise and respect the right of people with mental illness or psychological distress to speak and be heard in their own voices, from their own experiences and from within their own communities and cultures’.²¹⁷ While this is a worthy inclusion, it does not directly address the right to supported decision-making which is broader than the right to expression.

An express objective to promote supported decision-making is critical considering the vital importance of supported decision-making when it comes to safeguarding autonomy and human rights.²¹⁸ It would also help to facilitate a rights-based system by promoting

²¹³ Ibid 93.

²¹⁴ MHWa (n 85) s 12(d).

²¹⁵ Ibid s 12.

²¹⁶ See Part 5.

²¹⁷ MHWa (n 85) s 12(f).

²¹⁸ See Part 5.

cultures of service delivery that recognise the value of autonomy, affirming the rights of consumers and empowering them to exercise their autonomy in healthcare matters.

This objective would also support the Royal Commission's recommendation to align mental health decision-making laws with other decision-making laws.²¹⁹ The Victorian *Guardianship and Administration Act 2019* contains a similar objective,²²⁰ as does the *Mental Health Act* of the Australian Capital Territory.²²¹ Even the previously in force MHA contained an objective regarding supported decision-making,²²² albeit comparatively weak. Such differences from the MHW raise considerable questions vis-à-vis the right to equality as mental health consumers are supported with comparatively weak, and weakening, legislative objectives safeguarding their right to supported decision-making.

3.4 Rights-based principles

Recommendation 3.4

Take a rights-based approach to the mental health principles in the *Mental Health and Wellbeing Act* by aligning human rights obligations with Victorian and international laws.

The mental health principles of the MHW should be consistent with human rights obligations and principles. This will support the Royal Commission's aspiration for the development of a human rights-based culture within the mental health and wellbeing system.²²³ The development of rights-based principles was also explicitly supported by the Department of Health.²²⁴

To ensure the mental health principles are truly rights-based, they should include an obligation on mental health service providers and decision-makers to:

act compatibly with their obligations under the Victorian *Charter of Human Rights and Responsibilities Act*.

This would not impose additional obligations

as it merely refers to obligations already imposed by the Charter on public bodies.²²⁵ However, many workers and services do not understand their Charter obligations.²²⁶

Reiterating this obligation in the principles of MHW would therefore provide greater clarity for workers and services, supporting them to better understand and discharge their existing legal obligations vis-à-vis human rights.

Secondly, the 'dignity and autonomy' principle refers to the protection and promotion of rights. This language is welcome and consistent with Charter obligations. However, as discussed in Part 1,²²⁷ this language is inconsistent with Australia's international human rights obligations. To ensure the proper, equivalent legal standard applies, this language should be amended to 'respect, protect, promote and fulfill'.

3.5 Supported decision-making principle

Recommendation 3.5

Align the supported decision-making principle in the *Mental Health and Wellbeing Act* with approaches taken in other jurisdictions and under other Victorian legislation.

The proposed principle for supported decision-making should be strengthened and aligned with other decision-making laws, as expressly recommended by the Royal Commission.²²⁸

Currently, the MHW contains a supported decision-making principle that states:

Supported decision making practices are to be promoted. Persons receiving mental health and wellbeing services are to be supported to make decisions and to be involved in decisions about their assessment, treatment and recovery including when they are receiving compulsory treatment. The views and preferences of the person receiving mental health and wellbeing services are to be given priority.

This principle has much to commend it and is a significant improvement on

219 *Royal Commission Final Report* (n 4) vol 4, 362, Recommendation 56(4).

220 *Guardianship and Administration Act 2019* (Vic) s 7(1)(a) ('GAA').

221 *Mental Health Act 2015* (ACT) s 5(b).

222 *Mental Health Act 2014* (Vic) s 10(d)(i) ('MHA').

223 *Royal Commission Final Report* (n 4) vol 4, 424.

224 *Update and engagement paper* (n 196) 10.

225 *Charter* (n 29) s 38(1); see also *Royal Commission Final Report* (n 4) vol 4, 368.

226 Chris Maylea et al, 'Consumers' experiences of rights-based mental health laws: Lessons from Victoria, Australia' (2021) 78 (September–October) *International Journal of Law and Psychiatry* 1, 5.

227 See Part 1.1.

228 *Royal Commission Final Report* (n 4) vol 4, 407, Recommendation 56(4).

the related principle from the MHA.²²⁹ However, there remain some key gaps:

- Supported decision-making is limited to matters of ‘assessment, treatment and recovery’. Under Queensland’s *Mental Health Act 2016*, supported decision-making encompasses all decisions affecting a person’s life, including but not limited to decisions affecting their treatment and care.²³⁰ The breadth of this principle is appropriate, considering the CRPD’s requirement that supports be provided to enable people make all decisions that have legal effect, without constricting those decisions to healthcare matters.²³¹
- The principle contains no presumption of capacity. Such an inclusion can also be found in Queensland’s *Mental Health Act 2016*.²³²
- The principle excludes support in implementing decisions, although such has been included in relevant legislation internationally.²³³
- Supported decision-making practices should encompass supports that help a person to express their will and preferences. Such an inclusion can be found in Victoria’s *Guardianship and Administration Act 2019*²³⁴ and Queensland’s *Mental Health Act 2016*.²³⁵
- Supported decision-making practices should also encompass supports that help a person develop their decision-making capacity. Such an inclusion can be found in the *Guardianship and Administration Act 2019*²³⁶ and Tasmania’s *Mental Health Act 2013*.²³⁷
- Supported decision-making practices should also involve people in the *implementation* of relevant decisions. Such an inclusion can be found in the *Guardianship and Administration Act 2019*.²³⁸
- Supported decision-making practices are not defined.²³⁹ While the definition for ‘appropriate supports’²⁴⁰ might suffice in this regard, the different phrasing obscures the relevance of this definition. In distinction, Victoria’s *Medical Treatment Planning and Decisions Act 2016* includes references to various forms of supported decision-making.²⁴¹
- Expanding the supported decision-making principle accordingly would directly advance a consumer’s right to equality by providing an equivalent legislative basis for supported

decision-making that relevant comparators enjoy in other jurisdictions and/or under other legislation. By combining elements from these other statutory approaches, it would provide a gold-standard for supported decision-making protection across the nation. It would also advance all human rights in which supported decision-making is an essential component, such as the rights to health, recognition as a person before the law, and protection against medical treatment without consent. Finally, it would also provide a more solid foundation for an ethics of autonomy by providing a deeper appreciation of the broad value of supported decision-making in all its forms.

3.6 Holistic, integrated care principle

Recommendation 3.6

Include a new principle in the *Mental Health and Wellbeing Act* on ‘Holistic, integrated care’.

Finally, an additional principle should be included regarding the need to integrate mental health and wellbeing services with the surrounding social care system. This is essential considering the fact that many people with mental health issues experience co-occurring wellbeing needs, such as those associated with housing, education, legal and family violence matters. It is also important considering the relevance of these other needs to a person’s human rights, including the right to health. It is also consistent with the Royal Commission’s recognition of the need for holistic, person-centred care, taking into account all of a consumer’s needs,²⁴² not to mention the very name of the MHWB itself which has been expanded to include wellbeing matters.

Some of the principles comment on related matters but do not go far enough:

- While the ‘health needs’ principle recognises the need to identify and respond to a person’s ‘medical and other health needs’, this is too narrow to include other

²²⁹ MHA (n 222) s 11(c).

²³⁰ *Mental Health Act 2016* (Qld) s 5(b).

²³¹ CRPD (n 32) art 12(3); GCI (n 50) [16].

²³² *Mental Health Act 2016* (Qld) s 5(b).

²³³ Catalina Devandas Aguilar, *Report of the special rapporteur on the rights of persons with disabilities*, UN Doc A/HRC/37/56 (12 December 2017) [41].

²³⁴ GAA (n 220) s 8(1)(a)(ii).

²³⁵ *Mental Health Act 2016* (Qld) s 5(d).

²³⁶ GAA (n 220) s 8(1)(a)(iii).

²³⁷ *Mental Health Act 2013* (Tas) sch 1, s 1(j).

²³⁸ GAA (n 220) s 7(1)(a).

²³⁹ MHWB (n 85) s 3(1).

²⁴⁰ *Ibid* s 6.

²⁴¹ *Medical Treatment Planning and Decisions Act 2016* (Vic) s 7(f) (‘MTPDA’).

²⁴² *Royal Commission Final Report* (n 4) exec summary, 3.

matters, such as housing, education, legal and family violence matters.

- While the ‘diversity of care’ principle acknowledges the relevance of a person’s ‘accessibility requirements, relationships, living situation, any experience of trauma, level of education, financial circumstances and employment status’, it does so within the context of the provision of ‘care and support services’ which may be interpreted narrowly to relate only to mental health and wellbeing services.

The addition of a ‘Holistic, person-centred care principle’ is therefore required to impose obligations on services and relevant decision-makers to consider a person’s wellbeing and recovery within the full context of their lives.

3.7 Service action plans

Recommendation 3.7

Require and support services to demonstrate their compliance with the mental health and wellbeing principles through the strategic and ongoing development and implementation of action plans.

Services should be required and supported to demonstrate their compliance with the mental health and wellbeing principles through the strategic development and implementation of action plans. The resulting actions plans should then be used in commissioning and complaints management processes conducted by relevant bodies including the Department of Health and the Mental Health and Wellbeing Commission, respectively.

Currently, the MHWa imposes requirements on services to address one or more of the principles in annual reports.²⁴³ This is in addition to the direct obligations which the principles impose on services, including obligations to make reasonable efforts to comply with the principles²⁴⁴ and to give the principles proper consideration in decision-making processes.²⁴⁵ However, the restriction of reporting obligations to potentially one of 13

principles presents a barrier to the transparency and continuous improvement necessary to develop a truly rights-based system.

Services should therefore be required to develop, implement, measure and report on successive action plans address all of the principles. Considering the imperative of not imposing undue administrative burdens on provider bodies, services should be supported to do so with targeted funds, guidelines and resources, such as action plan templates, training opportunities and culture change mechanisms.

3.8 Enshrining the right to health

Recommendation 3.8

Include the right to health, along with other economic, social and cultural rights, in the Victorian *Charter of Human Rights and Responsibilities Act*.

The right to health is of such fundamental importance to the mental health and wellbeing system that it underlies all of the MHWa’s objectives.²⁴⁶ The right is also enshrined in the ICESCR²⁴⁷ and the CRPD,²⁴⁸ and its relevance to consumers has been recognised and developed within a range of other human rights treaties.²⁴⁹ However, the right to health is not protected in the Charter. In fact, almost no economic, social or cultural rights appear in the Charter at all.²⁵⁰

Inclusion of the right to health in the Charter has the potential to provide a solid foundation for a mental health and wellbeing system that is capable of recognising and responding to the rights of consumers. Such an inclusion would be beneficial in three key ways: it would support Victorian jurisprudence in balancing competing rights; it would clarify the legal obligations of mental health public authorities vis-à-vis the right to health; and it would strengthen the governance powers and functions of the Victorian Equal Opportunity and Human Rights Commission with regard to the mental health and wellbeing system.

243 MHWa (n 85) s 30.

244 Ibid s 29(a).

245 Ibid s 29(b).

246 Ibid s 12.

247 ICESCR (n 31) art 12(1).

248 CRPD (n 32) art 25.

249 Lisa Waddington and Bernadette McSherry, ‘Exceptions and Exclusions: The Right to Informed Consent for Medical Treatment of People with Psychosocial Disabilities in Europe’ (2016) 23 *European Journal of Health Law* 279, 281.

250 Mike Salvaris, ‘Economic and Social Rights: The Victorian Charter’s Unfinished Business’ (2007) 43 *Just Policy: A Journal of Australian Social Policy* 30.

With regard to the first point, the Charter imposes obligations on courts to interpret Victorian laws consistently with human rights,²⁵¹ while also allowing for the limiting of human rights.²⁵² This is important because human rights are indivisible, interrelated, and interdependent.²⁵³ They must be balanced against each other. No single right or set of rights are alone sufficient to address human rights concerns,²⁵⁴ and this is no less true for the mental health and wellbeing system. The absence of the right to health from the Charter therefore restricts the extent to which the judicial balancing of rights within the Charter can properly incorporate the right to health.

Secondly, the Charter imposes obligations on public authorities to act and make decisions compatibly with human rights.²⁵⁵ A 'public authority' includes designated mental health services, as well as the Mental Health Tribunal.²⁵⁶ As such, these bodies are required to consider Charter rights in decision-making processes, but these rights do not include the right to health. While the MHWa prioritises the right to health over other rights, the Charter does the opposite. This inconsistency fundamentally undermines both the principal objective of the MHWa and the proportionality principle of human rights law. It also leaves public authorities in the mental health and wellbeing system in a difficult situation when trying to figure out

just what their human rights obligations are.

Thirdly, the Charter confers powers and functions on the Victorian Equal Opportunity and Human Rights Commission (VEOHRC) to report on the operation of the Charter, to provide education about human rights and the Charter, and to advise the Attorney-General on operations relevant to the Charter.²⁵⁷ The absence of the right to health from the Charter therefore constrains VEOHRC from using these important governance functions to promote the right to health for people in the mental health and wellbeing system.

Finally, factors associated with other economic, social and cultural rights, such as the rights to housing, employment and education, are essential to the right to health. This is because these factors constitute the underlying determinants of health.²⁵⁸ Considering the indivisibility of human rights, and the particular relevance of other economic, social and cultural rights to health, amendment of the Charter to include the right to health should also include other economic, social and cultural rights as enshrined in the ICESCR. There are also strong arguments that have been advanced for such an amendment that extend well beyond mental health and wellbeing matters.²⁵⁹

251 *Charter* (n 29) s 32(1).

252 *Ibid* s 7(2).

253 *CRPD* (n 32) preambular para (c).

254 *PBU* (n 46) [86].

255 *Charter* (n 29) s 38(1).

256 *PBU* (n 46) [129].

257 *Charter* (n 29) ss 41–2.

258 UN Committee on Economic, Social and Cultural Rights, *General Comment No 14: The Right to the Highest Attainable Standard of Health (Art 12)*, 22nd session, UN Doc E/C12/2000/4 (11 August 2000) [4], [11].

259 See, eg, Mike Salvaris, 'Economic and Social Rights: The Victorian Charter's Unfinished Business' (2007) 43 *Just Policy: A Journal of Australian Social Policy* 30.

Part 4: Decision-making capacity

Decision-making capacity (DMC) is a central tenet of modern medical law, providing the legal foundation for consent to medical treatment. A person must be capable of providing informed consent to medical treatments as it is their valid consent which renders the treatment lawful.²⁶⁰ Without consent, or some other lawful justification, medical treatment amounts to unlawful assault and battery.²⁶¹

When a person does not have DMC to consent, questions arise as to who else, if anyone, can consent to medical treatment on that person's behalf, and how. Thus, DMC provides a critical tool in addressing the conflict between beneficence and autonomy by distinguishing between people who are able to make autonomous decisions about their healthcare and those for whom an alternative approach to decision-making may be required.

The MHWCA provides broad scope for substitute decision-making to occur, allowing treatments to be imposed on both persons who lack DMC²⁶² and persons who have DMC but refuse to consent to treatment²⁶³ (with limited exceptions).²⁶⁴ In this regard, the MHWCA makes no distinction between the decision-making rights of consumers who are able to consent to medical treatment and those who are not.

By allowing substitute decision-making regardless of a person's DMC, the MHWCA ignores a person's capacity for autonomy in decision-making processes. In doing so, it focusses exclusively on the value of beneficence, disregarding the value of autonomy and the human rights which embody it. This sort of imbalance cannot form the basis of a human rights-based approach which must be capable of balancing all rights and values against each other.

Victorian caselaw has confirmed that the administration of medical treatment to a person

whose DMC has not been properly recognised constitutes a severe infringement on their rights to autonomy and self-determination.²⁶⁵

The denial of a person's autonomy may further result in the effective denial of other human and legal rights, especially where medical treatment decision-making is concerned.²⁶⁶ For example, denial of a person's medical decision-making autonomy may result in further limitations on their rights to liberty, such as when they are made subject to an Inpatient Treatment Order.²⁶⁷

The MHWCA's substitute decision-making provisions also offend the right to equality. Outside the mental health and wellbeing system, other Victorian statutes²⁶⁸ and well-established common law principles²⁶⁹ protect the rights of persons with DMC to refuse necessary medical treatment. By not providing this same protection to people in the mental health and wellbeing system, the MHWCA proposes relatively fewer protections for the autonomy of mental health consumers.

A human rights-based approach requires laws that respect all human rights, including those that embody the value of autonomy. Where a person is capable of exercising autonomy, the law should allow space for that autonomy to operate. Otherwise, to deny an autonomous person their right to make their own medical decisions is to give undue weight to the value of beneficence. To do so on the basis of mental illness alone is tantamount to mental health discrimination.

In recognition of the critical importance of decision-making processes, the Royal Commission recommended that mental health decision-making laws be progressively aligned with other decision-making laws 'over time'.²⁷⁰ This recommendation was expressly made on the view that it would afford greater respect for the treatment decisions of consumers with DMC.²⁷¹ Thus, reform of

²⁶⁰ *Brightwater Care Group* (2009) 40 WAR 84, [25], referring to *Marion's Case* (1992) 175 CLR 218, 233 and *Rogers v Whitaker* (1992) 175 CLR 479, 489.

²⁶¹ *R (B) v Dr SS* [2005] EWHC 1936 (Admin) [35](i).

²⁶² *MHWCA* (n 85) ss 89(1)(a)(i), (3).

²⁶³ *Ibid* ss 89(1)(a)(ii), (3).

²⁶⁴ *Ibid* s 89(1)(b).

²⁶⁵ *PBU* (n 46) [139] citing *Starson v Swazey* [2003] 1 SCR 722, 759.

²⁶⁶ *Re Lifestyle Communities Ltd (No 3)* (2009) 31 VAR 286, [123]; see also *Shtukaturv v Russia*, no. 44009/05, § 71, ECHR 2008.

²⁶⁷ See Part 6.

²⁶⁸ *GAA* (n 220) s 30(2)(a); *MTPDA* (n 241) s 26(1).

²⁶⁹ See, eg, *Hunter and New England Area Health Service v A* [2009] NSWSC 761; *Re T (Adult: Refusal of Treatment)* [1992] EWCA Civ 18; *Airedale Hospital Trustees v Bland* [1992] UKHL 5; *Re PVM* [2000] QGAAT 1; *Rogers v Whitaker* (1992) 175 CLR 479 [12].

²⁷⁰ *Royal Commission Final Report* (n 4) vol 4, 407, Recommendation 56(4).

²⁷¹ *Ibid* 430.

DMC tests are consistent with the Royal Commission's vision for reform, and provide a ripe area for further analysis and reform.

To begin with, a rights-based system must operate with respect for the treatment decisions of persons with DMC on treatment matters. Next, to ensure DMC assessments operate appropriately in practice, consideration must potential alternative approaches as well as practical implementation and decision-making supports.

4.1 Protecting autonomous decision-making

Recommendation 4.1

Ensure all functions of the system operate with respect for the treatment decisions of persons found to have decision-making capacity on treatment matters.

All functions of the mental health and wellbeing system must operate with respect for the treatment decisions of persons found to have DMC on treatment matters. This is a critical safeguard to protect the value of autonomy, and the human rights which embody it, in line the MHWAs objectives²⁷² and principles²⁷³, the general principles of the CRPD,²⁷⁴ and the movement within the mental health and disability sectors towards recognition of individual agency, choice and control. In particular, this would necessitate the introduction of a capacity criterion for compulsory treatment.²⁷⁵

The relationship between decision-making and human rights is complex. SDM advances and promotes a number of human rights which directly protect the right to autonomous decision-making, but this must be weighed against the right to health which protects a person's access to health treatments. Overriding a person's refusal of medical treatment can support the right to health by facilitating the provision of necessary health services. However, evidence from the Royal Commission also

showed that some applications of substitute decision-making may actually generate harms to health, such as through the effects of distress and (re)traumatisation. Respecting refusals of treatment, on the other hand, deprives a person of access to the health benefits of clinically indicated treatments, while simultaneously preserve their medical decision-making autonomy which is itself an intrinsic element of the right to health.²⁷⁶ Rights to autonomous medical decision-making also carry a particular importance for mental health consumers.²⁷⁷

Thus, the values and interests embodied by human rights, and particularly in the right to health, can be seen to militate both for and against substitute decision-making. As the right to health, like all human rights, is holistic,²⁷⁸ absolute privileging of either clinical assessments of beneficence or medical decision-making autonomy carries risks and dangers for the individual. Health is more than a simple 'best-interests trade-off' between competing values.²⁷⁹ Considering the diverse experiences of consumers with regard to substitute decision-making, it is likely that the effect of such on a person's human rights will vary greatly between individuals.

DMC assessments provide an important tool to distinguish between when autonomous and substitute decision-making would be the most proportionate course of action. This is because the impact of overriding a person's medical treatment decisions on their human rights depends greatly on whether or not they possess the relevant DMC. If a person has DMC, then they are capable of making autonomous decisions. As a genuine expression of their autonomy, these decisions deserve legal protections. To do otherwise would risk breaching an array of their human rights on tenuous grounds.

If a person lacks DMC, however, then their decisions may not represent a genuine manifestation of their autonomy;²⁸⁰ protecting such decisions may therefore not in fact be in line with the value of autonomy at all. The scope for an autonomous decision operates within 'the space between an unwise decision

²⁷² MHWAs (n 85) ss 12(c)(iii), (e), (f).

²⁷³ Ibid ss 16, 17, 18, 19, 21, 23, 24.

²⁷⁴ CRPD (n 32) art 3(1).

²⁷⁵ See Part 6.2.

²⁷⁶ UN Committee on Economic, Social and Cultural Rights, *General Comment No 14: The Right to the Highest Attainable Standard of Health (Art 12)*, 22nd session, UN Doc E/C12/2000/4 (11 August 2000) [8], endorsed in PBU (n 46) [79].

²⁷⁷ Kracke (n 65) 570.

²⁷⁸ UN Committee on Economic, Social and Cultural Rights, *General Comment No 14: The Right to the Highest Attainable Standard of Health (Art 12)*, 22nd session, UN Doc E/C12/2000/4 (11 August 2000) [4], [8], [11].

²⁷⁹ PBU (n 46) [104].

²⁸⁰ *Hunter and New England Area Health Service v A* [2009] NSWSC 761 [31]–[34]; *Re T (Adult: Refusal of Treatment)* [1992] EWCA Civ 18 [5]; Sascha Callaghan and Christopher J Ryan, 'Rising to the human rights challenge in compulsory treatment – new approaches to mental health law in Australia' (2012) 46(7) *Australian & New Zealand Journal of Psychiatry* 611, 614.

and one which an individual does not have the mental capacity to take'.²⁸¹ Thus, when a person is unable to make an autonomous decision, space for the value of autonomy to operate is constricted and the value of beneficence may take precedence to the extent that this is true.

This approach is consistent with caselaw in Victoria (and beyond) that privileges the right to medical treatment decision-making autonomy over access to medical treatments for individuals with DMC. This is because the right to recognition as a person before the law is of fundamental importance; denial of this right is precedent to denial of a person's inherent humanity, and therefore risks effective denial of all other human and legal rights.²⁸² Limitations of such must therefore be taken very seriously. The common law therefore operates according to the principle that a person with the capacity to make an autonomous decision about their medical treatment is entitled to do so, even if their decision is 'not sensible, rational or well considered'.²⁸³ This is so even when the consequence of a legitimate refusal involves a risk of death.²⁸⁴

Although capacity-based decision-making frameworks are generally not regarded as CRPD-compliant,²⁸⁵ they have been described as 'a necessary first step toward a CRPD compliant legislative framework'.²⁸⁶ Ensuring all functions of the mental health and wellbeing system operate with respect for the treatment decisions of persons found to have decision-making capacity on treatment matters therefore provides important advancements for human rights. This approach advances protections for a person's medical decision-making autonomy, and the human rights that embody it, by protecting their capacitous decisions about their own healthcare. It also advances the right to equality by subjecting people with mental health issues to the same legal standard for medical treatment decision-making that are applied to others. At the same time, this approach ensures that access to the benefits of health treatments would not be denied to persons who are unable to make their own decisions on medical treatment matters.

4.2 Alternative approaches to decision-making capacity tests

Recommendation 4.2

Investigate alternative approaches to decision-making capacity tests, incorporating the concepts of will and preferences, relational capacity, and a spectrum of capacity.

Research should be undertaken to investigate alternative approaches to DMC tests that can better accommodate the realities of autonomy within a mental health context. Consideration may also be given as to whether DMC tests would be better conducted by independent assessors to avoid any real or perceived conflicts of interest. These efforts are likely to advance human rights by better identifying and protecting the rights of capacitous persons to make their own medical treatment decisions.

DMC tests have been criticised for a range of reasons.²⁸⁷ The MHWa currently employs a functional approach,²⁸⁸ according to which a person has DMC if they can:

- a) understand relevant information;
- b) remember that information;
- c) use or weigh that information; and
- d) communicate their decision by any means.²⁸⁹

This approach focuses on a person's cognitive functioning; it goes to, but does not directly ask, whether their decision is a genuine expression of their will and preferences. It also seeks to measure a person's individual ability only, and operates on a zero-sum basis: that is, one either has or does not have DMC.

There may be particular advantages to alternative approaches to measuring DMC that focus on or incorporate the concept of a person's 'will and preferences'.²⁹⁰ This would help to better identify when a person's consent or refusal to treatment represents a genuine expression of their autonomy. Such

281 *York City Council v C and another* [2014] 2 WLR 1 [54].

282 *Re Lifestyle Communities Ltd (No 3)* (2009) 31 VAR 286 [123].

283 *Hunter and New England Area Health Service v A* [2009] NSWSC 761 [10]; *Re T (Adult: Refusal of Treatment)* [1992] EWCA Civ 18 [39].

284 *Malette v Shulman* (Ont CA) 72 OR (2d) 417.

285 Eilionóir Flynn 'The rejection of capacity assessments in favor of respect for will and preferences: The radical promise of the UN convention on the rights of persons with disabilities' (2009) 18(1) *World Psychiatry* 50.

286 Chris Maylea et al, 'Consumers' experiences of rights-based mental health laws: Lessons from Victoria, Australia' (2021) 78 (September–October) *International Journal of Law and Psychiatry* 1, 7.

287 See, eg, *GCI* (n 50) [16]; George Szmukler and Brendan D Kelly, 'We should replace conventional mental health law with capacity-based law' (2016) 209 *The British Journal of Psychiatry* 449, 451.

288 *GCI* (n 50) [15].

289 *MHWa* (n 85) s 87(1).

290 George Szmukler and Brendan D Kelly, 'We should replace conventional mental health law with capacity-based law' (2016) 209(6) *The British Journal of Psychiatry* 449, 452.

a reformulation would advance human rights by ensuring that legal protections for medical treatment decisions apply to all consumers who legitimately refuse treatment, not just those with certain cognitive functions.

DMC assessments may also benefit from adaptation to address the ‘spectrum of capacity’. This concept explains that DMC operates along a continuum and should not be conceived as an all-or-nothing proposition.²⁹¹ Nevertheless, this is exactly what DMC tests do by only allowing for two possible conclusions: a finding of capacity, or a finding of incapacity. Between these two poles, however, is a broad spectrum of partial capacity which current DMC tests do not accommodate. It may be possible to develop an approach to DMC tests that allows for a middle ground between according full legal respect for the decisions of a capacitous person, and completely denying the decision-making rights of a person found incapacitous. Such an approach may also allow for a balancing of the degree of capacity with the degree of risk of harm which substitute decision-making seeks to avert, providing a greater space for human rights-based proportionality reasoning on the appropriate course of action.²⁹²

DMC also operates within the context of social relations.²⁹³ This understanding of ‘relational capacity’ is not in line with Victoria’s DMC test which relies on ascertaining DMC as an internal property of an individual. Applying the concept of relational capacity to mental health has the benefit of supporting the move towards supported decision-making as it recognises the central role of relationships in decision-making.²⁹⁴ However, legal frameworks enshrining relational capacity face numerous challenges including how to manage different relationships, situations of abuse, exploitation and undue influence, and situations where a person may refuse relational supports for decision-making.²⁹⁵ There is also much variation in understandings of relational capacity which may militate for different legal frameworks.²⁹⁶ Some of these risks may be partly mitigated with consideration of:

- the importance of assessing and comparing *both* individual and relational

capacity to identify situations where third parties may be interfering with, rather than supporting, a consumer’s DMC;

- proper consideration and use of a range of decision-making supports, including non-legal advocacy services, advance statements, nominated persons and formalised support roles, and options for ‘excluded persons’;
- the utility of establishing individual approaches to incorporating decision-making supports into DMC assessments at the first step of assessment, to ensure that future DMC assessments are undertaken consistently and appropriately for every individual; and
- the need to develop and disseminate supports to guide nuanced approaches to incorporating relational capacity into DMC assessments.

4.3 Practical implementation supports

Recommendation 4.3

Expand practical implementation supports, including training and education, and practice and culture resources, for workers conducting decision-making capacity tests, with specific attention paid to the use of personal and cultural values, beliefs, emotions and relationships in decision-making.

Practical implementation supports should be developed and disseminated, including training and education, and practice and culture resources, to ensure DMC tests are interpreted and applied appropriately. Funding for ACCOs and other community organisations may be required to develop supports and resources appropriate for diverse communities.

International studies show that DMC assessors often struggle to properly distinguish between ‘incapacitous’ and ‘unwise’ decisions,²⁹⁷ notwithstanding high rates of inter-rater reliability of DMC tests.²⁹⁸ There is also evidence

291 Linda Ganzini et al, ‘Ten myths about decision-making capacity’ (2004) 5(40) *Journal of the American Medical Directors Association* 263.

292 Joel Feinberg (1986) *Harm to Self: The Moral Limits of the Criminal Law* (Oxford University Press, 1986) 104–5.

293 Lucy Series, ‘Relationships, autonomy and legal capacity: Mental capacity and support paradigms’ (2015) 40 (May–June) *International Journal of Law and Psychiatry* 80.

294 Ibid.

295 Ibid.

296 Ibid.

297 Val Williams et al, *Making best interests decisions: People and processes* (Mental Health Foundation, University of Bristol and Bradford University, 2012); Charlotte Emmett et al, ‘Homeward bound or bound for a home? Assessing the capacity of dementia patients to make decisions about hospital discharge: Comparing practice with legal standards’ (2012) 36(1) *International Journal of Law and Psychiatry* 73; Lisa Eckstein and Scott YH Kim, ‘Criteria for Decision-Making Capacity: Between Understanding and Evidencing a Choice’ (2017) 24(3) *Journal of Law and Medicine* 678.

298 Vanessa Raymont et al, ‘The inter-rater reliability of mental capacity assessments’ (2007) 30(2) *International Journal of Law and Psychiatry* 112; Ruth Cairns, ‘Reliability of mental capacity assessments in psychiatric in-patients’ (2005) 187 *British Journal of Psychiatry* 372.

of improper applications of DMC assessments in Victorian caselaw,²⁹⁹ while international caselaw evidences the complexity of DMC assessments in mental health contexts.³⁰⁰

In particular, the ‘use or weigh’ criterion has been criticised as lacking sufficient clarity to guide DMC tests, thereby encouraging an inappropriate outcomes-driven approach.³⁰¹ Like all DMC test criteria, this criterion should focus on whether a person is *able* to use or weigh information, not whether they have done so with a sufficient degree of careful consideration.³⁰² What matters is not whether a person makes the ‘right’ decision, but whether they are capable of making their ‘own’ decision. Outcomes-driven approaches that focus on the quality of a decision have been observed and rejected by Victorian courts.³⁰³ They are also expressly out of step with the established legal requirement that a lack of DMC cannot be found ‘only because the person makes a decision that could be considered unwise’.³⁰⁴ Practical and education resources will therefore have particular value in supporting assessors to properly assess how a person uses and weighs information.

Particularly relevant to educative measures is assessment of how a person incorporates personal and cultural values into decision-making. Focussing on a person’s value system can help assessors focus on whether a person’s decision is truly their own or not, regardless of the perceived wisdom of the decision. When a person’s using or weighing of information appears more consistent with pathological process than a known set of values attributable to the person, it may be safe to conclude that their DMC has been impaired by the effects of a mental illness.³⁰⁵ Undertaking DMC assessments with these factors in mind finds considerable support in both caselaw³⁰⁶ and academic literature.³⁰⁷

However, the use of values is highly individualised and therefore requires careful and self-disciplined analysis and application to individual cases. The search for an ‘authentic’ value system should not replace the right of a

person to change values, sometimes suddenly or radically. Assessments therefore require empathic immersion in the identification of underlying reasons in the context of a person’s individual story and experiences,³⁰⁸ with potential benefit for a presumption of the authenticity of stated values.³⁰⁹

Values should also be distinguished from emotions, beliefs and relationships, each of which play their own roles in decision-making with significant variations between individuals. This variation is such that it may be impossible to produce definitive rules about when a decision is properly driven by autonomous factors and when it is influenced by pathological factors.³¹⁰ So too should care be taken not to interpret forms of ambivalence as incapacity.³¹¹ All of these considerations require careful analysis to be applied to individual cases in such a way as to properly identify mental health consumers with the requisite DMC to make their own treatment decisions.

A range of practical implementation supports should therefore be developed to support assessors apply the legislative test in context. This should include training and education resources, as well as practice and culture resources. In developing these resources, particular attention should be paid to recent legislative changes³¹² as well as advances in our understandings of how values, emotions, beliefs and relationships influence decision-making, mediated through individual and cultural approaches.

299 See, eg, *PBU* (n 46).

300 See, eg, *Re SB (A Patient: Capacity to Consent to a Termination)* [2013] EWHC 1417 (COP).

301 Charlotte Emmett et al, ‘Residence Capacity: Complexity and Confusion’ (2013) 3(2) *The Elder Law Journal* 159.

302 *PBU* (n 46) [239]–[243].

303 *Ibid* [239]–[243].

304 *MHWA* (n 85) s 87(2)(d); *MHA* (n 222) s 68(2)(d).

305 Lisa Eckstein and Scott YH Kim, ‘Criteria for Decision-Making Capacity: Between Understanding and Evidencing a Choice’ (2017) 24(3) *Journal of Law and Medicine* 678, 687.

306 See, eg *PBU* (n 46) [242]; *Re P(A)* [2011] CLB 20564.

307 Eckstein and Kim (n 305) 785 n 33.

308 Helena Hermann et al, ‘Emotion and Value in the Evaluation of Medical Decision-Making Capacity: A Narrative Review of Arguments’ (2016) 7 *Frontiers in Psychology* 765.

309 Eckstein and Kim (n 305) 687.

310 Hermann et al (n 308).

311 Elizabeth Fistein and Rebecca Jacob, ‘Clinical Ambiguities in the Assessment of Capacity’ in Rebecca Jacob, Michael Gunn and Anthony Holland (ed) *Mental Capacity Legislation* (Cambridge University Press, 2nd ed, 2019) 102, 104.

312 See, eg, *MHWA* (n 85) s 87(1)(a); cf. *MHA* (n 222) s 68(1)(a).

Part 5: Supported decision-making

Supported decision-making (SDM) encompasses a variety of processes that support people to make and communicate decisions about their lives.³¹³ SDM has the capacity to enhance human rights by supporting autonomy and self-determination, while also addressing power imbalances between consumers and clinicians.³¹⁴ For these reasons, SDM is the preferred response in international human rights law when a person's DMC is impaired.³¹⁵

To date, SDM has not been well-embedded within the Victorian mental health system.³¹⁶ To address this, the Royal Commission recommended the alignment of mental health and other relevant decision-making laws 'over time'.³¹⁷ Further reform of this area has already been flagged in an incoming independent review of decision-making and compulsory treatment laws.³¹⁸

The right to SDM is formally recognised in the CRPD which requires states 'to provide access by persons with disabilities to the support they may require in exercising their legal capacity'.³¹⁹ SDM is therefore a necessary element of the right to recognition as a person before the law which encompasses the right to legal capacity.³²⁰

SDM is also instrumental to other rights, including the right to privacy. By supporting people to make decisions about their healthcare, SDM advances personal autonomy and inviolability which are core values protected by the right to privacy.³²¹ Furthermore, SDM may promote access to other social and cultural rights,³²² while failure to provide SDM may give rise to claims of cruel, inhuman and degrading treatment.³²³ SDM is also complementary to obligations to provide reasonable accommodation.³²⁴

SDM has divergent effects on the right to health. The conflict between the values of autonomy and beneficence manifests here when

the autonomous decision-making inherent in an SDM approach impedes or prevents the delivery of beneficial medical treatments.³²⁵ In these situations, SDM will advance the right to health, insofar as it incorporates autonomous medical decision-making,³²⁶ while also detracting from the right to health, insofar as it stops the delivery of certain beneficial health treatments. Notwithstanding this conflict, health outcomes may sometimes be strengthened when a person participates in their treatment.³²⁷

The right to equality also bears particular mention here. This right includes equal protection of both legal rights³²⁸ and human rights³²⁹ which include the right to SDM. Thus, where the law provides comparatively weak protections for access to SDM in mental health and wellbeing systems, or provides access to SDM that is insufficient to support a person within the system to exercise their rights on an equal basis to others, their right to equality will be breached in addition to the precipitant breaches of their legal and human rights to SDM.

Expanding and strengthening consumer access to SDM would therefore advance and promote a range of human rights, while only limiting the right to health insofar as it would respect legitimate refusals of health treatments. To achieve these advancements in practice requires a practical investigation into gaps, opportunities and challenges to identify potential improvements to current arrangements for SDM. The operation and legal effect of advance statements should be strengthened, as should the role of persons to continue to have a say in treatment decisions when they are made subject to substitute decision-making processes. Finally, a range of practical implementation supports should be developed, including education and culture change programs, to ensure legislative goals translate into practice on the ground.

313 MB Simmons and PM Gooding, 'Spot the Difference: Shared Decision-Making and Supported Decision-Making in Mental Health' (2017) 34(4) *Irish Journal of Psychological Medicine* 5.

314 *Royal Commission Final Report* (n 4) vol 4, 393.

315 *CRPD* (n 32) art 12; *GCI* (n 50).

316 *Royal Commission Final Report* (n 4) vol 4, 393–5.

317 *Ibid* 362, Recommendation 56(4).

318 *What we heard* (n 146) 6.

319 *CRPD* (n 32) art 12(3).

320 *GCI* (n 50).

321 *PBU* (n 46) [128].

322 Australian Supported Decision Making Network, *Discussion Paper Calling for Development of a National Supported Decision Making Framework* (Report, April 2016).

323 Katterl and Maylea (n 95) 64.

324 *CRPD* (n 32) arts 2, 5(3); *GCI* (n 50) [34].

325 *Royal Commission Final Report* (n 4) vol 4, 395; see also Neil Rees, 'Learning From the Past, Looking to the Future: Is Victorian Mental Health Law Ripe for Reform?' (2009) 16(1) *Psychiatry, Psychology and Law* 69.

326 UN Committee on Economic, Social and Cultural Rights, *General Comment No 14: The Right to the Highest Attainable Standard of Health* (Art 12), 22nd session, UN Doc E/C12/2000/4 (11 August 2000) [8]. Endorsed in *PBU* (n 46) [79].

327 Senate Select Committee on Mental Health (Cth), *A national approach to mental health – from Crisis to Community* (First Report, March 2006) [3.62].

328 *Charter* (n 29) s 8(3); *ICCPR* (n 30) art 26.

329 *Charter* (n 29) s 8(2); *ICCPR* (n 30) art 2(1).

5.1 Practicable availability of decision-making supports

Recommendation 5.1

Provide adequate funding for decision-making supports, supported by an analysis of gaps, challenges and opportunities in available supports, drawing on the views of Victorian consumers and lessons from international models, with consideration of introducing new roles to complement existing supports.

Decision-making supports must be adequately available to ensure people can access the supports they need when they need them. This requires additional funding for existing support services, particularly non-legal advocacy services which are already due for expansion, as well as an analysis of gaps, challenges and further opportunities in available decision-making supports, based on the views and desires of Victorian consumers.

International law obliges states to facilitate the creation of decision-making supports.³³⁰ These supports must encompass a wide variety of services, 'both informal and formal support arrangements, of varying types and intensity' including peer support, advocacy and advance planning assistance.³³¹ The type and intensity of support required will vary according to individual needs,³³² and people have the right to use no supports at all.³³³ As such, any additional decision-making supports made available should only be provided on an optional or opt-out basis, and should never be mandatory.³³⁴

The MHW Act currently requires "appropriate supports" to be provided to a person when they are providing consent for treatment,³³⁵ undergoing a DMC assessment,³³⁶ or otherwise being communicated with under the Act.³³⁷ Appropriate supports are defined suitably broadly and relate specifically to

decision-making.³³⁸ Further SDM mechanisms under the MHW Act include particular provisions that empower consumers to:

- access non-legal advocacy services on an opt-out basis;³³⁹
- elect a 'nominated support person' to support them, advocate for their views and preferences, including vis-à-vis decision-making supports;³⁴⁰
- create an advance statement to outline their preferences for treatment and decision-making supports³⁴¹ (although these may be overridden in certain circumstances);³⁴²
- receive a statement outlining their rights under the MHW Act, and assessment and treatment processes;³⁴³ and
- access second psychiatric opinions.³⁴⁴

The expansion of non-legal advocacy services under the MHW Act provides a unique opportunity to strengthen access to SDM. Existing non-legal advocacy services through the Independent Mental Health Advocacy (IMHA) program enjoy strong support from consumers³⁴⁵ and were recognised by the Royal Commission as 'effective at putting supported decision-making into practice'.³⁴⁶ Non-legal advocacy services therefore provide a foundation for a Victorian model of SDM, with existing insights into consumer preferences and strategic opportunities to expand decision-making supports.

To satisfy Australian obligations to create decision-making supports, and to ensure that non-legal advocates are best able to support consumers to identify and access other decision-making supports that are appropriate for them, a gap analysis should be undertaken to identify whether and what additional supports should be developed. Such an analysis should also explore challenges and opportunities in realising the full benefits of existing decision-making supports. It should draw on the views of Victorian consumers, as well as lessons from international and academic models,³⁴⁷ in identifying strategic opportunities

³³⁰ *GCJ* (n 50) [29].

³³¹ *Ibid* [17].

³³² *Ibid* [18].

³³³ *Ibid* [19].

³³⁴ *Ibid*.

³³⁵ *MHW Act* (n 85) s 86(3)(c).

³³⁶ *Ibid* s 87.

³³⁷ *Ibid* s 7.

³³⁸ *Ibid* s 6.

³³⁹ *Ibid* pt 2.3.

³⁴⁰ *Ibid* pt 2.6.

³⁴¹ *Ibid* pt 2.5.

³⁴² *Ibid* s 90(1).

³⁴³ *Ibid* pt 2.2.

³⁴⁴ *Ibid* pt 2.7.

³⁴⁵ *Royal Commission Final Report* (n 4) vol 4, 396; Christopher Maylea et al, *Evaluation of the Independent Mental Health Advocacy Service (IMHA)* (Report, 2019).

³⁴⁶ *Royal Commission Final Report* (n 4) vol 4, 396.

³⁴⁷ UN Committee on the Rights of Persons with Disabilities, 'Chapter Six: From provisions to practice: implementing the Convention, Legal Capacity and

to expand the practicable availability of decision-making supports in Victoria.

Some of the options for consideration include:

- An ‘ombudsman’ or ‘supporter’ role could be introduced to support a person to make decisions according to the PO Skåne model.³⁴⁸ Careful consideration should be given to how this role may complement, rather than overlap with, non-legal advocacy supports.
- A ‘monitor’ role could be introduced to oversee the actions of decision-making support persons.³⁴⁹ Such a role could draw on lessons from similar efforts in British Columbia.³⁵⁰
- Consumers may have the option to formalise informal supports, including families, carers and supporters. This would have the benefit of empowering consumers to identify which family members, carers and/or supporters they want to participate in SDM processes.³⁵¹ It would also provide family members, carers and supporters wanting to play such a role with an alternative to nominated support persons, in acknowledgment of the potential conflicts between the roles of carers and nominated persons.³⁵² Such a role should draw on *Representation Agreements* in British Columbia³⁵³ and be supported with training and education on SDM.³⁵⁴
- A person may be allowed to appoint a substitute mental health decision-maker to make treatment decisions on their behalf. Such an option is currently permitted for physical health treatment decisions in Victoria³⁵⁵ and consideration of such for mental health matters was explicitly encouraged by the Royal Commission.³⁵⁶
- Consumers may be able to develop a network of decision-making supporters³⁵⁷ by combining one or more decision-making supports including non-legal advocates, trusted mental health workers, and other decision-making supports identified above.
- Consumers should also have the option to nominate ‘excluded persons’. Such persons would be excluded from the consumer’s

care, including relevant SDM processes and information-sharing arrangements.³⁵⁸

- Carers, families and supporters should also have access to non-legal advocacy services to help them identify relevant SDM supports, as required.³⁵⁹

5.2 Binding and non-binding advance statements

Recommendation 5.2

Provide legislative options for binding advance statements, with limited exceptions, and non-binding values statements.

The MHWAs should provide legislative options for binding advance statements and non-binding values statements to support the autonomous decision-making of consumers. The Royal Commission noted the limited effectiveness of advance statements in Victoria,³⁶⁰ encouraging the making of advance statements binding in ‘all but very limited circumstances’.³⁶¹

By enshrining a person’s preferences when they have DMC, binding advance statements provide greater scope for a person’s autonomy to operate upon the loss of DMC. They therefore support the rights to health, privacy and recognition as a person before the law, each of which incorporate the right to autonomous medical treatment decision-making while reducing risks to other human rights engendered in substitute decision-making.³⁶² At the same time, binding advance statements advance the right to equality by bringing advance statement safeguards into line with advance planning tools in physical health legislation,³⁶³ at common law,³⁶⁴ and under international mental health laws.³⁶⁵

Under the MHWAs, an advance statement sets out a person’s treatment preferences

Supported Decision-Making’ in *UN Handbook for Parliamentarians on the Convention on the Rights of Persons with Disabilities* (Geneva, 2007); see also Michael Bach and Lana Kerzner, *A New Paradigm for Protecting Autonomy and the Right to Legal Capacity: Advancing Substantive Equality for Persons with Disabilities through Law, Policy and Practice* (Report, October 2010); Piers Gooding, ‘Supported Decision-Making: A Rights-Based Disability Concept and its Implications for Mental Health Law’ (2013) 20(3) *Psychiatry, Psychology and Law* 431.

348 PO Skåne, *Information about Personligt Ombud in English and other languages* (Web Page, 2015) <<http://po-skane.org/in-foreign-languages>>.

349 Michael Bach and Lana Kerzner, *A New Paradigm for Protecting Autonomy and the Right to Legal Capacity: Advancing Substantive Equality for Persons with Disabilities through Law, Policy and Practice* (Report, October 2010) 118.

350 Ibid.

351 See, eg, Victoria Legal Aid (n 110) 10.

352 *Royal Commission Final Report* (n 4) vol 4, 403.

353 Michael Bach and Lana Kerzner, *A New Paradigm for Protecting Autonomy and the Right to Legal Capacity: Advancing Substantive Equality for Persons with Disabilities through Law, Policy and Practice* (Report, October 2010).

354 See Part 5.4.

355 *MTPDA* (n 241) s 26(1).

356 *Royal Commission Final Report* (n 4) vol 4, 429–30.

357 World Health Organization, *Guidance on community mental health services: Promoting person-centred and rights-based approaches* (Report, 2021) 6–7.

358 Victorian Mental Illness Awareness Council, *Act on the Act: Mental Health and Wellbeing Act Submission 2021* (Submission, 2021) 6.

359 *What we heard* (n 146) 13.

360 *Royal Commission Final Report* (n 4) vol 4, 399–403.

361 Ibid 430.

362 See, eg, ibid 302.

363 *MTPDA* (n 241) s 60.

364 *Hunter and New England Area Health Service v A* [2009] NSWSC 761 [56].

365 *GCI* (n 50) [17].

in the event that they become subject to compulsory treatment, or other relevant substitute decision-making provisions.³⁶⁶ A preferred treatment outlined in an advance statement may be overridden if it is 'not clinically appropriate' or otherwise 'unable to be provided' by the service.³⁶⁷ Further consideration should be given to these provisions.

A risk associated with binding advance statements is the potential to limit the provision of beneficial treatments, raising the common tension between autonomy and beneficence.³⁶⁸ To address this, limited exceptions should be provided to allow for the override of advance statements, in line with the legislative approach taken in physical health settings.³⁶⁹ It is important that these exceptions be as limited as possible, in line with the Royal Commission's suggestion,³⁷⁰ to ensure that a proportionate balance is struck between competing rights.

The term 'not clinically appropriate' is vague and well-understood; it may even be so vague as to be unjusticiable; its use to define a lawful reason to override an advance statement is therefore not consistent with a rights-based approach which requires clarity on when human rights may be justifiably limited. An alternative might be to link back to the purpose of the overarching order, and only permit overrides when necessary to achieve the purpose of the order. There may also be advantages in applying or adapting exceptions to instructional care directives in physical health settings, such as when the process of making the statement may be impugned due to reliance on incorrect information or assumptions.³⁷¹ Exceptions should also be subject to time limits. This is particularly important in the mental health context where crisis situations may require short-term overrides which will lose their necessity in the context of ongoing care.

Ideally, a binding advance statement should be made with the person's treating team, and only when the person is confirmed to have DMC. This will ensure the statement provides a practicable and legitimate expression of a consumer's will and preferences. However, there are advantages

to the MHWA's broad approach, including maximising options for consumers to prepare advance statements. It may be that additional approaches can be provided in the alternative, with a higher threshold for exceptions protecting advance statements that are prepared with greater assurances of legitimacy.

Binding advance statements may be associated with some risks which require recognition and response. For example, binding advance statements may increase risks of legal liabilities associated with non-treatment, including criminal responsibilities for consumers and tortious liabilities for services and workers. These perverse outcomes should be considered and addressed, such as through legislative or other protective assurances for workers and services acting in accordance with binding advance statements, as well as a review of mental impairment defence laws.

A non-binding alternative should also be provided for those consumers who wish to use it.³⁷² This would support the Royal Commission's aim for the alignment of decision-making laws, as similar options exist for advance planning for physical health matters. The Victorian *Medical Treatment Planning and Decisions Act 2016* provides for the making of both binding instructional directives and non-binding values directive.³⁷³ The Australian Capital Territory also has a legal framework for 'advance agreements' and 'advance consent directions'³⁷⁴ which should be drawn upon when designing Victorian provisions. Such an approach would support the equality of mental health consumers, while also empowering them to direct the interaction of the values of autonomy and beneficence in substitute decision-making processes. They may do this by selecting, when they have DMC, whether they would prefer more weight to be given to autonomy, by restricting an authorised psychiatrist's override decisions to legislated exceptions, or to beneficence, by using advance planning to guide but not direct clinical substitute decision-making.

Should consumers be provided with the option of nominating a substitute decision-

366 MHWA (n 85) s 57.

367 Ibid s 90(1).

368 Neil Rees, 'Learning From the Past, Looking to the Future: Is Victorian Mental Health Law Ripe for Reform?' (2009) 16(1) *Psychiatry, Psychology and Law* 69.

369 MTPDA (n 241) ss 23, 51.

370 Royal Commission Final Report (n 4) vol 4, 430.

371 MTPDA (n 241) ss 23, 51; Weller, Penelope, *New Law and Ethics in Mental Health Advance Directives: The Convention on the Rights of Persons with Disabilities and the Right to Choose* (Taylor & Francis Group, 2012) 151.

372 Vrinda Edan and Chris Maylea, 'A Model for Mental Health Advance Directives in the New Victorian Mental Health and Wellbeing Act' (2021) *Psychiatry, Psychology and Law* doi: 10.1080/13218719.2021.1976302.

373 MTPDA (n 241) s 12(2); see also Vrinda Edan and Chris Maylea, 'A Model for Mental Health Advance Directives in the New Victorian Mental Health and Wellbeing Act' (2021) *Psychiatry, Psychology and Law* doi: 10.1080/13218719.2021.1976302.

374 Mental Health Act 2015 (ACT) pt 3.3.

maker,³⁷⁵ a hybrid model for advance planning would allow for advance planning documents to inform decisions made by the selected substitute decision-maker.³⁷⁶ This may be achieved through similar means to Victorian guardianship laws which require appointed guardians to exercise their powers with the represented person's will and preferences directing decisions 'as far as practicable'.³⁷⁷

Proportionate consequences for non-compliance may be provided through the ordinary functions of the Mental Health and Wellbeing Commission provided the Commission has a clear compliance function³⁷⁸ in line with the strong oversight envisioned by the Royal Commission for advance planning.³⁷⁹ Further research into the relationship between advance planning laws, and attitudes and practices in the mental health and wellbeing sector, should inform further consideration of whether a stronger regulatory framework is required.³⁸⁰

Further efforts will also be required to drive culture change and provide workers with resources and practical supports³⁸¹ to implement advance planning.

5.3 Substitute decision-maker obligations

Recommendation 5.3

Strengthen obligations for substitute decision-makers to 'give effect to' the views and preferences of consumers 'as far as practicable'.

Where substitute decision-making is implemented, obligations imposed on decision-makers to consider consumer views and preferences must be strengthened. The Royal Commission recognised concerns that consumer views and preferences are not always being considered in such cases,³⁸² and the Department of Health has confirmed its intention to strengthen relevant obligations at law.³⁸³ This technically constitutes 'shared' not supported decision-making, as the ultimate decision does not rest with the consumer;³⁸⁴ it is nevertheless a key legislative tool to give consumers a stronger say in their treatment.

Under the MHW, decision-makers are required to 'have regard' to the views and preferences of consumers, as well as relevant others, 'to the extent that is reasonable in the circumstances' when making decisions about treatments,³⁸⁵ treatment orders,³⁸⁶ and other matters.³⁸⁷ The MHW makes equal reference to consumers, support persons and other relevant people in most of those decision-making processes. It is no doubt appropriate to incorporate the views of multiple actors in SDM processes; however, it is also important that the views and preferences of the consumer occupy a special place in order to safeguard their autonomy and human rights.³⁸⁸

Strengthened decision-maker obligations should therefore place more onerous obligations on decision-makers to consider the views and preferences of consumers over other relevant persons. This may be achieved by separating provisions on the views and preferences of consumers to those relating to others. While

375 See Part 5.1.

376 Neil Rees, 'Learning From the Past, Looking to the Future: Is Victorian Mental Health Law Ripe for Reform?' (2009) 16(1) *Psychiatry, Psychology and Law* 69.

377 GAA (n 220) ss 8(1)(b), 41(1)(a).

378 See Part 1.4.

379 Royal Commission Final Report (n 4) vol 4, 430.

380 Weller, Penelope, *New Law and Ethics in Mental Health Advance Directives: The Convention on the Rights of Persons with Disabilities and the Right to Choose* (Taylor & Francis Group, 2012).

381 See Part 5.4.

382 Royal Commission Final Report (n 4) vol 4, 394.

383 Update and Engagement Paper (n 196) 16.

384 Royal Australian and New Zealand College of Psychiatrists, Victorian Branch, 'Enabling supported decision-making' (Position Paper, May 2018) <<https://www.ranzcp.org/files/branches/victoria/enabling-supported-decision-making-vic-branch-posi.aspx>>.

385 See, eg, MHW (n 85) ss 70(d), 76(4), 89(4), 93(2), 99(2), 104(2), 109(2), 114(2).

386 See, eg, ibid ss 180(2)(a), 190(2)(a), 192(3)(a), 200(2)(b), 201(2)(a), 204(4), 207(3), 224.

387 See, eg, ibid ss 131(2), 132(5), 136(2), 214(c), 545(5).

388 Victoria Legal Aid (n 110) 10.

it may be appropriate to 'have regard' to all in the latter category, the former category may be prioritised with stronger language, such as 'give effect to... as far as practicable'. This is no less relevant for consumers who lack DMC and/or who are subject to compulsory treatment.³⁸⁹ Consideration of advance statements should occupy the same privileged position, and a developmentally appropriate approach should also be taken with children and young people.

5.4 Practical implementation supports

Recommendation 5.4

Expand practical implementation supports, including training and education, and practice and culture resources, for consumers, carers and workers to identify, understand and implement decision-making supports.

The Royal Commission recognised the importance of expanding education and training on SDM for people with lived experience and the mental health workforce.³⁹⁰ These, along with other practical implementation supports including organisational change strategies, will be critical to ensuring legal protections for SDM are translated into practice. Funding for ACCOs and other community organisations will be required to develop supports and resources appropriate for their communities.

Educative resources are firstly required to ensure consumers have access to appropriate supports. Many consumers currently do not know of, or cannot access, existing decision-making supports; less than 3% of adult consumers have an advance statement or nominated person,³⁹¹ while one study found more than 60% of consumers agreed or strongly agreed that relevant information was hard to find.³⁹² As a result, the benefits of existing decision-making supports are not being fully realised.³⁹³ Local Mental Health and Wellbeing Services may be

used to support some of these activities with other mechanisms, including outreach services and education campaigns, also being considered.

Workers also require more resources to understand and implement SDM, including education and training tools, communities of practice, and appropriate supports and opportunities to implement training in practice.³⁹⁴ These resources should address how to implement SDM within the context of a crisis-driven and reactive system,³⁹⁵ and the value of SDM in practice³⁹⁶ including when a person has been subject to compulsory treatment. Specific training will be required for advance statements, encompassing legal obligations, best-practice approaches³⁹⁷ and the value of advance planning, including vis-à-vis voluntary patients.³⁹⁸

Existing training and education efforts should be scaled up, while gaps should be identified and filled. Independent Mental Health Advocacy's SDM training modules, the Royal Australian and New Zealand College of Psychiatrists' Victorian Enabling Supported Decision-Making and the Public Trustee Queensland's Structured Decision-Making Framework project provide examples of SDM training and educational efforts which have already produced good outcomes. Potential gaps to be considered include the need for ACCOs to be funded to develop Aboriginal-specific resources and supports, and the educative needs of all relevant workforces, including professions strictly beyond the mental health and wellbeing system like general practitioners.

Specific attention should also be given to practical supports like structured facilitation to support the creation of advance statements³⁹⁹ and a state-wide register to ensure advance statements are accessible to services and workers.⁴⁰⁰ Organisational change supports should be explored as a part of a law reform implementation initiative.⁴⁰¹ The utility of an MBS item to support general practitioners to engage in advance planning may also be considered. The South Australian Office of the Public Advocate's SDM project provides further examples of practical supports that may be provided for workers.⁴⁰²

389 Weller, Penelope, *New Law and Ethics in Mental Health Advance Directives: The Convention on the Rights of Persons with Disabilities and the Right to Choose* (Taylor & Francis Group, 2012) 36–7.

390 *Royal Commission Final Report* (n 4) vol 4, 428.

391 *Ibid* 399.

392 Victorian Mental Illness Awareness Council, *VMIAC Consumer Survey: Advance Statements and Nominated Persons* (Report, 2018) 8.

393 *Royal Commission Final Report* (n 4) vol 4, 393, 396.

394 *Ibid* 393–5.

395 *Ibid* 401.

396 *Ibid* 305.

397 See, eg, Weller, Penelope, *New Law and Ethics in Mental Health Advance Directives: The Convention on the Rights of Persons with Disabilities and the Right to Choose* (Taylor & Francis Group, 2012).

398 Victorian Mental Illness Awareness Council, *Act on the Act: Mental Health and Wellbeing Act Submission 2021* (Submission, 2021).

399 Weller, Penelope, *New Law and Ethics in Mental Health Advance Directives: The Convention on the Rights of Persons with Disabilities and the Right to Choose* (Taylor & Francis Group, 2012) 159.

400 *Update and Engagement Paper* (n 196) 16.

401 See Part 2.1.

402 Office of the Public Advocate, *Evaluation of the Supported Decision Making Project* (Report, November 2012).

Part 6: Coercive practices

Coercive practices, which include compulsory assessment and treatment, and seclusion and restraint, present significant risks for human rights. This is because they are, by their very nature, coercive, and therefore directly counter to the autonomy of consumers. Their use must therefore be restricted to situations where it is absolutely necessary.

Often, coercive practices are employed to advance the right to health. A person may only be subject to compulsory assessment and treatment when necessary to prevent deterioration in their physical or mental health,⁴⁰³ or otherwise to prevent harm to themselves or someone else.⁴⁰⁴ Restrictive practices are similarly purposed for the prevention of harm⁴⁰⁵ and, for bodily restraint, to administer medical treatment.⁴⁰⁶ The relevance of these provisions to the right to health is underscored by the legislative objectives and principles⁴⁰⁷ and the statement of compatibility.⁴⁰⁸ Applications of both compulsory assessment and treatment, and restrictive practices, are further limited to situations where there is no less restrictive alternative available to effect the intervention,⁴⁰⁹ an important reflection of the proportionality principle.

Coercive practices may also compromise the right to health which includes both medical decision-making autonomy and access to services.⁴¹⁰ Firstly, by the very fact of their coercive nature, coercive practices limit a person's autonomy. Secondly, while coercive practice often directly facilitate access to treatment, they may also have deleterious

effects on a person's health, wellbeing, safety and recovery,⁴¹¹ as recognised by both the Royal Commission⁴¹² and Victorian caselaw.⁴¹³ Many people experience negative health effects from episodes of compulsory treatment, including (re)traumatisation,⁴¹⁴ while others cycle through successive episodes without sustained improvements in their health.⁴¹⁵ Thus, like other areas of mental health law,⁴¹⁶ coercive practices produce divergent effects on the right to health.

Furthermore, coercive practices limit other human rights which protect autonomy, including the right to recognition as a person before the law, and the right to privacy. Both of these rights protect medical decision-making autonomy which coercive practices,⁴¹⁷ by their very nature, limit.⁴¹⁸ As a result, the CRPD has rejected substitute decision-making as fundamentally incompatible with the right to equal recognition as a person before the law,⁴¹⁹ although such a view has been disputed.⁴²⁰

Some coercive practices also limit other rights. To facilitate compulsory treatment and assessment, Inpatient Treatment and Assessment Orders require the detention of a person within a designated mental health service.⁴²¹ In so doing, they present a direct limitation on the right to liberty.⁴²² Restrictive practices involve the restriction of a person to a secluded room, or the use of restraints to restrict a person's movement. Such restrictions on movement also present direct limitations on the right to liberty.⁴²³

Coercive practices may also limit the rights to

403 *MHWA* (n 85) ss 142(b)(i), 143(b)(i).

404 *Ibid* ss 142(b)(ii), 143(b)(ii).

405 *Ibid* s 127(a).

406 *Ibid* s 127(b).

407 *Ibid* s 12; pt 1.5; see also *PBU* (n 46) [100].

408 Statement of Compatibility, *Mental Health and Wellbeing Act 2022* (Vic).

409 *MHWA* (n 85) ss 142(d), 143(d), 128(2).

410 *PBU* (n 46) [97].

411 World Health Organization, *Guidance on community mental health services: Promoting person-centred and rights-based approaches* (Report, 2021) 8.

412 *Royal Commission Final Report* (n 4) vol 4, 304–5, 370–2.

413 *PBU* (n 46) [257].

414 *Royal Commission Final Report* (n 4) vol 4, 363.

415 See, eg, *ibid* 367.

416 See Parts 4, 5 and 7.

417 See "Human rights in context".

418 *Kracke* (n 65) [569], [681].

419 *GC1* (n 50) [47].

420 See, eg Neeraj S Gill, 'Human Rights Framework: An Ethical Imperative for Psychiatry' (2019) 53(1) *Australian and New Zealand Journal of Psychiatry* 8, 9; George Szmulikler, 'Involuntary Detention and Treatment: Are We Edging Toward a 'Paradigm Shift'?' (2020) 46(2) *Schizophrenia Bulletin* 231, 233; Sascha Mira Callaghan and Christopher Ryan, 'Is There a Future for Involuntary Treatment in Rights-Based Mental Health Law?' (2014) 21(5) *Psychiatry, Psychology and Law* 747, 747; John Dawson, 'A Realistic Approach to Assessing Mental Health Laws' Compliance with the UNCRPD' (2015) 40 *International Journal of Law and Psychiatry* 70, 70.

421 See, eg, *MHWA* (n 85) ss 146(3), 182(3), 195(3).

422 *Kracke* (n 65) [626]; UN Human Rights Committee, *General Comment No.35 – Article 9: Liberty and Security of person*, 112th session, UN Doc CCPR/C/GC/35 (16 December 2014) [5]; *A v. New Zealand*, Communication No 754/1997, UN Doc CCPR/C/66/D/754/1997 (3 August 1999) [7.2].

423 UN Human Rights Committee, *General Comment No.35 – Article 9: Liberty and Security of person*, 112th session, UN Doc CCPR/C/GC/35 (16 December 2014) [5]; UN Human Rights Committee, *Concluding observations of the Human Rights Committee: Czech Republic*, 90th session, UN Doc CCPR/C/CZE/CO/2 (9 August 2007) [13]; UN Human Rights Committee, *Concluding observations of the Human Rights Committee: Republic of Korea*, 88th session, UN Doc CCPR/C/KOR/CO/3 (28 November 2006) [13].

humane treatment when deprived of liberty,⁴²⁴ protection against violence and abuse,⁴²⁵ as well as torture and cruel, inhuman or degrading treatment.⁴²⁶ Compulsory treatment, including powers to make treatment decisions for persons, notwithstanding their inability or refusal to give consent,⁴²⁷ along with powers to use bodily restraint to administer such treatment, directly compromise the right to protection against medical treatment without full, free and fair consent. Coercive practices also engage the right to equality insofar as they are applied, or associated safeguards are provided, in ways that are unequal or discriminatory.⁴²⁸

Reducing recourse to restrictive practices firstly requires a reorientation of system funding toward voluntary services that provide alternatives to coercion. It also necessitates consideration of alternative frameworks for compulsory treatment that can ensure it is only applied when absolutely necessary. Furthermore, legal advocacy for Mental Health Tribunal matters requires expansion, while continuous and rigorous efforts must be undertaken to achieve the Royal Commission's vision to eliminate restrictive practices.

424 World Health Organization, *Strategies to End Seclusion and Restraint: WHO Quality Rights Specialized Training* (Course Guide, 2019) 8; Castan Centre for Human Rights Law, *Submission to the Royal Commission into Victoria's Mental Health System* (Submission, July 2019) 3–5.

425 Bernadette McSherry, 'Regulating seclusion and restraint in health care settings: The promise of the Convention on the Rights of Persons with Disabilities' (2017) 53 *International Journal of Law and Psychiatry* 39.

426 Juan Mendez, *Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment*, UN Doc A/HRC/22/53 (1 February 2013) [63]; UN Committee Against Torture, *Concluding observations of the Committee against Torture: Canada*, 48th session, UN Doc CAT/C/CAN/CO/6 (25 June 2012) [19](d); Manfred Nowak, *Interim Report of the Special Rapporteur of the Human Rights Council on torture and other cruel, inhuman or degrading treatment or punishment*, UN Doc A/63/175 (28 July 2008) [55].

427 *MHWA* (n 85) s 89.

428 See, eg, *GCI* (n 50).

6.1 Reorientation of system funding structures

Recommendation 6.1

Expand community-based voluntary services that provide genuine alternatives to coercive practices.

A reorientation of system funding structures to give precedence to community-based non-coercive models of care is crucial to minimising the risks to human rights associated with coercive practices. The Royal Commission recognised that reducing the use and duration of compulsory treatment depends on ensuring people have 'ready access' to a range of voluntary services.⁴²⁹ Less reliance on compulsory treatment will in turn be critical in reducing the use of restrictive practices.⁴³⁰

Coercive practices engender risks to a range of human rights but have the potential to advance human rights in one singular way: by promoting access to health services. Expanding access to voluntary services provides the same advancement of the right to health while simultaneously reducing the considerable risks that coercive practices pose for other human rights. System reorientation towards voluntary service provision therefore presents a singularly direct way of advancing the broad range of human rights associated with coercive practices.

Reorienting system funding towards community-based non-coercive models of care requires a sustained commitment from the Victorian Government, beyond the Royal Commission's ten-year reform agenda. Historically, chronic under-resourcing of the system has led to an over-reliance on crisis responses and acute inpatient services at the cost of community-based voluntary services.⁴³¹ At the same time, community-based service provision is more cost-effective than inpatient care.⁴³² A sustainable mental health and wellbeing system therefore requires a reorientation of funding towards services that provide genuine alternatives to coercive practices.

Particular efforts must be made to ensure that voluntary service expansion actually translates into practicable and accessible alternatives to coercion.⁴³³ Expansions should therefore explicitly target cohorts at risk of compulsory treatment, such as through the expansion of community-based crisis treatment and assessment teams, and community-based outreach teams, which are crucial to the delivery of care to people with urgent and/or complex needs in the community.⁴³⁴

More broadly, expanding access to voluntary services must occur in magnitude as well as proportion. It is not enough to improve access to community-based voluntary services if funding structures continue to incentivise crisis-driven approaches. Only a genuine reorientation of system funding towards community-based voluntary services will be capable of realising the full benefits of deinstitutionalisation.

6.2 A capacity criterion for compulsory treatment

Recommendation 6.2

Introduce a decision-making capacity criterion into the compulsory assessment and treatment criteria.

A decision-making capacity criterion should be introduced into the criteria for compulsory assessment treatment. This would bring Victorian law into line with legislation in Queensland, South Australia, Tasmania and Western Australia.⁴³⁵

As discussed previously,⁴³⁶ protecting the treatment decisions of persons with the DMC to make them is essential to advancing autonomy and human rights in the mental health and wellbeing system. To achieve this, a lack of DMC should be included as a requirement within the compulsory assessment and treatment criteria. This would ensure that people with DMC to make their own treatment decisions are afforded the legal right to make them.

429 *Royal Commission Final Report* (n 4) vol 4, 412.

430 *Ibid* 302.

431 *Ibid* 386.

432 See, eg, Javier Vazquez-Bourgon, Luis Salvador-Carulla, and Jose L. Vazquez-Barquero, 'Community alternatives to acute inpatient care for severe psychiatric patients' (2012) *Actas Españolas de Psiquiatría* 40(5) 323, 328; *Royal Commission Final Report* (n 4) vol 4, 432–3.

433 For details on the kinds of services required, see Piers Gooding et al, *Alternatives to Coercion in Mental Health Settings: A Literature Review* (Report, 2018).

434 *Royal Commission Interim Report* (n 5) 90.

435 *Mental Health Act 2016* (Qld) s 12(1)(b); *Mental Health Act 2009* (SA) s 21(1)(ba); *Mental Health Act 2013* (Tas) s 40(e); *Mental Health Act 2014* (WA) s 25(1)(c).

436 See Part 4.1.

6.3 A new framework for compulsory treatment

Recommendation 6.3

Design a new framework for compulsory treatment to form the basis of further consultation and consideration, based on the following elements:

- a capacity threshold excluding consumers with relevant decision-making capacity;
- decision-making according to determination of a person's will and preferences, or where such cannot be determined, either a "best interpretation of will and preferences" test or a "best interests" test incorporating a broad range of considerations in a flexible and holistic assessment, with the ultimate purpose of "promoting personal recovery";
- a fusion model applying to all settings including mental health and wellbeing, disability and physical health;
- a participative approach involving a consumer and their support network; and
- decision-making through a multidisciplinary body of experts.

A new framework for compulsory treatment should be considered in light of the significant risks to human rights engendered by the compulsory provision of mental health treatments. The Victorian Government's commitment to an independent review of compulsory treatment criteria⁴³⁷ is a welcome and unique opportunity in this regard.

An appropriate amount of caution should be exercised, however, in introducing any new framework, both due to questions as to the effectiveness of an untested framework, and the potential for significant challenges in implementation. Furthermore, applications of frameworks from other jurisdictions will require careful consideration regarding how best to adapt to fit into Victoria's legislative framework, including vis-à-vis mental health and wellbeing, human rights and other relevant laws.

A new framework should therefore be designed, based on human rights principles, to work within the specific context of Victoria's legislative framework. Such a framework should incorporate a number of elements (discussed below) and be used as a basis for consultation across the mental health and wellbeing sector. Elements of the framework should be considered individually, as well as together, to identify the most appropriate framework to implement in Victoria.

A capacity threshold

As discussed previously,⁴³⁸ ensuring all functions of the mental health and wellbeing system operate with respect for the treatment decisions of persons found to have DMC on treatment matters is essential to advance and promote human rights. This requires a lack of DMC to be a threshold requirement for compulsory treatment.⁴³⁹ Any new framework for compulsory treatment must therefore categorically exclude persons with DMC on treatment matters.

Will and preferences

When a person lacks DMC to make decisions about their treatment, decision-making responsibilities necessarily fall to someone else. However, this does not necessitate the complete rejection of consumer autonomy; wherever possible, supported or at least shared decision-making should still be facilitated in preference to substitute decision-making.

The CRPD requires that compulsory treatment frameworks, as measures that relate to the exercise of legal capacity, respect the rights, will and preferences of consumers.⁴⁴⁰ Even when a consumer lacks the DMC to articulate their will and preferences, they may be ascertained through other means, such as through advance planning documents, insights from carers, family members and supporters, and other decision-making supports.

Where a consumer's will and preferences cannot be determined, the CRPD requires a "best interpretation of will and preferences" test over a "best interests" test,⁴⁴¹ although it does not specify precisely what is meant by this.⁴⁴² While some commentators have sought to clarify how such a test would be best implemented,⁴⁴³ others have argued that a "best interests" test

⁴³⁷ *What we heard* (n 146) 6.

⁴³⁸ See Part 4.1.

⁴³⁹ See Part 6.2.

⁴⁴⁰ CRPD (n 32) art 12(4).

⁴⁴¹ GCI (n 50) [21].

⁴⁴² Mary Donnelly, 'Best Interests in the Mental Capacity Act: Time to say Goodbye?' (2016) 24(3) *Medical Law Review* 318, 318.

⁴⁴³ See, eg, Paul Skowron, 'Giving substance to "the best interpretation of will and preferences"' (2019) 62 (January-February) *International Journal of Law and Psychiatry* 125.

may be adapted to be CRPD-compliant, so long as it is only used when a person's will and preferences cannot be determined.⁴⁴⁴ Such an approach is already employed in Victoria's *Guardianship and Administration Act 2019*.⁴⁴⁵

Whichever test is employed, the ultimate objective should be to 'promote personal recovery'. Using alternative language to frame a best-interests test has already been used in other Victorian legislation,⁴⁴⁶ and using personal recovery as a benchmark for a best-interests test in the mental health and wellbeing system is important to orient the decision-making analysis towards what would best facilitate an individual's personal sense of recovery. Training should be provided to support decision-makers on the relevant test, including how to avoid an overfocus on beneficence through skilled interviewing, deep listening and empathic immersion.

If a best-interests test is used, it must be applied through a suitably flexible approach to incorporate both medical and non-medical factors.⁴⁴⁷ Such an approach may not be too difficult to implement considering the Charter already requires compulsory treatment decision-makers to consider human rights implications and countervailing interests;⁴⁴⁸ a best-interests approach may simply make such requirements clearer. There is also evidence that some clinicians already see a best-interests test as the 'primary paradigm' for healthcare, albeit within a narrower scope.⁴⁴⁹

A best-interests test is preferable to a framework that relies solely on clinical assessments of medical need which inevitably overemphasise the right to health over other rights. Such frameworks, as currently found in the MHW, will by their very nature be incapable of

providing a proportionate assessment in every case. At times, they may even risk limiting support for the right to health through reliance on a threshold of seriousness to define which harms to health merit intervention, rather than focussing on when intervention is the best option.⁴⁵⁰ A best-interests approach is preferable as it would facilitate proportionate and timely assessments of need, incorporating clinical and non-clinical factors, by shifting the framework's scope of operation from the prevention of serious harm to the loss of DMC.⁴⁵¹

The following matters will be relevant considerations to a best-interests test, although legislation should not define such a list exhaustively to preserve the adaptability of the analysis to individual cases:

- the person's will and preferences, insofar as they can be ascertained;⁴⁵²
- the person's mental health and wellbeing,⁴⁵³ including clinical assessments and considerations, risks and past experiences of trauma, and the underlying determinants of health including non-clinical factors affecting a person's mental health and wellbeing;
- the person's human rights, including their right to health;
- risks the person poses to the health and safety of themselves or others;⁴⁵⁴
- the least restrictive means of treatment, as a way of preserving the person's autonomy;⁴⁵⁵
- the person's personal and cultural values, beliefs and commitments;⁴⁵⁶
- the comparative effects of not providing compulsory treatment; and
- the views of other relevant persons.⁴⁵⁷

Compulsory treatment should only be authorised when a realistic account of prospective costs and benefits produces a 'relatively significant'

444 See, eg, Wayne Martin et al, *Essex Autonomy Project*; Essex: 2014. *Achieving CRPD Compliance: Is the Mental Capacity Act of England and Wales Compatible with the UN Convention on the Rights of Persons with Disabilities? If Not, What Next?* (Report, September 2014).

445 GAA (n 220) s 145(3)(a).

446 Ibid ss 4, 145(3)(a).

447 *Re A (Medical Treatment: Male Sterilisation)* [2000] 1 FCR 193 [2000]; Peter Bartlett, 'The Necessity Must be Convincingly Shown to Exist': Standards for Compulsory Treatment for Mental Disorder under the Mental Health Act 1983' (2011) *Medical Law Review* 19(4): 514, 542-3; see also *R (N) v M98* [2002] EWHC 1911 (Admin) [88]-[106]; *R (B) v SS* [2006] EXCA Civ 28 [62].

448 *Charter* (n 29) s 38; Katterl and Maylea (n 95) 63.

449 Chris Maylea et al, 'Consumers' experiences of rights-based mental health laws: Lessons from Victoria, Australia' (2021) 78 (September-October) *International Journal of Law and Psychiatry* 1, 6.

450 Sascha Callaghan and Christopher J Ryan, 'Rising to the human rights challenge in compulsory treatment – new approaches to mental health law in Australia' (2012) 46(7) *Australian & New Zealand Journal of Psychiatry* 611, 618.

451 John Dawson and George Szmukler, 'Fusion of mental health and incapacity legislation' (2006) 188 *British Journal of Psychiatry* 504, 504.

452 Mary Donnelly, 'Best Interests, Patient Participation and The Mental Capacity Act 2005' (2009) 17(1) *Medical Law Review* 1; Weller, Penelope, *New Law and Ethics in Mental Health Advance Directives: The Convention on the Rights of Persons with Disabilities and the Right to Choose* (Taylor & Francis Group, 2012) 33; Wayne Martin et al, *Essex Autonomy Project*; Essex: 2014. *Achieving CRPD Compliance: Is the Mental Capacity Act of England and Wales Compatible with the UN Convention on the Rights of Persons with Disabilities? If Not, What Next?* (Report, September 2014).

453 See *Re Marion* (No 2) (1992) 17 Fam LR 336 for a list of considerations relevant to an assessment of best interests vis-à-vis health treatments.

454 John Dawson and George Szmukler, 'Fusion of mental health and incapacity legislation' (2006) 188 *British Journal of Psychiatry* 504, 504.

455 George Szmukler and John Dawson, 'Reducing discrimination in mental health law – the 'fusion' of incapacity and mental health legislation Coercive Treatment' in Thomas W Kallert, Juan E Mezzich and John Monahan (eds) *Psychiatry: Clinical, Legal and Ethical Aspects* (John Wiley & Sons Ltd, 1st edition, 2011) 97, 111; see also PBU (n 46) [109]; *PJB v Melbourne Health and another* (2011) 39 VR 373 [18].

456 George Szmukler 'The UN Convention on the Rights of Persons with Disabilities: 'rights, will and preferences' in relation to mental health disabilities' (2017) *International Journal of Law and Psychiatry* (2017) 54 *International Journal of Law and Psychiatry* 90; George Szmukler and John Dawson, 'Reducing discrimination in mental health law – the 'fusion' of incapacity and mental health legislation Coercive Treatment' in Thomas W Kallert, Juan E Mezzich and John Monahan (eds) *Psychiatry: Clinical, Legal and Ethical Aspects* (John Wiley & Sons Ltd, 1st edition, 2011) 110.

457 Cf. George Szmukler and John Dawson, 'Reducing discrimination in mental health law – the 'fusion' of incapacity and mental health legislation Coercive Treatment' in Thomas W Kallert, Juan E Mezzich and John Monahan (eds) *Psychiatry: Clinical, Legal and Ethical Aspects* (John Wiley & Sons Ltd, 1st edition, 2011) 97, 110.

likelihood of overall benefit⁴⁵⁸ after the above matters have been properly considered. There may also be advantages to defining alternative levels to compulsory treatment in specific situations, such as for emergency treatment, for people who lack DMC and do not object, for serious interventions like electroconvulsive therapy and neurosurgery, and for forensic and secure patients.⁴⁵⁹

A fusion model

A unique benefit of a capacity-based compulsory treatment framework is that it can apply equally to situations beyond mental health and wellbeing, including disability and physical health settings. The benefits of such an approach were expressly recognised by the Royal Commission when it suggested alignment of substitute decision-making frameworks for both mental and physical health.⁴⁶⁰

By facilitating the compulsory treatment of persons with mental illness on an equal basis to others through a non-discriminating framework, a fusion model entirely eschews limitations on the right to equality.⁴⁶¹ Such an approach has already been taken in places like Northern Ireland,⁴⁶² suggesting that frameworks which do target mental health consumers may be strictly unnecessary and therefore disproportionate limitations on the rights of mental health consumers to equality and non-discrimination.

A participative approach

A participative approach with a focus on SDM and family-inclusive practice is also important. Individuals, along with their carers, family members and supporters, are best placed to evaluate competing priorities with respect to treatment decisions, in accordance with that individual's own beliefs and values. As such, a participative model is necessary to ensure the best decision is made for everyone. A participative approach also provides benefits for other rights, including the rights of children⁴⁶³ and the cultural rights of Indigenous peoples.⁴⁶⁴

Multidisciplinary decision-making

On the above analysis, a best-interests test must extend beyond clinical matters. Such an approach would be best facilitated through a multidisciplinary decision-making group with requisite expertise across a range of knowledges. This would ensure proper consideration is given to different interests and perspectives that extend beyond the professional scope of any one profession. Psychiatric expertise would be a critical component of such a group, complemented by other mental health and wellbeing, legal, lived experience and community expertise. Different approaches to multidisciplinary decision-making may be considered, including the use of dual authorisation and authorised mental health professionals in the UK.

6.4 Expanded decision-making obligations

Recommendation 6.4

Expand the decision-making obligations that apply to substitute decision-making.

Decision-maker obligations may be strengthened by expanding the decision-making principles. Currently, the MHW Act contains a set of decision-making principles that apply to substitute decision-making processes.⁴⁶⁵ The principles acknowledge the importance of autonomy,⁴⁶⁶ the potential harms of coercive practices⁴⁶⁷ and the need to balance the harm to be prevented by the use of coercive practices with the harm that may result from their use.⁴⁶⁸ Consideration should also be given to:

- the potential harm of overriding a person's preferences in other situations, such as when an advance statement is overridden;
- the risks of retraumatisation when a person is subjected to substitute decision-making processes;

458 *Re A (Medical Treatment: Male Sterilisation)* [2000] 1 FCR 193 [206].

459 George Szmukler and John Dawson, 'Reducing discrimination in mental health law – the 'fusion' of incapacity and mental health legislation Coercive Treatment' in Thomas W Kallert, Juan E Mezzich and John Monahan (eds) *Psychiatry: Clinical, Legal and Ethical Aspects* (John Wiley & Sons Ltd, 1st edition, 2011) 97, 107.

460 *Royal Commission Final Report* (n 4) vol 4, 430.

461 See, eg, George Szmukler and John Dawson, 'Reducing discrimination in mental health law – the 'fusion' of incapacity and mental health legislation Coercive Treatment' in Thomas W Kallert, Juan E Mezzich and John Monahan (eds) *Psychiatry: Clinical, Legal and Ethical Aspects* (John Wiley & Sons Ltd, 1st edition, 2011).

462 *Mental Capacity Act (Northern Ireland) 2016* (NI).

463 Jane Kotzmann et al, 'A human rights-based approach to compulsory treatment of young people experiencing mental disorder' (2018) 24(1) *Australian Journal of Human Rights* 20.

464 See, eg, Te Puni Kōkiri, *Understanding whānau centred approaches: Analysis of Phase One Whānau Ora research and monitoring results* (Report, 2015) 17.

465 MHW Act (n 85) pt 3.1.

466 *Ibid* s 83.

467 *Ibid* s 80.

468 *Ibid* s 82.

- the presumption that all persons have the potential to recover;
- the preferability of treatments and interventions that reflect a person's will and preferences;
- factors that may influence a 'balance of harms' assessment, including:
 - the nature and seriousness of the harm sought to be prevented;
 - the likelihood that the harm will be prevented;
 - the extent to which the harm is likely to be prevented;
 - the nature and seriousness of the harm that may result;
 - the likelihood that the harm will result;
 - the extent to which the harm is likely to result;
 - attributes of the person may impact their experience of substitute decision-making, including age, disability, culture, and trauma history.

Additionally, decision-maker obligations may be imposed at defined junctures when SDM is critical, such as during an episode of compulsory treatment, or upon the overriding of an advance statement.

6.5 Legal representation at the Mental Health Tribunal

Recommendation 6.5

Drastically increase legal aid funding to ensure that every consumer seeking legal representation at the Mental Health Tribunal is able to access it.

Legal aid funding requires a drastic increase to ensure that every consumer seeking legal representation at the Mental Health Tribunal (the Tribunal) is able to access it. Indeed, the Royal Commission explicitly recommended increased access to legal representation for consumers who appear before the Tribunal.⁴⁶⁹

Although Victorian consumers are legally entitled to legal representation when appearing before the Tribunal,⁴⁷⁰ legal representation rates are extraordinarily low: in 2018–19, only 13% of consumers had representation at the Tribunal.⁴⁷¹ In contrast, 83% of consumers in NSW had representation in the same time period.⁴⁷² The Royal Commission recognised funding limitations as a 'major reason' behind Victoria's low representation rate.⁴⁷³

A lack of legal representation can compromise a number of rights. Analysis from the Royal Commission showed that a lack of legal representation was associated with increases in Treatment Orders and their durations,⁴⁷⁴ and therefore all the human rights limitations engendered by compulsory treatment. Deficits in legal representation also directly compromise the right to a fair hearing which requires tribunals to act impartially,⁴⁷⁵ which may be compromised where one party lacks access to legal support.

Conversely, legal representation provides a key support in a consumer's ability to exercise their autonomy and legal capacity,⁴⁷⁶ a core component of the right to recognition as a person before the law.⁴⁷⁷ Legal representation is also important to improve transparency and accountability in Tribunal activities and decisions, and to ensure consumers are supported to participate in decision-making,⁴⁷⁸ which in turn advance and promote a number of human rights.⁴⁷⁹

⁴⁶⁹ *Royal Commission Final Report* (n 4) vol 4, 362, Recommendation 56(3).

⁴⁷⁰ *MHWA* (n 85) s 365(3).

⁴⁷¹ Mental Health Tribunal (Vic), *Annual Report 2018–19* (Annual Report 2019) 27, Table 30.

⁴⁷² Mental Health Review Tribunal (NSW), *Annual Report 2018–19* (Annual Report, 2019) 25.

⁴⁷³ *Royal Commission Final Report* (n 4) vol 4, 397.

⁴⁷⁴ *Ibid* 398.

⁴⁷⁵ *ICCPR* (n 30) art 14(1).

⁴⁷⁶ *GCI* (n 50) 10; *Royal Commission Final Report* (n 4) vol 4, 398; Aisha Macgregor, Michael Brown, and Jill Stavert, 'Are Mental Health Tribunals Operating in Accordance with International Human Rights Standards? A Systematic Review of the International Literature' (2019) 27(4) *Health and Social Care in the Community* e494, e509.

⁴⁷⁷ *GCI* (n 50) 8.

⁴⁷⁸ *Royal Commission Final Report* (n 4) vol 4, 398.

⁴⁷⁹ See Part 5.

6.6 Reducing restrictive practices

Recommendation 6.6

Draw on Australian and international models to develop a continuous and rigorous multi-pronged approach to achieve the Royal Commission's vision of eliminating seclusion and restraint, including an evaluation of efforts in 10 years' time.

A continuous and rigorous multi-pronged approach to reducing restrictive practices is required to achieve the Royal Commission's vision of eliminating seclusion and restraint. Considering the significant risks to human rights engendered by the use of restrictive practices, and the Royal Commission's explicit aim for their elimination, this goal requires little further justification. Adequate funding and sustained commitment will be crucial factors in ensuring and maintaining a trajectory towards elimination.

Numerous Australian and international models should be drawn upon to reduce the use and duration of coercive practices.⁴⁸⁰ *Safewards*, for which an effective trial has already been run in Victoria,⁴⁸¹ provides a useful starting point, as does the work of the Victorian Senior Practitioner vis-a-vis the use of restrictive practices in disability settings.⁴⁸² While each approach has value, none represent a comprehensive catalogue of tools and so a combination of approaches is required.

A multipronged approach should address matters of:

- leadership;
- consumer participation;
- workforce supports including training and practice tools;
- internal policy and procedure reviews;
- clinical and prescribing guidelines;
- adequate staff-to-patient ratios;
- supports for consumers including activities;
- advance planning and behaviour support plans;
- debriefing techniques;
- environmental and design factors;
- culture change efforts;
- data usage;
- governance and oversight including meaningful handling of complaints;
- evaluation within a continuous improvement model; and
- broader system reform.

Such an approach should also incorporate a 10-year review to evaluate the success of efforts to achieve the Royal Commission's vision of elimination. This review should also consider the need to address other forms of restraint not expressly addressed in the MHW, such as psychological or environmental restraint.

480 For a review of strategies, see Piers Gooding et al, *Alternatives to Coercion in Mental Health Settings: A Literature Review* (Report, 2018).

481 Justine Fletcher et al, 'Outcomes of the Victorian Safewards Trial in 13 Wards: Impact on Seclusion Rates and Fidelity Measurement' (2017) 26(5) *International Journal of Mental Health Nursing* 461.

482 Department of Families, Fairness and Housing (Vic), *Victorian Senior Practitioner report 2019–20* (Report, March 2021).



Part 7: Data sovereignty

Data sovereignty refers to the ways in which people or peoples can, or should have control over their own information.⁴⁸³ This concept heralds significant potential to advance and promote human rights in the mental health and wellbeing system by clearly identifying the ‘owner’ of a consumer’s data as the consumer themselves. That is, taking a rights-based approach to data sovereignty requires maintaining a focus on a person’s consent for the collection, use or sharing of information.

The application of data sovereignty to the mental health and wellbeing system is complex. The collection, use and sharing of information affects human rights in a range of ways, with divergent effects on the rights to health and privacy. On the one hand, restrictions on the collection, use and sharing of information often protect consumer rights to privacy while also supporting the right to health insofar as it protects autonomy. On the other hand, restrictions may at times pose risks for the consumer’s right to health, and the rights of carers, family members and supporters to privacy and family, as well as, in rare cases, their safety. Furthermore, when a consumer lacks DMC to provide the relevant consent, questions arise as to the appropriate process for decision-making.

Information arrangements are essential to support the right to health in particular. The Royal Commission recognised the necessity for service providers to have access to ‘appropriate, timely and accurate’ information to understand consumer needs, experiences and preferences, and to thereby provide suitable services.⁴⁸⁴

Where such information is not readily available, consumers may be forced to retell their stories which can be retraumatising. Information-sharing is sometimes also necessary to support the collaboration required for seamless transitional care between services, and for the good governance and accountability required to ensure service quality and safety.⁴⁸⁵ However, information-sharing also poses challenges for

the right to health, particularly in the context of the stigma that surrounds mental illness.⁴⁸⁶

The right to privacy directly protects personal information.⁴⁸⁷ Provisions which allow for the collection, use and sharing of information without a person’s consent therefore constitute direct limitations on the right to privacy. The complexity of laws also bears on the right to privacy insofar as it results in inconsistent and unpredictable, and therefore arbitrary, applications of legal requirements. Indeed, the Royal Commission recognised the complexity of information-sharing arrangements as a key barrier for their consistent implementation.⁴⁸⁸

Data sovereignty is essential to cultural rights. Communal ownership of data and data analytics is crucial to informing system and program design and development so that communities are able to access models of care that are culturally appropriate due to their basis in culturally specific data. Further work is required to identify suitable mechanisms to facilitate data sovereignty on a communal scale, especially for Aboriginal communities.

Information collection, use and sharing provisions under the MHLA also limit the right to equality insofar as they provide lesser protections for consumers than relevant comparators. Both the *Health Records Act 2001*⁴⁸⁹ and the *Privacy and Data Protection Act 2014*⁴⁹⁰ already provide principles that govern matters of data sovereignty broadly. The differential treatment of consumers under the MHLA therefore requires careful justification.

The rights of carers, family members and supporters are also affected by information arrangements. Sometimes, their own right to health may be affected,⁴⁹¹ especially when the burden of communication falls to them, or in rare cases where safety issues arise. Most commonly, it is their right to privacy which will be affected, as this guards against interferences with the family as a fundamental attribute of

483 Patrik Hummel et al, ‘Data sovereignty: A review’ (2021) 8(1) *Big Data & Society* 1.

484 *Royal Commission Final Report* (n 4) vol 5, 69.

485 *Ibid.*

486 *Ibid* 70.

487 UN Human Rights Committee, *General Comment 16: Article 17 (Right to privacy)*, 32nd session, UN Doc CCPR/GEC/6624/E (8 April 1988) [10].

488 *Royal Commission Final Report* (n 4) vol 3, 100.

489 *Health Records Act 2001* (Vic) sch 1.

490 *Privacy and Data Protection Act 2014* (Vic) sch 1.

491 *Royal Commission Final Report* (n 4) vol 5, 75.

7.1 Rights-based disclosure permissions

a person's private life.⁴⁹² However, while the right to privacy may protect a person's right to their family member's health information, this right cannot take precedence over an individual's right to protection of their own health information which constitutes a more direct manifestation of the right to privacy.

To begin with, then, specific efforts may be made to amend the mental health privacy principles to vest them with human rights principles and align them with privacy principles that apply in other contexts. To strengthen a consumer's control over their own data, access to one's personal information should be made easier, while decision-maker obligations to share information should be limited to situations where the consumer consents. Finally, practical implementation efforts will be crucial to ensure that services and workers have the capacity to collect, use and share information in accordance with legal requirements, consumer wishes and established protocols.

Recommendation 7.1

Ensure permissions for non-consensual disclosure align with human rights obligations and principles, including through improved specificity, inclusion of reasonableness and necessity qualifiers, and the incorporation of consent and decision-making capacity considerations.

The MHWa's privacy principles should align with human rights obligations and principles. To achieve this, three things are required: principles should be sufficiently precise, and have reasonableness and necessity qualifiers embedded into them, along with considerations of DMC and consent.

Firstly, international law requires legislation to specify the 'precise circumstances' in which interferences with privacy may be permitted.⁴⁹³ In the absence of such precision, there is a risk that disclosures will be permitted too broadly to ensure fidelity to human rights principles, including proportionality and consistency. Some of the mental health privacy principles, however, are expressed in overly broad terms, permitting disclosures to specified persons without limitations as to the circumstances in which, or purposes for which, such disclosures are allowed.⁴⁹⁴ Without greater specificity, mental health privacy principles will continue to be implemented poorly and inconsistently, raising associated risks for human rights.

In particular, the MHWa allows for health information to be disclosed in 'general terms' to a friend, family member or carer.⁴⁹⁵ 'General terms' are not defined, as was the case under the MHA.⁴⁹⁶ However, the Royal Commission found that general information has not been uniformly provided by workers,⁴⁹⁷ and concluded that the MHA's provision was not well understood.⁴⁹⁸ To be consistent with international law, a definition of 'general terms' is therefore required in legislation and/or in statutory guidelines, drawing on existing jurisprudence around general information and applying it to the context of

⁴⁹² Charter (n 29) s 13(a); *Director of Housing v Sudi* [2011] VSCA 266 [29].

⁴⁹³ UN Human Rights Committee, *General Comment 16: Article 17 (Right to privacy)*, 32nd session, UN Doc CCPR/GEC/6624/E (8 April 1988) [8].

⁴⁹⁴ MHWa (n 85) ss 730(2)(f), (h), (i).

⁴⁹⁵ *Ibid* s 730(2)(f).

⁴⁹⁶ MHA (n 222) s 346(2)(g).

⁴⁹⁷ *Royal Commission Final Report* (n 4) vol 3, 100.

⁴⁹⁸ *Ibid* vol 3, 101.

mental health and wellbeing service delivery.

Secondly, disclosures should only be permitted when they are reasonable or necessary to achieve their stated purpose. Disclosures that are unreasonable or unnecessary are arbitrary in nature, and therefore directly offend the right to privacy.⁴⁹⁹ Particularly where information is to be shared with a public authority, international law only permits the sharing of private information that is 'essential in the interests of society'.⁵⁰⁰ The MHWa does not uniformly impose reasonableness and necessity qualifiers for all the mental health principles.⁵⁰¹ As a result, disclosures may be permitted in cases regardless of whether they are reasonable or necessary to achieve the stated purpose. Restricting permissible disclosures to cases where it is reasonable and necessary would ensure decision-making is undertaken with greater respect for the privacy of consumers and human rights principles more broadly.

Thirdly, the concept of consent, and the associated respect for the autonomy of capacitous persons, should be embedded into the mental health privacy principles. The MHWa permits disclosure of information when consent is provided,⁵⁰² but otherwise lists 18 permissions for disclosure with no further mention of consent.⁵⁰³ These permissions do not vary according to the reason for non-consent, so the same approach can be taken for a person who capaciously refuses to give consent as for a person who lacks the capacity to consent. Conversely, multiple Health Privacy Principles limit permissible disclosures to where a person provides consent or does not have the DMC to do so.⁵⁰⁴ Such considerations should be imported into the mental health privacy principles wherever relevant.

7.2 Alignment with Health Privacy Principles

Recommendation 7.2

Align mental health and wellbeing privacy laws with the Health Privacy Principles in the *Health Records Act* insofar as is possible, with consideration of direct application subject to limited exceptions.

Wherever possible, mental health and wellbeing privacy laws should align with the Health Privacy Principles that apply to physical health settings. Ideally, information arrangements will be based on the Health Privacy Principles with the MHWa providing a reduced set of principles which act as exceptions to these general rules. This would support the Royal Commission's vision for simplified information-sharing provisions as an essential part of legislative reform.⁵⁰⁵ It would also minimise limitations on the right to equality engendered in the maintenance of different legal frameworks governing the physical health, and mental health and wellbeing, systems, while support the implementation of privacy principles by services that provide both physical health and mental health and wellbeing services.

While complete alignment may not be possible or desirable, improvements are indeed possible. Many of the circumstances in which information-sharing is permitted under the MHWa find easy justification in the Health Privacy Principles.⁵⁰⁶ Even where some deviance from the Health Privacy Principles is required for mental health consumers, this would be best allowed through exceptions to otherwise equal treatment under the law, rather than the current legislative scheme under which unequal treatment is the rule rather than the exception.

499 *PJB v Melbourne Health and another* (2011) 39 VR 373 [80]–[81] referring to UN Human Rights Committee, *General Comment 16: Article 17 (Right to privacy)*, 32nd session, UN Doc CCPR/GEC/6624/E (8 April 1988) [4] and *Toonen v Australia* (1994) 69 ALJ 600, [8.3].

500 UN Human Rights Committee, *General Comment 16: Article 17 (Right to privacy)*, 32nd session, UN Doc CCPR/GEC/6624/E (8 April 1988) [7].

501 *MHWa* (n 85) ss 730(2)(b), (e), (f), (h), (i), (j), (k), (l), (m), (r).

502 *Ibid* s 729.

503 *Ibid* s 730(2).

504 *Health Records Act 2001* (Vic), sch 1, s 2, principle 2.2.

505 *Royal Commission Final Report* (n 4) vol 3, 101.

506 See, eg, *Health Records Act 2001* (Vic) sch 1, s 2, principles 2.1, 2.2(b), (c), (e); cf. *MHWa* (n 85) ss 729, 730(2)(a), (d), (e).

7.3 Open but protected access to information

Recommendation 7.3

Draw on Recommendation 62 of the Royal Commission and relevant work in other jurisdictions to ensure consumers have open access to their files, incorporating:

- allowances for the unilateral addition and collaborative amendment of information;
- a dynamic consent model allowing for the provision, variation and withdrawal of consent for relevant matters; and
- limited exceptions for consumer access where a person's health, safety or confidentiality may be compromised.

Mental health consumers should have open access to their files. It should be noted that only consumers should have 'open' access to their files, with continued limitations for access for workers and services, reflecting the Royal Commission's approved principle of 'open and presumed but protected access'.⁵⁰⁷

Open access would directly support the right to privacy by ensuring consumers have control, or 'sovereignty', over their own information. It would also help consumers to exercise medical decision-making autonomy,⁵⁰⁸ thereby supporting the rights to health and recognition as a person before the law, and further buttressing the right to privacy, all of which incorporate autonomy as a core value. Such an approach has already been implemented in some Victorian services and is standard practice in other jurisdictions, including the UK.⁵⁰⁹

Currently, many consumers are obliged to request access to their files through provisions under the *Freedom of Information Act 1982* which involves an onerous process ill-suited for consumer needs.⁵¹⁰ Instead, the Royal Commission's recommendation for the development of a modern interactive digital

interface⁵¹¹ should be used to facilitate open access as well as dynamic consent. The latter is an approach whereby people can make granular and timely decisions to provide, withdraw or vary consent,⁵¹² further supporting consumers to exercise their rights to privacy and medical decision-making autonomy.

There may, however, be some ways in which open access systems may compromise human rights. The implementation of open but protected access for consumers should therefore be made subject to limited exceptions, and monitored to identify and respond to any perverse outcomes. Some potential exceptions are explored below.

Firstly, where a carer provides confidential information to a worker, a consumer's access to such would compromise the carer's right to privacy. Secondly, where a consumer's access to information poses a risk to the health and safety of themselves or others, restrictions may be appropriate. This should also be addressed through training and education, and other workforce supports, to ensure workers record information safely and appropriately.⁵¹³

Finally, open but protected access systems may present risks to the quality of data used to deliver health services, thereby compromising the right to health. This may occur where consumers delete information required by workers, or where workers resort to the maintenance of separate information systems to avoid consumers accessing their notes. Victoria should draw on other jurisdictions who have implemented similar systems to address these issues in practice.

The development of an open but protected system of data access should therefore draw on both the Royal Commission's recommendations and the experiences of international jurisdictions. It should aim to allow consumers to access and add information to their files with minimal restrictions considered for matters of health, safety and confidentiality. Consumers should also be able to amend or delete information in collaboration with workers, and provide, vary or withdraw their consent for various matters, including treatment decisions and information-sharing arrangements, whenever they choose.

⁵⁰⁷ Royal Commission Final Report (n 4) vol 5, 97.

⁵⁰⁸ Ibid 67.

⁵⁰⁹ Mental Health Victoria, *Mental Health and Wellbeing Act Update and Engagement Paper: Mental Health Victoria's response to key topics* (Submission, July 2021) 10.

⁵¹⁰ Royal Commission Final Report (n 4) vol 5, 77–9.

⁵¹¹ Ibid 66, Recommendation 62.

⁵¹² Megan Pricot et al, 'Dynamic Consent: An Evaluation and Reporting Framework' (2020) 15(3) *Journal of Empirical Research on Human Research Ethics* 175.

⁵¹³ See Part 7.5.

7.4 Information-sharing duties

Recommendation 7.4

Conduct further consultation to refine the legislative duty to provide specified information at defined points to carers, families and supporters of consumers, with the consumer's consent.

Legislative duties to share certain information with carers, family members and supporters, with the consumer's consent, at defined points of care⁵¹⁴ require further consultation and refinement. The MHWA established these duties following a consultation which did not propose specific points of care to which the duty applies. As a result, the current provisions are based on limited public consultation. Considering the complexity of the issue, and the imperative of seeking a broad range of lived experience perspectives to strike the best legislative balance, further consultation and refinement is required.

The general imposition of these duties aligns with a rights-based approach by requiring the sharing of information which supports a person's care and recovery. At the same time, requiring a consumer's consent for information-sharing maintains appropriate protections for the right to privacy. It is also likely to encourage a change in culture to support a greater focus on seeking and following a consumer's consent when it comes to matters of information-sharing.

However, permissions requiring information-sharing with consent should not be defined overly narrowly. The MHWA already contains enumerated exceptions where a service may withhold information despite having the consumer's consent to share it.⁵¹⁵ Otherwise, requirements to share information consensually should be provided broadly in accordance with the right to privacy and the principles of data sovereignty. Further consideration should be given to the types of information that can be shared, persons with whom sharing may occur, and the purposes for and points at which information-sharing is required. Such details should be determined upon further consultation with the sector.

7.5 Practical implementation supports

Recommendation 7.5

Expand practical implementation supports, including training and education programs, and resources to support practice and culture change, for services and workers to interpret information laws and develop and consolidate rights-based practices.

Practical implementation supports will be a crucial lever in the development of rights-based cultures around the collection, sharing and usage of information. The Royal Commission acknowledged that there is currently insufficient guidance available to support workers,⁵¹⁶ with the complexity of laws adding to the difficulty.⁵¹⁷ Providing training and education programs, and practical resources, for all relevant workers, including within and beyond the mental health and wellbeing system, is therefore required to turn legal and human rights into on-the-ground realities. Funding for ACCOs and other community organisations may be required to develop supports and resources appropriate for diverse communities.

The development of new principles, duties and processes risks adding to an already complex framework. To the extent that overly complex legislation impedes the consistent and predictable application of laws when interpreted and applied by different services and workers, the application of information-sharing laws may result in unpredictable, and therefore arbitrary, outcomes. Practical implementation supports are therefore important tools to reduce this complexity, ensuring services and workers interpret laws and implement rights-based practices in ways that are consistent with each other, while also adapted to unique contexts.

Training and education programs should cover:

- the concept of data sovereignty and its application to the mental health and wellbeing system;
- the need to strike a proportionate balance between competing human rights;

⁵¹⁴ MHWA (n 85) s 731.

⁵¹⁵ Ibid s 732.

⁵¹⁶ Royal Commission Final Report (n 4) vol 3, 100; see also Annegret Kampf and Bernadette McSherry, 'Confidentiality in Therapeutic Relationships: The Need to Develop Comprehensive Guidelines for Mental Health Professionals' (2006) 13(1) *Psychiatry, Psychology and Law* 124, 125.

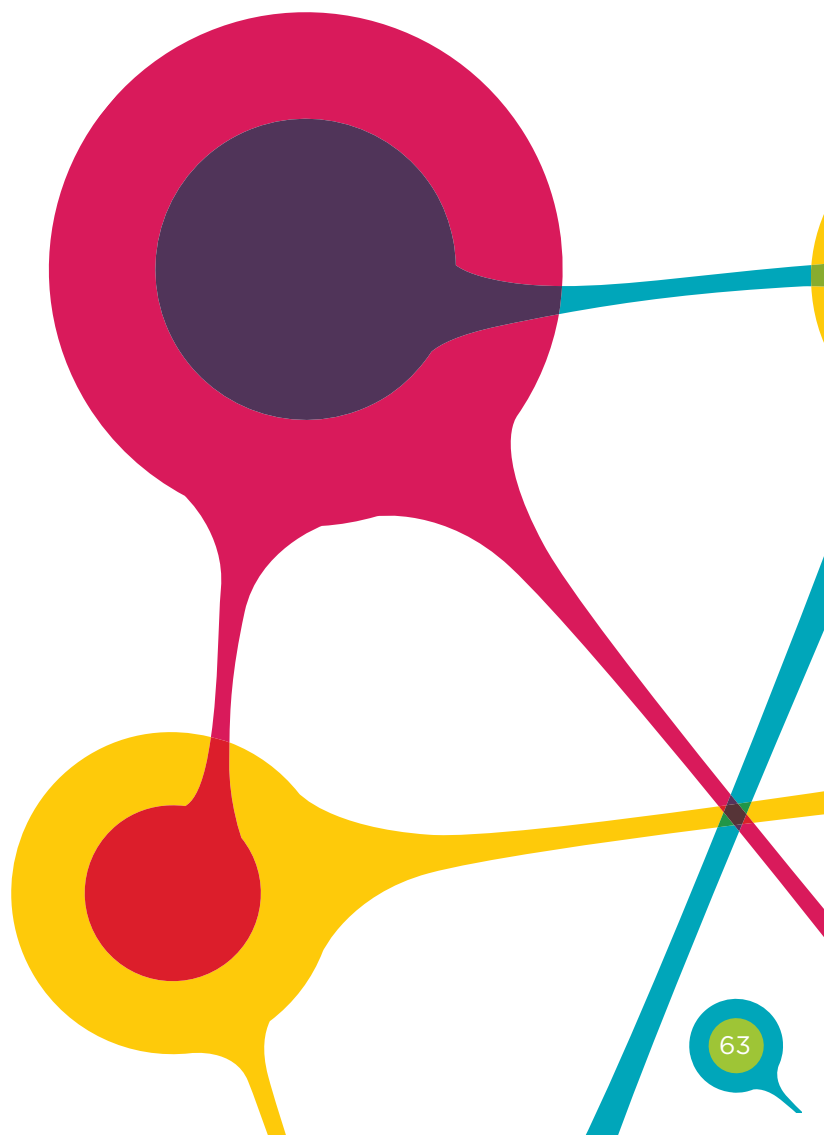
⁵¹⁷ Royal Commission Final Report (n 4) vol 3, 100; see also Bernadette McSherry, 'Health Professional-Patient Confidentiality: Does the Law Really Matter?' (2008) 15 *Journal of Law and Medicine* 489, 493.

- the risks and benefits of information collection, usage and sharing, including the risks and benefits of utilising and refraining from utilising information processes;
- the application of general, mental health-specific and human rights-related laws to different cases and contexts in order to determine what, why, when and with whom information can and must be shared;
- best-practice approaches to information management, including minimum datasets;
- how to facilitate consumer involvement through co-authoring approaches whereby information management processes are designed and implemented collaboratively;
- legal and ethical requirements, and practical opportunities, regarding the sourcing of consent, including the use of interactive digital interfaces to facilitate dynamic consent approaches;
- how to involve carers, family members and supporters, both vis-à-vis eliciting and disclosing relevant information;
- how to ensure consumers, carers, family members and supporters are provided with clear explanations of data management protocols, and provided with suitable opportunities for further discussion and negotiation;

- making decisions about which carers, family members and supporters to involve, taking account of formalised and informal support relationships, and excluded persons; and
- practical tips for developing internal data governance frameworks in partnership with consumers, including the role of a data custodian, and how to standardise, implement, and monitor data collection, usage and sharing protocols across an organisation.

Training and education programs should be supported with the development of resources for organisational practice and culture change. These may include statutory and clinical guidelines, co-authoring resources and data governance framework templates. Where relevant resources already exist, they should be reviewed in light of legislative changes and observed deficits in practice. Additional advice should be provided to services to support internal efforts at implementation and culture change.⁵¹⁸

⁵¹⁸ See Part 2.1.





Conclusion

Historically, mental health systems have been dominated by the value of beneficence. Safeguarding the human rights of consumers, however, requires a system that can balance the value of beneficence with the equal value of autonomy. The State of Victoria currently has the unique opportunity to recalibrate its mental health and wellbeing laws, cultures and practice to achieve just this.

Ensuring all functions of Victoria's mental health and wellbeing system operate with respect for the treatment decisions of persons found to have decision-making capacity on treatment matters is essential to creating a rights-based mental health system. Doing so would protect the autonomy of consumers who have the capacity to exercise it. To achieve this in practice, reforms are required across a range of areas, including vis-à-vis decision-making laws, coercive practices and information collection, usage and disclosure arrangements.

However, there are issues with this approach. Decision-making capacity assessments may not always properly distinguish between people whose decisions represent legitimate expressions of their will and preferences, and those whose decisions may be impugned by disturbances in mental processes. Furthermore, even when a person's autonomy is impugned, immediate resort to substitute decision-making is problematic. If progress is the realisation of Utopias, protecting the autonomy of capacitous consumers should be properly seen as merely the first step towards a rights-based system, not an end goal.

Creating a rights-based mental health and wellbeing system therefore also depends on continuous reorientation of the system towards human rights-based approaches. This requires embedding human rights principles into all decision-making processes to ensure that risks and limitations to human rights are always visible, even as they evolve following the implementation of reforms. It also requires embedding human rights principles across all parts of the system, from governance and

oversight, to legislative underpinnings, through to lived experience participation, workforce development, culture change and developments in service delivery and intersectoral integration.

Crucially, practical implementation supports are required across all of these areas to ensure that reforms to law and policy translate into practice and culture. This requires a dedicated implementation initiative to educate and train workers on legal and human rights obligations, to support culture and organisational change, and to identify ongoing implementation needs.

Finally, the development, implementation and monitoring of successive strategies to create a rights-based mental health system is essential. The Royal Commission has laid out an ambitious framework for reform, and this paper lays out 40 practical next steps that support the Royal Commission's vision. However, these reforms can only lay the groundwork for a rights-based system; they cannot alone create it. Only continuous and rigorous effort and attention will keep us focussed on the journey ahead. For now, the way forward is clear.

'Human rights are more than noble ideas. They have the power to change lives.'

— Dr Tedros Adhanom Ghebreyesus
Director-General, World Health Organization⁵¹⁹

⁵¹⁹ Lawrence O Gostin and Benjamin Mason Meier, *Foundations of Global Health and Human Rights* (Oxford University Press, 2020).

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MentalHealth Victoria

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