WITNESS STATEMENT OF DR CHRISTOPHER MAYLEA

I, Dr Christopher Maylea, Senior Lecturer at RMIT University, of 124 Latrobe Street, Melbourne, say as follows:

Professional background

1 I am a Senior Lecturer in Social Work at RMIT University in Melbourne. I have been an employee of RMIT University for seven years. My particular areas of research are in the intersections of health, welfare and the law, which a focus on mental health law, mental health social work, involuntary mental health and program management and evaluation. My past research projects have included mental health law and supported decision-making, legal and non-legal advocacy in involuntary mental health, gendered violence in mental health inpatient units and advance statements. I hold a Doctorate in Social Work, a Juris Doctor, a Masters of Human Services Management and Policy, a Bachelor of Social Work (Honours), a Graduate Diploma in Legal Practice and an Advanced Diploma of Community Sector Management.

2 In addition to being a Senior Lecturer and academic, I am also a qualified lawyer providing pro bono legal services through the Mental Health Legal Centre. I have appeared on behalf of clients in the Mental Health Tribunal, including in relation to applications for compulsory treatment orders.

3 I am also Chair of the Committee of Management of the Victorian Mental Illness Awareness Council (**VMIAC**), serving as a member of that Committee since October 2018. I have also served as Chair of the VMIAC Human Rights Subcommittee. VMIAC is the peak Victorian organisation for people with a lived experience of mental health problems or emotional distress. We are an advocacy organisation run by consumers, for consumers. Our vision is for a world where all mental health consumers stand proud, live a life with choices honoured, rights upheld and these principles are embedded in all aspects of society.

4 Between 2012 and 2014, I was an advisory committee member at the Mental Health Commission of New South Wales. I have also had experience managing mental health services at On Track Community Programs from 2011 to 2013. Prior to this, I was a social worker in New South Wales.

5 I have used and continue to use mental health services but do not have a lived experience of being involuntarily treated. I do not base my evidence on my own lived experience.

5 I am giving this statement to the Royal Commission in both my personal capacity and as a representative as the Chair of VMIAC. Where I give evidence in my capacity as the Chair of VMIAC, I have authorisation to do so, drawing on VMIAC's work in consulting with people who have experienced compulsory treatment and advocating for human rights. Specifically, our recent unpublished work consulting on human rights for the Department of Health and Human Services and the 'Declaration' project.[1]

Definition of compulsory treatment

6 I consider the concept of compulsory treatment and the people impacted by it broadly. In my view, it includes:

(a) the use of seclusion and bodily restraint under the *Mental Health Act 2014* (Vic) (the **Act**);

(b) chemical restraint administered by mental health services without the person's consent;

(c) the making of treatment orders under the Act (including both Community Treatment Orders and Inpatient Treatment Orders);

(d) consumers/survivors of mental health services feeling 'threatened' or 'apprehensive' about the possibility of seclusion, restraint and treatment orders being imposed on them; and

(e) any witnessing of a person being subject to compulsory treatment (for example, witnessing a co-patient being restrained or secluded).

7 Where I discuss compulsory treatment in this statement, I am referring to this broader consideration as expressed in the paragraph above.

QUESTIONS FOR PANEL MEMBERS

Question 1: How and why does the approach to compulsory treatment in mental healthcare, differ to other areas of healthcare where greater agency is provided to individuals?

8 Compulsory treatment is significantly different to other areas of healthcare in relation to an individual's agency in the following ways:

(a) There is no other part of the healthcare system where people are regularly not provided the right to consent to aspects of their health care and where treatment is imposed on them irrespective of their wishes and autonomy to choose. Compulsory treatment represents the only context in terms of healthcare where

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[1] https://www.vmiac.org.au/declaration/

a person’s individual agency is removed as a matter of course. This lack of individual agency and compulsory treatment being imposed upon a person can lead to the institutionalisation of people and disallows them the opportunity to make mistakes and learn from these mistakes which ultimately builds a person’s resilience and capacity.

(b) People receiving compulsory treatment are fundamentally discriminated against based on having a diagnosis of mental illness. This is because a person with a diagnosis of mental illness may pose the same risks to themselves or the community as a person who does not have a diagnosis of mental illness, however the outcome for a person with the diagnosis may be being placed on a treatment order. Based on the compulsory treatment regime, a person with a diagnosis of mental illness is always discriminated against, and treated differently, to a person who does not have a diagnosis of mental illness. This discrimination is a breach of human rights.

(c) Other areas of health are not as impacted by stigma and discrimination in the way that mental health is. The conceptualisation of mental health as a medical issue has contributed to this issue and is prevalent throughout the system. This issue needs to be addressed not only in mental health services, but also in insurance companies, the legal system (particularly the Coroner’s Court), the media and other linked systems. Public misconceptions about mental distress and risk feed through government which prevents meaningful reform away from risk management.

(d) There are few aspects of healthcare where risk is the fundamental starting point in terms of the type of treatment that is offered. The legal test around the making of compulsory treatment orders under the Act is in relation to a person’s risk of harm to themselves or others. This is essentially a subjective test with little consistency in its application and promotes a myth in the community that people with mental health issues are ‘riskier’ and more likely to self-harm or harm others than ‘general members’ of the community who do not have a mental health issue. Further, empirically we know that the majority of risk assessments of people with mental health issues often do not in fact assess risk in any meaningful way.

Question 2: From your perspective, in what ways, if any, does compulsory treatment provide benefit to:

a. ***people living with mental illness, including children and young people***

b. ***family and carers***

c. ***the community***

d. ***diverting demand for more acute mental health services, such as admission to an acute mental health inpatient unit?***

9 There is no evidence that compulsory treatment provides overall benefit to people subject to compulsory treatment or communities, including children and young people. In fact, in my view the application of compulsory treatment, particularly in the community, does not 'work' particularly when its consequence is the degradation of a therapeutic relationship between a person with a diagnosis of mental illness and their clinician or worker. This is not to say that compulsory treatment has not been of benefit to some people requiring mental health services. For those people, I consider it is essential that they be provided the choice of participating in compulsory treatment should their mental health decline. However, this ought to be based on a person's right to choose their form of treatment and being provided with supported decision making and information and education about the forms of treatment available.

10 The only benefit in respect of compulsory treatment is that currently it is the sole way that people can access the best quality and free mental health treatment and services in Victoria. In an inpatient setting, the best service according to clinical definitions of mental health provision is probably Thomas Embling Hospital, which usually requires a person to have committed a serious crime. Similarly, in order to get clinically assessed and be provided what is currently considered clinical 'best practice' treatment and care in the community, a compulsory treatment order is required. However, there are obvious alternatives to compulsory treatment required, which would involve investment into Victoria's mental health services (particularly in community mental health services) and a re-focus on general themes of recovery-based treatment, early intervention and support, choice and the increased availability of peer work services and workers. Further, improvements in State funding for services such as housing and other forms of inequality for all people, not just those in mental distress, would decrease the perceived need for compulsory treatment and discrimination in the provision of mental health services.

Question 3: Are there other alternative methods to compulsory treatment to engage people in treatment? If so:

a. what are they?

b. what factors needs to be present in an individual for these methods to work?

c. what features or circumstances need to be present at a systemic level for these methods to work?

d. to what extent could these methods be replicated or used more widely in Victoria?

11 I consider there are effective alternatives to compulsory treatment that could be implemented in Victoria. As discussed at paragraph 10 above, compulsory treatment is being relied on in Victoria to ensure that a person receives the best and free mental health services available in Victoria, either in an inpatient or community setting. This has the impact that people who want to engage voluntarily with mental health services are often not provided with any, or sufficient, mental health services. This is a symptom of the substantial underfunding of the mental health sector in Victoria.

12 Practical alternatives to compulsory treatment include the increase in the workforce and funding of mental health nursing staff and peer run services and workers to encourage people to feel supported. I have discussed this in at paragraphs 94 to 97 below.

13 Having warm, approachable and safe expanded and well-resourced voluntary services such as Prevention and Recovery Care Centres (PARC) that individuals in mental distress or crisis can approach directly for supportive both clinical and non-clinical peer worker care (without forced medication). People must be able to refer themselves directly instead of having to go through the hospital system, a system where many may have experienced trauma and therefore be reluctant to approach.

14 The other practical implication on recovery-based treatment for people requiring mental health services is to assist them in being safe and secure in their lives. For example, this includes people being provide secure housing, adequate food, adequate physical health care services and adequate treatment for alcohol or drug issues. Without these factors present in a person's life, it will be difficult for a person to be in a position to take 'ownership' of their mental health treatment and to be supported to make decisions about their healthcare. Broader social determinants, such as poverty, family violence, discrimination, colonialisation and racism must also be addressed.

Question 4: In Victoria, the Mental Health Act 2014 (Vic) states that the compulsory treatment is to be used to provide immediate treatment to prevent a serious deterioration

in the person's mental or physical health or to prevent serious harm to the person or to another person.

a. Are there other factors that influence how clinicians may seek to use compulsory treatment? Please consider the impacts, if any, of resource constraints within the current mental health system.

15 In my view, the factors of 'serious deterioration in a person's mental or physical health' or 'prevention of serious harm' under the *Mental Health Act 2014* (the **Act**) are often not the factors considered by the Mental Health Tribunal (the **Tribunal**) when making compulsory treatment orders. There is no common definition of 'serious', allowing decision makers to inject their own bias into any decision. Similarly, there is no critical engagement with the concept of 'deterioration' which is understood only in terms of clinical symptomology and fails to take into account deterioration in trust, dignity and a sense of self. In my experience, what often occurs is that the Tribunal 'reverse engineers' its decisions so the legal criteria under the Act for the making of a compulsory treatment order is met. This reverse engineering often occurs so a person can access mental health services that are not available on a voluntary basis given the underfunding in the mental health service sector in Victoria. These tests must be abandoned and replaced with a process to ensure that people are supported to make their own decisions at all times. It is vital that people who wish to subject themselves to compulsory treatment are able to do so and that people who do not wish to do so are able to refuse treatment.

16 For members of the workforce within the community, the use of compulsory treatment orders are practically utilised to assist them with an overload in their workload. For example, under a compulsory treatment order, a social worker may call the police and ask them to locate a person and bring them into a mental health service in the community so the social worker can provide a service. This is because the social worker does not have sufficient time to locate an individual in the community because of their immense workload and over-allocation of clients. However, the negative ramification of this is that the use of the compulsory treatment order and, for example, requesting police involvement will very likely negatively impact on the therapeutic relationship between the social worker and their client. Similarly, rather than working to provide an environment that people actually want to stay in, inpatient staff default to detention to keep people in their hospitals.

Question 5: To what extent are the existing safeguards contained in the Mental Health Act (including advance statements, nominated persons and the second opinion scheme) as well as current non-legal advocacy and legal representation arrangements:

a. ***reflective of contemporary practice and evidence?***

b. ***compatible with international conventions on human rights?***

c. ***operating as intended?***

d. ***currently taken up by people who use mental health services?***

e. ***currently taken up by families and carers?***

f. ***currently considered in practice by clinicians when determining assessment and temporary treatment orders?***

g. ***currently considered by the Mental Health Tribunal when determining treatment orders?***

17 I refer to my paragraphs 46 to 58 in responding to this question.

18 Please also see the evaluation of Independent Mental Health Advocacy (**IMHA**), released in 2019.[2] IMHA is a non-legal representational mental health advocacy service run by VLA and funded by DHHS. IMHA operates across Victoria, advocating with and for people who are subject to, or at risk of, compulsory treatment. This research found that existing safeguards are insufficient and recommended that legal and non-legal advocacy be extended to every person who wanted it, on an opt-out basis.

19 The specific recommendations made in that report in regard to the Act are:

(a) The Role of the IMHA should be legislated, including:

(1) Responsibility for IMHA to contact every person on a Treatment Order (opt-out system);

(2) Responsibility for mental health services to provide details of every person on a Treatment Order to IMHA (opt-out system);

(3) Right for IMHA to access individuals;

(4) Right for IMHA to access inpatient units;

(5) Consequences for obstruction of IMHA advocates; and

(6) IMHA should have a statutory function for systemic advocacy including a responsibility to table an annual report in Parliament.

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[2] Chris Maylea et al, *Evaluation of the Independent Mental Health Advocacy Service (IMHA)* (Social and Global Studies Centre, RMIT University, 2019) 56 <sway.office.com/GZJrEJJcVJZlGGvY>.

(b) Decision makers under the Act and all designated mental health services staff should be required to undertake regular training to ensure they understand the principles of the Act and their obligations to comply with them, particularly in regard to least-restrictive practice supported decision making and supporting recovery.

20 That evaluation also called for adequate funding for IMHA and broader systemic reform:

(a) Increase IMHA funding to increase the number of advocates to ensure all people who are eligible are able to access IMHA;

(b) Resource IMHA to provide supported decision-making training to mental health services;

(c) DHHS to form a formal collaborative network of oversight bodies, led by DHHS and including VLA, OPA, SPOS, MHCC, MHLC, VMIAC, Tandem, OCP and the Tribunal;

(d) Designated mental health services should be required to report on progress towards a recovery-oriented model of service using a definition of recovery consistent with DHHS policy and the Act;

(e) Designated mental health services should be required to include reporting of the number of people being compulsorily treated by setting and service including demographic data;

(f) Designated mental health services should be required to work with IMHA to identify opportunities for cultural change to improve an understanding of the value of representational advocacy; and

(g) The *Your Experience of Service* (YES) Survey should include a question about consumer access to advocacy.

Question 6: Do current independent oversight mechanisms governing the use of compulsory treatment need to be improved?

a. If so, how?

b. What is required to ensure any changes are successfully implemented?

21 Yes, there does need to be an improvement in independent oversight mechanisms governing the use of compulsory treatment as currently the compulsory treatment system is inherently discriminatory as discussed in paragraph 8(b) above.

22 On a broader level, there appears to be a reluctance of regulators to meaningfully enforce the *Charter of Human Rights and Responsibilities Act 2006* (Vic) (the **Charter**) and the

Act. The responsive regulatory model developed by Braithwaite and Ayres[3] sought to resolve the tension between self-regulatory models and compliance or deterrence approaches. It did so by taking the benefits of both approaches and is often expressed in terms of the regulatory pyramid, with more persuasive or educative approaches underpinning the system, but reinforced by more coercive interventions at the pointy end. What is important to note here, is that persuasive and educative approaches – those that assume voluntary compliance – are only capable or reliable when coercive measures encourage them. There is a lower cost for providers to undertake preventative approaches, lest they risk more coercive interventions.

23 We are almost six years into the Act, but we do not know if these coercive measures are being used, or who they are being used against. We do not know what is happening within mental health services because the complaints data is not released. And yet consumers are telling us daily that their human rights are being violated, and that the only law that applies is that which allows force against them, not those that protect their human rights. The gap between law and practice is meant to be bridged, in part, by regulation. Therefore a significant portion of the responsibility for these issues lay with the regulators, and the solutions lay with a real commitment to responsive forms of regulation. There are several regulatory improvements that could be made.

24 The Second Psychiatric Opinion Service (**SPOS**) should publish the outcomes data from its services, including how many of the second opinions have a contrary finding to the original opinion.

25 The Office of the Chief Psychiatrist (**OCP**) should be required to publish data on the issues identified in its work, including in its clinical advisor phone line, as well as the human rights issues that arise from this work. The OCP should also report on why it chooses, or chooses not to, use its powers in response to these issues.

26 The Mental Health Complaints Commissioner (**MHCC**) should publicly report on:

(a) The recommendations made to specific mental health services, and the implementation rates of those recommendations.

(b) The reports it provides to individual mental health services on their local complaints, in full but deidentified.

(c) The development of practice guidelines by the MHCC to assist mental health services to fully realise the principles of the Act.

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[3] Ian Ayres and John Braithwaite, *Responsive Regulation: Transcending the Deregulation Debate* (Oxford University Press, 1992).

(d) Outcomes data from its informal phone complaints service, as consumers have expressed concern that this does not resolve their concerns in a timely or effective fashion.

Question 7: To what extent, if any, should compulsory treatment be used in Victoria's future mental health system?

a. Why or why not should compulsory treatment be used in Victoria's future mental health system?

b. From your perspective, if compulsory treatment is to continue, which services and settings should be permitted to use compulsory treatment?

27 Overall, my view is that compulsory treatment should only be used in Victoria's future mental health system for those people who choose it as a means of treatment. However, where it is used, the key aspects of choice, consent and its application in a non-discriminatory way are essential. At a minimum, the Act must contain a mechanism for a person who is assessed as capacious to exempt themselves from or consent to future compulsory treatment using an advance directive. The advance directive must include the conditions and circumstances where the directive is able to be changed. This is not compliant with the Convention on the Rights of Persons with Disabilities (**CRPD**), but would be of assistance to many.

28 If compulsory treatment is to continue, I consider that there is work required to decrease the rates of compulsory treatment orders. Enhancements in safeguards discussed at paragraphs 46 to 58 below should be inbuilt and oversight mechanisms of the Tribunal and compulsory treatment providers be enhanced. The current high rates of compulsory treatment are a symptom of a failed mental health system and a failed social support system.

29 At a minimum there must be target reductions over a period of time towards elimination. Funding must be contingent on meeting these targets and compliance with these targets must be published publicly and regularly.

Question 8: Other than legislation, what are the other ways that could be used to reduce rates of compulsory treatment use? Please consider policy, data collection and dissemination, funding and operational levers.

a. How could they be deployed in Victoria and by whom?

b. What is required to ensure the use of these levers are successfully implemented?

30 As discussed at paragraphs 46 to 58 below, there are a range of ways required to reduce compulsory treatment. However, reduction does not satisfy human rights requirements outlined by the CRPD – only elimination of compulsory treatment would do this. Victoria

must be a world leader in setting a clear target for elimination of compulsory treatment on grounds of mental illness diagnosis.

31 The use, in particular the prolonged use, of compulsory mental health treatment corrupts an individual's sense of dignity and risks disabling their opportunities to make choices. Over the long-term, I have witnessed the institutionalising effects that compulsory mental health treatment has on consumers/survivors.

32 In consulting for VMIAC's 'Declaration', people told us that "First and foremost, people need to feel safe. Being free from violence and coercion is essential."

33 My experience and research indicates that the impact of compulsory treatment is tragic and traumatic, particularly if people have had a personal history of being victims of trauma. An example of this is in recent study published this year (which I was involved in), in relation to the prevention of gender-based violence in mental health inpatient units in Australia[4]. This study related to the experience of women in mental health services who may have experienced a past trauma of sexual assault or gendered violence. The findings suggested that when these women were subject to compulsory treatment, or witnessed co-patients being subject to compulsory treatment, it replicated their experience of past sexual assault or violence and re-enlivened past trauma, particularly in circumstances where the women were not permitted to leave the mental health unit based on the conditions of the imposed treatment order.

34 As indicated, forced treatment is also fundamentally discriminatory. It only applies to people labelled with a diagnosis of mental illness and not to everyone in the community, resulting in direct discrimination against this group of people. It is also rife with indirect discrimination. People who use interpreters are three times more likely to be forced to receive treatment than others.[5] First Nations people are disproportionately forced to receive treatment in many jurisdictions, and where they are not it is often because they are denied access to basic services.[6] Any legislation that takes away people's right to make their own decisions must not be based on a person's mental health diagnosis and must apply equally to all citizens. This includes ensuring it does not indirectly discriminate against people with certain diagnoses or other protected attributes. Capacity-based legislation is not appropriate as it indirectly discriminates against people in mental distress and violates the human rights principle of assuming and supporting capacity, requiring

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[4] See Watson, J.,Maylea, C.,Roberts, R.,Hill, N.,McCallum, S. (2020). Preventing gender-based violence in mental health inpatient units In: *Australia's National Research Organisation for Women's Safety Limited (ANROWS)* Sydney, Australia.

[5] Steve Kisely et al, 'Efficacy of Compulsory Community Treatment and Use in Minority Ethnic Populations: A Statewide Cohort Study' (2020) 54(1) *Australian & New Zealand Journal of Psychiatry* 76 ('Efficacy of Compulsory Community Treatment and Use in Minority Ethnic Populations').

[6] Ibid.

the de-linking of legal and mental capacity. Dangerousness-based legislation is not appropriate as risk assessment tools cannot accurately predict dangerousness, particularly in relation to suicide risk, at the individual level. If capacity-based or dangerousness-based legislation are to be considered, they must apply to all citizens equally, not only those labelled with a mental illness diagnosis, and dangerousness-based legislation must require a clear empirical evidence that the harm is more likely than not.

35 The other serious impact of compulsory treatment on people is that the therapeutic relationships built between them and supports is entirely diminished and degraded through the imposition of compulsory treatment. This can override any benefits or advances made in a person's recovery. This is because the mere fact that a clinician can apply for, or impose, compulsory treatment diminishes the trust in the therapeutic relationship and blocks the positive factors needed in relation to the clinical relationship to achieve recovery-based treatment. The opportunity for a mental health service to provide supportive, safe and quality care, in my view, is degraded by the presence and the domination of compulsory treatment being used a form of treatment. In my view, this has a practical effect of disrupting a person engaging with voluntary treatment after the discharge or revocation of a compulsory treatment order.

36 Much opposition to eliminating compulsory treatment is based on the premise that people will suffer if they do not receive treatment or that they will end up in the prison system if not treated and/or detained. The first is easily addressed by providing treatment and treatment settings that people actually want to use. The second suggests that we should use one potentially traumatic form of State-run detention to avoid another form of traumatic State-run detention. Eliminating compulsory treatment requires that we provide meaningful responses to violence rather than responding to violence with more violence.

USE OF COMPULSORY TREATMENT IN VICTORIA

Effective therapeutic relationships and the impact on the decision to use compulsory treatment

37 I consider the use of compulsory treatment is not required to be used when a person using mental health services has access to, and a good therapeutic relationship with, their clinicians on a voluntary basis. A key factor in recovery-based treatment and care is a strong and positive relationship between the person using the mental health service and a clinician with traits such as honesty, hope and trust being key and for the person to feel safe in that relationship. Compulsory treatment, or the threat of compulsory treatment, blocks a positive therapeutic relationship.

38 It is important to note that good therapeutic relationships need to be supported by good systems of care. While much of the unnecessary use of compulsory treatment is drawn

from bad practice, historical issues within the psychiatric profession and a failure of safeguarding systems to protect human rights, it is important to note that it is also due to a lack of effective systems to support voluntary therapeutic treatments. Systems geared towards compliance do not incidentally result in compulsory treatment; they rely upon it. Systems should be geared around choice, consumer control and human rights, most importantly systems that support consumers to make their own decisions and are incapable of restricting their autonomy.

Supports for consumers moving between different types of compulsory treatment orders or being discharged from compulsory treatment orders

39 Currently, due to the underfunded nature of the mental health system in Victoria, the supports provided to people when moving between different compulsory treatment orders or being discharged from such orders, are limited. This is because when people are moved between different compulsory treatment orders and moved from an inpatient setting to a community setting, they have no continuity in their support and are likely to be cycling through different workers and clinicians. This makes it virtually impossible for workers and clinicians to provide continuity in care and build trust, honesty and rapport. Without this type of relationship, it is virtually impossible to establish the right circumstances for recovery-oriented care. There are insufficient cultural supports for First Nations people, insufficient supports to address trauma for victim/survivors of family violence, sexual assault and other traumas and a lack of care for people's basic human rights, including housing, basic amenities and the right to refuse medical treatment.

40 In my view, the essential concern is not the moving between the different types of compulsory treatment orders (as that is essentially just a transition between different treatment settings and different support teams) or being discharged from compulsory treatment, but the fact that the structure of current services is that if a person is not on a compulsory treatment order, particularly in the community, they are very unlikely to receive any support or treatment whatsoever even if they are prepared to have a high level of engagement with voluntary treatment. This is also consistent with my experience of representing and researching the making of compulsory treatment orders by the Tribunal. A treating team may advise the Tribunal that unless a person is subject to, or continues on, a compulsory treatment order they will not receive any services on a voluntary basis. My impression is that clinicians feel more duty-bound to provide care and treatment to people on compulsory treatment orders than a person who could be treated on a voluntary basis.

41 There are some supports available to people in these points of transition, although these are underfunded and consequentially unable to provide support to everyone who requires

it. IMHA is an excellent example of this.[7] IMHA provides instructions-based advocacy to people who are, or who are at risk of, being compulsorily treated. IMHA is an excellent service which is highly valued by consumers/survivors but is not available to all who need it. To address this, all consumers/survivors subject to compulsory treatment should be offered an IMHA advocate. A similar ‘opt out’ system exists for the Mental Health Advocacy Service in Western Australia. Currently, IMHA is not sufficiently funded to offer crisis advocacy or out of hours advocacy meaning that many people made subject to assessment orders are denied their right to an advocate.

TREATMENT CRITERIA AND PRACTICE

Appropriateness of the ‘serious harm of self or others’ threshold for compulsory treatment under the Act

42 I do not believe the current threshold for compulsory treatment in Victoria is appropriate for two reasons.

(a) Firstly, as discussed, it is fundamentally discriminatory that a person with a diagnosis of mental illness may be subject to compulsory treatment against their will when they pose the same risk as a person who may have the same risk profile who does not have a diagnosis of mental illness. This feeds into common misconception in the community that people experiencing mental distress are more likely to harm themselves or others, which is not the case.

(b) Secondly, the workforce in mental health is unable to accurately assess risk or whether someone will harm themselves or others.[8] There are exceptions to this in some forensic risk assessments, however for the general population they are ineffective and discriminatory. Risk can be effectively predicted at the population level but not at the individual level.

In my view, the idea that clinicians can assess risk efficiently and effectively in relation to individual people who require mental health services needs to be abandoned, particularly when the imposition of a treatment order is likely to diminish the therapeutic relationships between a person and their mental health treating team. Compulsory treatment *increases* risk of harm as people refuse to engage with services which have caused them trauma in the past. The formation of a positive therapeutic relationship is a fundamental protective factor for people who may be at risk of self-harm or harm to members of the community.

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[7] Maylea et al (n 2).

[8] Matthew Michael Large et al, ‘Can We Usefully Stratify Patients According to Suicide Risk?’ (2017) 359 *BMJ* j4627.

Approval of the use of electroconvulsive therapy (ECT) and neurosurgery and the impact on consumer outcomes and access to treatment

43 In my responses below, I focus on ECT rather than on neurosurgery as ECT is a more common form of treatment. However, these same points apply to neurosurgery.

44 Firstly, it is important that people who want and value ECT as a form of treatment are permitted and supported to receive this form of treatment. Some people are assisted by the benefits of ECT, particularly on a short-term basis, and would rather have treatment through ECT than ineffective psychotropic medication. However, receiving ECT ought to be based on a person's individual choice over forms of treatment and should be based on supported decision making and health education. If a person chooses to have ECT as a form of treatment, I consider it unnecessary for the Tribunal to make treatment orders approving its use, although history clearly shows that some form of oversight is required to ensure that people are genuinely consenting to this treatment.

45 However, the circumstances where the Tribunal can approve the compulsory use of ECT should be disallowed. When forced, ECT can cause extreme trauma for a person experiencing mental distress. It should additionally be noted that the long-term effects of ECT are not well understood. Importantly, I have witnessed how the harmful effects of ECT, both in seeking consent and in rationalising compulsory use of it. There should be no test of capacity for any compulsory treatment, instead all persons must have their capacity assumed and be supported to make decisions. This is the only position that is human rights compliant.[9]

SAFEGUARDS

46 The failure of current safeguarding systems to uphold and protect human rights has created a two-tier legal system: an enforced one, that applies to consumers/survivors, and a voluntary one, that applies or does not apply to decision makers in clinical mental health services. Compliance with the law by consumers is ensured through the use of violence, or threats of it, by mental health services and police. Compliance with the law by mental health services is irregular, lacking in oversight and public data, but most importantly, discretionary. These safeguarding laws – human rights laws – exist in a far more liminal status than the treatment criteria or those enabling compulsory treatment. This emerges from unequal enforcement of the law, and it results in consumers/survivors being placed firmly within the law, with their rights out of reach. If a consumer/survivor

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[9] Tina Minkowitz, *Prohibition of Compulsory Mental Health Treatment and Detention Under the CRPD* (SSRN Scholarly Paper No ID 1876132, Social Science Research Network, 30 June 2011) <http://papers.ssrn.com/abstract=1876132>.

does not comply with the Act, the police are called. If a clinician does not comply with the Act, there are virtually no consequences.

The implementation of stronger safeguards for compulsory treatment

47 Stronger safeguards need to be implemented for people using mental health services. A person who requires mental health services should not bear the onus to ‘take up’ safeguards and there should be stronger safeguards inbuilt in the Act for people who may be subject to compulsory treatment. If the safeguards were better inbuilt into the Act, this would go some way in attempting to correct the power imbalance present between a person requiring mental health services and medical professionals who recommend compulsory treatment. The focus should be on providing holistic supports (including peer workers, social workers and mental health nurses) rather than on compulsory treatment which tends to focus on medication and other medical-type interventions.

48 There are several key safeguards connected to the Act, but consumers have indicated that they lack confidence in these. I will provide some examples: (1) we do not know when or how the OCP plans to enforce guidelines under the Act – is there evidence of directives to comply with these, particularly as they relate to human rights?; (2) despite the data being captured by the Mental Health Complaints Commissioner for four years, including reports handed to each mental health service, these are not made public; (3) despite the existence of the SPOS, we do not know how many second opinions have ever overruled a prior decision by a psychiatrist, although experience and anecdotal evidence indicates it may be around the 2% mark.

49 If there are issues with the “take up” of safeguards, it is that consumers lack the confidence in their effectiveness. Impartiality requires transparency. A responsive regulatory approach to quality-assuring the system and safeguarding of human rights should include a range of responses to poor service and human rights abuses. Those can range from the preventative approaches, like education, more specific recommendations to services that, upon completion, can be reasonably expected to prevent human rights abuses, to compliance orders where necessary. They are a continuum, and the more palatable approaches, such as education and recommendations, will not prove effective in the absence of more targeted coercive responses for instances of human rights abuses. Without this, there are no incentive for voluntary compliance by mental health services.

50 For serious or repeated violations, violation of a person’s human rights under the Act must result in criminal sanctions for both services and offending clinicians. Such offences exist in other mental health legislation,[10] however they are almost never enforced.

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[10] See, e.g. *Mental Health Act 2007* (NSW) s 69.

51 I also consider that the following safeguards should be implemented through legislative changes of the Act. Examples of legislative change that must be inbuilt include:

(a) a person be required to be legally represented before the Tribunal where a compulsory treatment order is sought (unless the person chooses not to be legally represented);

(b) IMHA must be made available to all people subject to compulsory treatment on an 'opt-out' basis.

(c) changes to the making of advance statements under the Act to address the fact that currently, an advance statement is a not a sufficient or effective safeguard. I consider the following changes to the advanced statement process should be considered:

   (1) the Act ought to be amended so an advance statement is binding on the clinicians treating a person. Currently, advance statements are often ignored and not considered in practice by clinicians.[11] This creates false hope in people about their autonomy in relation to their care and is likely to have the negative effect of degrading the therapeutic relationship between a person and their clinicians;

   (2) the Act be changed so that an application is required to the Tribunal to override a person's advance statement;

   (3) infrastructure be created about the dissemination of advance statements. Practically, advance statements are often not contained in various health files that a person may have at different mental health services or hospitals for clinicians to even consider. Further, police or ambulance services will not have access to advance statements. The appearance to a client is that their wishes in an advance statement have been ignored which can be traumatic for clients. For example, a participant in research I conducted was a woman who indicated in her advance statement that she understood she needed compulsory treatment at times when she was unwell. However, she asked to not be taken to a particular mental health service because she had been previously sexually assaulted at that service. However, practically this would not be known by the police or any ambulance service who transported the woman to this mental health service because they would not have access to her advance statement; and

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[11] Chris Maylea et al, 'Consumers' Experiences of Mental Health Advance Statements' (2018) 7(2) *Laws* 22.

(4) a statutory prohibition on the contents of advance statements being used as evidence that the legal criteria for the making of a compulsory treatment order is met, both by authorised psychiatrists and the Tribunal; and

(d) legislative change be explored about a person's right to seek a second psychiatric opinion. In my experience, I have rarely seen an SPOS opinion differ significantly to the original opinion because they have the background of reading the original psychiatrist's opinion and interpretation of events. Psychiatrists consulting through SPOS are generally also working in the public mental health system and operate through the same practice modalities as the original psychiatrists. When changes are recommended by SPOS, there is no mechanism for enforcing these recommendations with the treating team. As such, this is not a genuine safeguard in the Act.

52 I consider the essential safeguard for people using mental health services is around protecting and supporting people's right to make their own decisions and to prevent a situation where a person's decision making, and autonomy is taken away from them. This has the practical impact that a person will be subject to the ramifications of their decision making, as is the case for the rest of the community, and the process becomes less discriminatory. Part of what is required is an increase in supported decision making and the need for additional heath education and public health campaigns about mental health and mental health services.

53 Organisations such as IMHA must be funded to provide supported decision-making training and organisations such as VMIAC must be funded to provide eCPR and other similar training, but this is only one aspect of cultural change required. While compulsory treatment exists, mental health clinicians will default to violence when challenged by their work.

54 Safeguards must operate in real time. The underfunded post-hoc complaints system managed by the MHCC is too little, too late and has been shown to be demonstrably ineffective in reforming practice. Real time safeguards must include crisis oversight in the community, with CATT, police and PACER teams, in Emergency Departments and out-of-hours in inpatient units. Realistically, the level of safeguarding required to make compulsory treatment a lawful exercise of state power is probably impossible to achieve, and compulsory treatment should be abolished.

55 The most fundamental safeguard against human rights violations for people subject to compulsory treatment is that they have *all* their human rights upheld, including their rights to housing, health, community participation etc. These are clearly detailed in the CRPD. One way to mitigate the harms of compulsory treatment would be to empower the Tribunal

to order that social-type services be provided to people receiving mental health services, particularly if compulsory treatment is retained in the Act. My impression is that often the Tribunal feels bound to make an order because a person does not have access to housing, support services or health services.

56 If the Tribunal was empowered to grant orders that required a person to be provided with public housing and other 'in-home' support services (akin to services provided under the National Disability Insurance Scheme), then in my view the need for, and number of treatment orders would decrease. There has been no research in relation to this safeguard as currently this system has not been implemented in any jurisdiction in the world. These orders must only be made with the consent of the person. This may initially be resource intensive however it is likely that as with prison reinvestment the long-term savings would outlay the ongoing costs.

57 There must also be more rigorous oversight of the oversight bodies. For example, any appeal from the Tribunal is held de novo at VCAT, resulting in no effective judicial review of Tribunal decisions or decision-making processes. There is, I understand, capacity for the Supreme Court to exercise inherent jurisdiction but this does not occur in practice. The Tribunal should also be required to support a person to access oversight and safeguarding bodies such as SPOS, IMHA or the MHCC where the person raises concerns outside the jurisdiction of the Tribunal.

58 Similarly, I consider there is a reluctance by the Office of the Public Advocate and MHCC to publicly use their more coercive powers to reform services highlights a need for both more meaningful coercive powers and encouragement to actually use them to aggressively police human rights violations and advance service reform.[12]

FUTURE STATE

Data collection, synthesis and publication and the reduction of compulsory treatment

59 The collection and publication of data around the use of compulsory treatment does play a role in reducing the use of compulsory treatment. For example, VMIAC's Seclusion Report highlighted the varying rates of seclusion across Victoria, resulting in public responses from mental health services.[13] Currently, oversight bodies are failing to identify poor practices and make these poor practices public. For example, the OCP collects data on the rates of sexual assault in mental health inpatient units but refuses to release it publicly or to researchers.

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[12] Richard Carver and Lisa Handley (eds), *Does Torture Prevention Work?* (Liverpool University Press, 2016).

[13] VMIAC, *Seclusion Report: How Safe Is My Hospital?* (Victorian Mental Illness Awareness Council, 2019) <https://www.vmiac.org.au/seclusion-report-how-safe-is-my-hospital/>.

60 If compulsory treatment is to be included in the mental health system going forward, there must be scaled target reductions over time for mental health services. This data must be made public.

61 Currently, it is unknown how many people are subject to compulsory treatment orders in Victoria as this information is not publicly available. The lack of data prevents researchers, such as myself, and advocacy organisations, such as IMHA and VMIAC, being able to properly analyse data to identify trends and advocate for changes and improvements and impedes a form of oversight over the Tribunal's decision making powers. Detail is required for this data, not just broad percentage changes. It is essential that we can distinguish the number of orders per person from the total number of orders, the number of assessment, temporary and treatment orders, the rate of variations, the length of order, number of sequential orders and much more. All this data must also be able to be stratified by demographic data so we can highlight and combat the discriminatory nature of the compulsory treatment. For example, it must be possible to identify which hospitals are more likely to compulsorily treat First Nations people or young people.

62 Currently, I am part of a research project that is seeking a funding grant from the Australian Research Council for funding so we can research how many people are subject to compulsory treatment orders in Victoria and what mental health services rely on compulsory treatment orders more than others. In my view, academics should not require academic grant funding to ensure that this data is released by mental health services. I consider that this data should be publicly available through the Department of Health and Human Services or other formal State means.

63 Data should be available on all levels of the service system. For example, if people are being made subject to community treatment, what services and support are they being provided with? What percentage of self-identified goals in recovery plans are being met? Currently, mental health service provision is opaque. Transparency can be achieved with good data, which can be used to drive service reform.

64 There are data sets already collected but by safeguarding bodies such as the OCP, SPOS and MHCC. This information is not being shared with the public. For example, the MHCC requires public mental health services to report twice a year on complaints arising directly in their mental health service. The MHCC then works closely with mental health services to develop a specific report analysing the quantitative and thematic elements of complaints as compared with previous reporting periods. This is valuable information that should be released to the public so that consumers can assess the quality of their mental health service, and so that the civil society organisations and consumer groups can drive quality improvement in mental health services.

65 If for no other reason, this data must be made publicly available so that people can avoid hospitals with high seclusion rates, high rates of compulsory treatment or high rates of sexual assault. People from specific communities, such as First Nations people or people who use interpreters, have a right to know if they are likely to be discriminated against at a particular service.

66 This data collection framework should be undertaken by a safeguarding coordinating council in the short-term, including stakeholders such as the OCP, MHCC, Victoria Legal Aid, IMHA, SPOS, VMIAC, the Victorian Ombudsman and Tandem. These functions should then be incorporated into the Optional Protocol to the Convention against Torture (**OPCAT**) Victorian National Preventive Mechanism (**NPM**) upon its appointment.

67 All data collected which can be reliably deidentified must be released at least quarterly. Nearly all of this data is already collected by mental health services and merely requires repackaging for publication, although many services have poor data collection consistency.

Research and the reduction of compulsory treatment

68 I consider research around the use of compulsory treatment plays a significant role in reducing the use of compulsory treatment.

69 The diversity of perspectives and experiences are only beginning to be documented and many questions remain unanswered. For example, it is not settled the extent to which a person should be able to voluntarily commit themselves to future compulsory treatment and at which points they might be able to change their mind in a way that is consistent with the CRPD. Many people use formal or informal advance directives for this purpose.

70 The converse is also required – research on the avoidance of compulsory treatment. For example, *Alternatives to Coercion in Mental Health Settings: A Literature Review*,[14] highlights the alternatives in place in many countries around the world. Many of these alternatives require further research to determine their applicability in the Victorian context. Others already have a sound research base but have not been adopted in Victoria, so research is clearly only one part of the process. Research can also play a part in supporting implementation, with rigorous evaluation required to determine the impact of new reforms.

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[14] Piers Gooding et al, *Alternatives to Coercion in Mental Health Settings: A Literature Review* (Melbourne Social Equity Institute, 2018) <www.socialequity.unimelb.edu.au>.

Possible obligations on the State and mental heath services to provide services

71 I consider there should be obligations on the State and mental health services to provide services to people experiencing mental health issues, rather than relying on compulsory treatment.

72 Specifically, as identified above in relation to safeguarding, the Tribunal or some other body must have powers to make orders binding the State in the provision of adequate services. This gives real meaning to the 'least restrictive' principle which is currently a meaningless legal fiction aimed at giving the appearance of dignity. If mental health services could only impose compulsory treatment when all other approaches had been tried, they would almost never be able to impose compulsory treatment. For example, 'least restrictive' options must include housing, social network mobilisation, supported decision making, access to healthcare, and, as required, spiritual and cultural responses. These options must all be provided with the informed consent of the person.

73 The origins of mental distress extend beyond the mental health system. The direct correlation between the failures of the prison and legal systems, child protection systems, general health systems and broader social factors such as inequality, colonisation and gendered violence must be understood in reforming the mental health system.

74 In consultations for VMIAC's 'Declaration'; 'The places people most spoke about were peer-run services, and this included many variants: peer-run respites, recovery houses, crisis centres, peer support groups, recovery colleges and retreats. Many people dreamed about the importance of nature in an ideal healing space: gardens, trees, lawns, flowerbeds. Many also dreamed about light and windows.' It is important to note that 'A minority of people told us that hospital was the best place for them in a crisis. But these people spoke about the need for hospitals to be nicer, cleaner, with more light and unlocked doors.'

RESTRICTIVE PRACTICE

Victoria's rates of seclusion and physical restraint and the reduction of these rates

75 As indicated, I consider that compulsory treatment is more than the narrow definition of seclusion and restraint and I refer to paragraph 6 where I outline my broader definition of compulsory treatment.

76 I consider the rates of seclusion and restraint are higher than the national average because Victoria's mental health system is poorly conceived and underfunded, and exploration has not occurred of alternatives that would provide more effective recovery-based care and treatment. Human rights, recovery, coproduction and other meaningful reforms are given lip service but rarely embedded into practice.

77 For example, in an inpatient environment, if we eliminated options for restraint and seclusion rooms and employed more mental health nursing staff to have improved ratios of nursing staff to clients (including on a 1:1 basis if required), then any need for seclusion and restraint will decline.[15] I do not suggest that maintaining the current system but with more nurses is any kind of solution but use this example to illustrate how seclusion and restraint could be eliminated even without other necessary system reform.

78 Practical approaches to reducing seclusion and restraint have been proposed by others and have had demonstrated success,[16] but without major system change they will continue to be used. Germany's accidental experiment ending coercive treatment shows that removing the legal power for services to behave in this way means that with the right supports they can develop alternative ways to engage with people.[17]

79 Practically, if we employed peer workers to provide support in peer run services, I consider this would have a significant impact in reducing the need and trends towards compulsory treatment, including seclusion and restraints. An example of the positive impacts of peer workers and supports is the 'Safe Haven Café' run at the Fitzroy campus of St Vincent's Hospital. This café is staffed by social workers, peer support workers and volunteers and provides a safe alternative from an emergency department for people over 18 who are experiencing loneliness, personal difficulties or seeking social connection. This avoids a person needing to wait approximately 12 hours for assessment or being admitted into an emergency department and is a more personal form of care. Whilst the Melbourne Safe Haven Café is currently being evaluated, we know from similar cafes and arrangements in the United States, that these reduce inpatient admissions.[18] An added advantage of programs such as the Safe Haven Café is the cost benefits to the State in the reduction of hospital admissions.

80 Part of the reason for the high rates of force in the Victorian system is a failure of regulation. There are laws regarding supported decision-making, informed consent, the least restrictive assessment and treatment - but these laws are not been adequately enforced. There is some limited promotion and education on the Act and Charter rights, but little enforcement despite wide-scale failures to comply. From a responsive regulatory standpoint (discussed in paragraphs 21 to 26 above), strategic public coercive measures by regulators - namely the MHCC and OCP - are required to ensure voluntary compliance with laws. Without this, there are few incentives to drive quality improvement and the

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[15] Ben Beaglehole et al, 'Unlocking an Acute Psychiatric Ward: The Impact on Unauthorised Absences, Assaults and Seclusions' (2017) 41(2) *BJPsych Bull* 92.

[16] Martin Zinkler and Sebastian von Peter, 'End Coercion in Mental Health Services—Toward a System Based on Support Only' (2019) 8(3) *Laws* 19.

[17] Martin Zinkler, 'Germany without Coercive Treatment in Psychiatry—A 15 Month Real World Experience' (2016) 5(1) *Laws* 15.

[18] Michelle Heyland and Mary Johnson, 'Evaluating an Alternative to the Emergency Department for Adults in Mental Health Crisis' (2017) 38(7) *Issues in Mental Health Nursing* 557.

elimination of force, and services are instead led to focus on other incentives that drive risk-approaches to governance and mental health.

81 Services must have clear targets for the reduction and elimination of coercive practices. Funding must be dependent on reducing and eliminating coercive practices.

82 As detailed above, universal access to advocacy such as IMHA would also drive down seclusion and restraint.

The role of service providers and independent oversight and monitoring statutory bodies in the reduction of restrictive practices

83 Attempts that currently exist to explore alternatives to restrictive practices are limited by resourcing and a lack of imagination. While compulsory treatment exists clinicians will default to it when faced with challenges. Only by abolishing compulsory treatment can mental health services become places of health and healing.

84 If compulsory treatment is to remain in the short-term, a comprehensive framework towards the reduction and elimination of compulsory treatment alongside the below. We note the particular importance of this given the ambitions of Mental Health Reform Victoria to oversee the creation of 170 new beds for the mental health system.

85 Services should report on this framework publicly and should report to consumer consultants and consumer advisory groups. Minutes from meetings and comments from those groups must be published publicly.

86 Funding must be dependent on consistency with human rights. For example, services should report on their compliance with the Charter and the CRPD in their annual reports, and to relevant safeguarding bodies.

87 Mental health services should – if they have not already - develop clinical practice guidelines and training regimes that are consistent with the Charter and the Act. These guidelines should be co-designed with consumers, such as through their consumer consultants and consumer advisory groups. These practice guidelines should be publicly available, with complaints information noted for consumers and carers who believe that guidelines have not been followed.

88 Clinicians must have to demonstrate to an independent decision-making body such as the Tribunal that all less restrictive options have been genuinely tried. Funding and other resourcing must be made available to ensure that all less restrictive options are available, and funding and resourcing restraints must be statutorily prohibited from being considered as ‘reasonable’ barriers to providing necessary services and support alternatives.

89 All decision makers under the Act and all mental health services staff must undergo human rights training prior to working in involuntary settings. Human rights principles must be built into clinical supervision frameworks and consequences, including criminal offences, must apply for human rights violations.

90 Early safeguards are critical to prevent the use of restrictive interventions. International research has shown that the risk of ill-treatment and torture is at its greatest during the early stages of detention, and that the most protective factors are access to lawyers and independent actors. VMIAC members in regional and remote areas of Victoria regularly speak of the inequities in access to these safeguards. This is another compelling reason to institute a funded opt-out IMHA scheme and ensure universal access to lawyers and the Tribunal at early stages of detention.

91 There should be provisions developed or promoted to allow for the investigation and prosecution of abuse and mistreatment that amounts to torture under the UN Convention Against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (**UNCAT**). There has been considerable research showing that abuse and ill-treatment that amounts to breaches of UNCAT go regularly unpunished, but that the consistent application of these laws are among the best ways to protect human rights.

92 The United Nations Special Rapporteur on torture and other cruel, inhuman or degrading treatment of punishment has stated that “practices such as … psychiatric intervention based on “medical necessity” of the “best interests” of the patient … generally involve highly discriminatory and coercive attempts at controlling or “correcting” the victim’s personality, behaviour or choices and almost always inflict severe pain or suffering. … such practices may well amount to torture.”[19] Other scholars have highlighted that the failure to keep women safe in mental health inpatient units may also amount to torture.[20]

93 The Royal Commission should ensure that the appointment of the OPCAT NPM in Victoria is done in consultation with civil society, and ensures that people with lived experience of detention or restrictions on liberty - in this case people subject to compulsory treatment - are made part of the NPM structure. This is required if the implementation of OPCAT in Victoria is going to be CRPD compliant, which requires that people with a disability are included in governance structures and the design of policies. A failure to do so risks implementing a best-interests approach to OPCAT implementation and practice in Victoria.

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[19] United Nations Special Rapporteur on torture and other cruel, inhuman or degrading treatment of punishment, *Torture and Other Cruel, Inhuman or Degrading Treatment of Punishment* (No A/HRC/43/49, United Nations Human Rights Council, 14 February 2020).

[20] Penelope Weller, ‘OPCAT Monitoring and the Convention on the Rights of Persons with Disabilities’ (2019) 0(0) *Australian Journal of Human Rights* 1.

WORKFORCE

Enhancing workforce capabilities and skills to reduce compulsory treatment and restrictive practices

94 I consider that in respect of the workforce for mental health services, there should be a significant push for peer run services and peer workers. There is clear empirical evidence that peer workers and peer run services are the most effective way of supporting and people in mental distress. This is because recovery is best achieved by a person feeling supported on a side by side basis rather than it being imposed from a top down position by clinicians. Peer workers can build trust and rapport in a therapeutic relationship with a person requiring care for their mental health almost immediately based on a more equitable power relationship between the worker and the client. This is unlike a psychiatrist, psychologist or even a social worker which are founded on positions of an imbalance in power relations and the idea that these medical professionals are always correct based on this position of power and their expertise. I additionally consider the efficacy of the peer worker model to be based on the fact that the peer worker can better offer treatment and support on an ‘instructions based’ model akin to a lawyer/client relationship.

95 For existing clinical staff, re-education will be necessary with clear and consistent reformulation of expectations. Supervision, oversight and continuing education will be essential. Champions of service reform will need to be identified and supported. In consulting for VMIAC’s ‘Declaration’, ‘The two qualities that we most often dreamed about were listeners and compassion.’ Clinicians unable to work from a human rights perspective will need to supported into more appropriate roles outside of the mental health system.

96 New graduates must have specific human rights training embedded into the curriculum. As no mental health specific qualifications currently exist for social work and nursing, these will have to be developed or redeveloped to incorporate a human rights basis.

97 There must be a re-focus away from a clinician’s role primarily being one of assessing risk. The focus ought be redirected to a recovery based approach and what treatment, care and support could be offered to support this recovery, rather than a focus on risk.

Attached to this statement and marked ‘CM-1’ is a copy of my curriculum vitae.

sign here ►

print name Christopher Maylea

date 30/4/2020

ATTACHMENT CM-1

This is the attachment marked ‘CM-1’ referred to in the witness statement of Christopher Maylea dated 30 April 2020.

DR CHRISTOPHER MAYLEA - CURRICULUM VITAE

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Areas of Specialty	Mental health	Law and justice	Social work

Education

Doctor of Social Work 2013
Charles Sturt University, *Wagga Wagga*

Juris Doctor (with Distinction) 2015
RMIT University, Melbourne

Master of Human Services Management and Policy 2010
Charles Sturt University, Wagga Wagga

Bachelor of Social Work (Hons 1st Class) 2008
RMIT University, Melbourne

Graduate Diploma of Legal Practice 2015
Australian National University, Canberra

Advanced Diploma of Community Sector Management 2012
MHCC, Sydney

Certificate IV Small Business Management 2011
About Training, Byron Bay

Certificate IV Information Technology and Support 2002
Bradfield College, Sydney

Academic experience

RMIT UNIVERSITY, Melbourne 2013 to present

Course Coordinator & Lecturer
Deputy Program Manager, Bachelor of Social Work (Hons)
Deputy Program Manager, Bachelor of Social Work (Hons)/Bachelor of Social Science (Psychology)
Coordinator, Concurrent Studies Master of Social Work and Juris Doctor
Early Career Research Lead, Law and Social Justice, Social and Global Studies Centre
Research Integrity Advisor

- Course design, delivery and coordination
- Postgraduate and undergraduate
- Honours supervision
- Sessional staff leadership and management
- Research and scholarship
- Research Integrity Advisor

CHARLES STURT UNIVERSITY, Wagga Wagga 2013
Sessional Subject Coordinator

- Distance Education
- Course delivery and coordination

Legal experience

MENTAL HEALTH LEGAL CENTRE, Melbourne 2014 to present

Pro Bono Lawyer

- Mental Health Tribunal representation
- Magistrates' and County Court representation
- Prison clinic and night service helpline

Human services experience

ON TRACK COMMUNITY PROGRAMS, Lismore 2011 - 2013

Mental Health Services Manager

- Management of multiple teams and programs, including Aboriginal, residential, outreach, children and family, respite and youth programs
- Rebuilding damaged and isolated teams
- Supporting and leading team coordinators
- Networking and local strategic development
- Working in partnership with multiple funding bodies and partner organisations
- Advocacy, community education and development
- Acting Operations Manager

INTERACT INJURY MANAGEMENT, Tweed Heads/Gold Coast 2010 - 2011

Regional Manager (Maternity Leave Position)

- Team management and leadership
- Mediation and dispute resolution
- Occupational rehabilitation and counselling
- Regional marketing and business development

BALLINA DISTRICT COMMUNITY SERVICES, Ballina 2010

Youth Housing Case Manager

- Youth homelessness case management
- Policy development and implementation
- Evaluation development and implementation

MELBOURNE CITYMISSION, Melbourne 2007-2009

Residential Youth Support Worker & Youth Housing Telephone Information and Referral Worker

- Youth homelessness case management
- Crisis response
- Network integration and support

CATCHMENT YOUTH SERVICES, Melbourne 2007

Residential Youth Support Worker

- Youth homelessness case management

SCUBA DIVING & YACHTING INSTRUCTOR, Byron Bay, Cairns, Egypt, Fiji 2002-2006

- Instructor duties, managing teams of dive masters and assistants
- Camel dive safaris
- Ocean and closed water sailing instruction

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33. Maylea, C. (2016) An end to involuntary treatment in Australian mental health social work, *Social Work and Health: Inclusive Practice Research and Education*, Paul, N. & Jones, P. (eds) Depaul Centre for Research and Development, Kerala, India.
34. Maylea, C. (2016). Food scarcity and the Paracel Islands - What can be done to maintain traditional fishing grounds? *New Community Journal*, 14, 78 – 84.
35. Hirsch, A. & Maylea, C. (2016) Education denied: people seeking asylum and refugees trapped in limbo, *New Community Journal*, 14, 19 – 24.

Unpublished corporate reports

Publications (cont.)

36. Maylea, C. (2017) *Report on Housing, Homelessness and Mental Health Workshop Consultations* (Commissioned by the National Mental Health Commission)
37. Maylea, C. (2017) *Report on Housing, Homelessness and Mental Health Online Consultations* (Commissioned by the National Mental Health Commission)
38. Roberts, R. & Maylea, C. (2016) *Integration and primary health care- Implications for cross-agency collaboration for better health and well-being* (Commissioned by the NSW Mental Health Branch) (2016)
39. Roberts, R. & Maylea, C. (2016) *Cross-sector mental health and social emotional well-being policy and initiatives* (Commissioned by the NSW Mental Health Branch)
40. Roberts, R. & Maylea, C. (2016) *Mental Health Workforce State and National Policy Analysis* (Commissioned by the NSW Mental Health Branch)
41. Maylea, C. (2011) *On Track NGO Grant Snapshot Evaluation* (OnTrack)
42. Maylea, C. (2011) *Scoping study to identify needs of rural and regional Aboriginal and mainstream mental health consumers in relation to the NDIS in NSW* (OnTrack)
43. Maylea, C. (2011) *On Track Aboriginal HASI Healing Retreat Evaluation* (OnTrack)
44. Maylea, C. (2010) *Stepping Up, Stepping Out Youth Homelessness Program Evaluation* (BDCSA)

Postgraduate theses

- Doctoral Thesis - *Understanding Service Delivery to New and Expectant Fathers by Health and Welfare Professionals*
- Master of Human Services Management and Policy thesis - *My School - It's Only an Education Revolution If You Win - A three part analysis of the My School website*
- Juris Doctor thesis - *New powers for social workers under the Mental Health Act 2014*

Awards

- Dean’s Research Impact Award 2020
- Dean's Early Career Research Excellence Award for excellence in research and publication in the field of mental health law and social work, 2018
- GUSS High Performance Teaching Star, 2017
- Nominated for *Vice-Chancellor's Award for Research Excellence – ECR* 2019

Media engagement

- Perkins, M. (2018) ‘Mental Health Patients Overlooked in Compulsory Treatment: Research’. The Sydney Morning Herald. 18 March 2018.
- Corsetti, S. (2018) ‘Lack of Legal Representation Impacting Mental Health Patients, Law Service Says’. ABC News. 21 March 2018.
- ABC News Radio Victoria. Discussing Mental Health Tribunals. 19 March 2019.
- ABC Radio, Mornings Illawarra. Promoting Equally Well. 17 October 2018.
- Tomazin, F (2019) ‘'It's as though you’re some kind of rabid animal': Seclusion in mental health units on the rise’. The Age. 4 April 2019.
- Wahlquist, C (2019) Mental health service should be expanded to an opt-out model, expert says’. The Guardian. 8 April 2019.
- McInerney, M (2019) ‘Why the physical health of people with mental illness is a critical human rights issue’. Croakey. 7 April 2019.
- Taylor, G (2019) ‘Support services vital during forced mental health treatment’. RMIT News. 08 April 2019.
- Lyons, A (2019) ‘Physical health as a human right’. *news*GP. 02 May 2019.
- Lucadou-Wells, C (2019) ‘Send me an angel’. Dandenong Star. 12 April 2019.
- Gregory, K (2020) ‘Calls for segregated mental health wards to reduce sexual assault risk. ABC News. 13 February 2020.

Academic Grants

Evaluation of Eastern Community Legal Centre's Elder Abuse Response Services, Commonwealth Attorney General's Department (Lead evaluator)	$55,000
Evaluation of the Integrated Chronic Care Programs in North West Melbourne funded by NWMPHN, administered by Neami/cohealth (Lead evaluator)	$95,000
Closing the mental health care gap: Co-designing resources for Emergency Department staff, RMIT Opportunity Fund (Chief Investigator)	$123,926
Enhancing the coordination of housing supports for individuals leaving institutional settings, AHURI funded (Co-Investigator)	$565,208
Evaluation of Victoria Legal Aid's Independent Family Advocacy Service (Lead Evaluator)	$59,880
Evaluation of Victoria Legal Aid's Independent Mental Health Advocacy program (Lead Evaluator)	$99,637
Preventing gender-based violence in inpatient mental health units, ANROWS funded (Category 1 Grant) (Co-Chief Investigator)	$123,645
Equally Well: Improving the physical health and wellbeing of people living with mental illness, National Mental Health Commission & Charles Sturt University (Manager – External relationships and consumer engagement and participation)	$528,000
RMIT College of Business Friendship Grant – Lawyers and Social Workers working together (Co-Chief Investigator)	$10,000
Application, research and review of the Medical Treatment Planning and Decisions Act, VMIAC	$2,500
Ian Potter Foundation Knowledge Grant	$1,500
RMIT Social Global Studies Centre Research Seed Grant	$3,000

Invited Keynotes

Physical Health as a Human Rights Issue – Equally Well Symposium, Melbourne	2019
Supported decision-making: an alternative to compulsory treatment? – World Social Work Day, Melbourne	2019
How social workers can work towards ending involuntary treatment in mental health – Victorian Mental Health Social Worker's Conference, Melbourne	2018
MHLC Advance Statements Project - Advance Statements and Nominated Persons - Chief Psychiatrist's Forum, Melbourne	2018
Keynote address - *Ending Homelessness – Supporting people in mental distress and housing stress* - at Dual Dilemma Conference, Sale	2017

Boards and Committees

Chair, Victorian Mental Illness Awareness Council	2020 ongoing
Deputy Chair, Victorian Mental Illness Awareness Council	2018-2020
Victorian DHHS Equally Well Steering Committee	2020 ongoing
National Equally Well Project Group	2017 ongoing
GUSS Professional Development Committee	2017-2018
GUSS Sessional Staff Working Group	2016-2017
NSW Mental Health Commission Community Advisory Council, Member	2012-2015
Lismore Family Law Pathways Steering Committee, Member	2011-2013
Byron Bay Youth House Management Committee, Secretary & Treasurer	2010-2013

Reviewer for

- *BMC Psychiatry* (Q1)
- *International Journal of Law and Psychiatry* (Q1)
- *Australian Social Work* (Q1)
- *Journal of Social Policy* (Q1)
- *Ethics and Social Welfare* (Q1)
- *Journal of Psychiatric and Mental Health Nursing* (Q1)
- *International Social Work* (Q2)
- *Australian Journal of Rural Health* (Q2)
- *Radical and Critical Social Work*
- *Australian Universities' Review*

Course development

Courses designed or redesigned at RMIT:

- Advanced Law for Social Work Practice (HWSS2184)
- Mental Health and Wellbeing (HUSO1298)
- Critical Social Work (HWSS2049)
- Program Management and Evaluation (HWSS1141)
- Community Development Strategies (HUSO2068)
- Contemporary Themes in Professional Practice (HWSS2210)
- Group and Community Work Strategies (HWSS2213)
- Law for Social Work Practice (HWSS2163)

Courses taught and coordinated at RMIT:

- Advanced Law for Social Work Practice (HWSS2184)
- Mental Health and Wellbeing (HUSO1298)
- Critical Social Work (HWSS2049)
- Program Management and Evaluation (HWSS1141)
- Community Development Strategies (HUSO2068)
- Law for Social Work Practice (HWSS2163)
- Social Work with Groups (HWSS2093)
- Models and Sites of Youth Work Practice (HWSS2133)
- Mapping the Youth Work Sector (HWSS2130)

Courses taught and coordinated at Charles Sturt University:

- Advanced Social Policy Analysis and Planning (SPE501)
- Social Work and Social Policy Practice (SPE502)
- International Social Development (SWK414)