Royal Commission into Victoria's Mental Health System

WITNESS STATEMENT OF PROFESSOR PENELOPE WELLER

I, Penelope Weller, Professor at RMIT University, of 124 La Trobe St, Melbourne, Victoria 3004, say as follows:

1 I make this statement on the basis of my own knowledge, except where otherwise stated. Where I make statements based on information provided by others, I believe that information to be true.

2 I am giving evidence to the Royal Commission in my personal capacity and not on behalf of my employers or organisations of which I am a member.

Features of human rights frameworks that could be elevated or better operationalised in a reformed mental health system

3 In my view, a human rights approach could be adopted to better operationalise a reformed mental health system.[1] By 'human rights framework', I refer to a framework that gives full recognition to the right to health in international human rights law. The most significant United Nations treaty for the purposes of the provision of health services to those with mental health needs is the Convention on the Rights of Persons with Disabilities (**CRPD**).[2] A human rights framework is consistent with a public health approach but extends that framework by incorporating the legal determinants of health.

4 A human rights framework reflects a commitment to recognise and work toward a realisation of the human right to health and mental health as the foundation for policy and law reform.[3] Human rights generally, and the human right to health and mental health, provide a fertile conceptual framework to guide and inform transformation of the mental health system.[4]

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[1] Weller, P. (2017) 'Health and Human Rights' in Farrell, Karpin, Devereaux and Weller (eds) *Health Law: Frameworks and Context*, Cambridge University Press.
[2] *Convention on the Rights of Persons with Disabilities* (CRPD), opened for signature 13 December 2006, GA Res 61/106 (entered into force 3 May 2008), UN Doc A/Res/61/106 <https://www.ohchr.org/EN/HRBodies/CRPD/Pages/ConventionRightsPersonsWithDisabilities.aspx#1>. [Accessed 29 April 2020].
[3] See Weller, P. (2010) 'The right to health: The Convention on the Rights of Persons with Disabilities' (2010) 35:2 *Alternative Law Journal* pp. 66–71; Weller, P. (2010) 'Developing law and ethics: The Convention on the Rights of Persons with Disabilities' (2010) 35:1 *Alternative Law Journal* pp. 8–12; Weller, P. (2013) 'Towards a genealogy of coercive care' in Ian Freckelton and Bernadette McSherry (eds) *Coercive Care,* Routledge.
[4] See Weller, P. (2017) 'Health and Human Rights' in Farrell, Karpin, Devereaux and Weller (eds) *Health Law: Framework all s and Context*, Cambridge University Press.

Please note that the information presented in this witness statement responds to matters requested by the Royal Commission.

The right to health and mental health

5 The right to health, which is shorthand for the 'right to the highest attainable standard of physical and mental health' is an embedded norm under international law carrying 'considerable legal weight'.[5] It is a foundational concept in international human rights law,[6] and is given substance in Article 12 of the International Covenant on Economic Social and Cultural Rights (**ICESCR**)[7] and ICESCR General Comment 14.[8] The right to health is reiterated in all of the subsequent thematic conventions.[9]

6 The right to health is an expansive right to the physical, social and economic conditions necessary to support health and promote the conditions in which people can lead a healthy life. It includes the right to control one's health and body, the right to access systems of health protection, prevention, treatment and control of diseases; the right to timely and appropriate health care; and a right to provision for the underlying and social determinants of health.[10]

7 The minimum core obligations of the right to health are to:

(a) ensure access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable and marginalised groups;

(b) ensure access to the minimum essential food, which is sufficient, nutritionally adequate and safe, and ensure freedom from hunger for everybody;

(c) ensure access to basic shelter, housing and sanitation and an adequate supply of safe and potable water;[11]

(d) provide access to essential drugs;

(e) ensure equitable distribution of all health facilities, goods and services; and

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[5] Toebes B, 'Introduction' in Toebes B, Ferguson R, Markovic M M and Nnamuchi O (eds), *The Right to Health: A Multi-Country Study of Law, Policy and Practice* (Springer, 2014), xiii.
[6] *Universal Declaration of Human Rights*, GA Res. 217A (III), at 71, UN GAOR, 3d Sess., 1st plen. mtg., UN Doc. A/810 (10 December, 1948) (UNHR). Art 25. Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.
[7] *International Covenant on Economic Social and Cultural Rights*, 19 December 1966, (entered into force 3 January 1976), 993 UNTS 3 (ICESCR).
[8] Committee on Economic Social and Cultural Rights, General Comment No 14, *The Right to the Highest Attainable Standard of Health* (Article 12 of the Covenant) UN Doc E/C 12/2000/4 (2000).
[9] *International Convention on the Elimination of All Forms of Racial Discrimination (ICERD),* art 5(iv); *Convention on the Elimination of Discrimination Against Women (CEDAW),* art 12; *Convention on the Rights of the Child (CRC)*, art 24; *Convention on the Rights of Persons with Disabilities (CRPD)*, art 25.
[10] General Comment 14, [8].
[11] The right to water has emerged as discrete human right. See ICESCR *General Comment No 15: The Right to Water* (Arts 11 and 12 of the Covenant) 20 January 2003, E/C12/2002/11.

(f) adopt and implement a national public health strategy and action plan based on evidence, addressing the health concerns of the whole population.[12]

8 With respect to the provision of health care, Article 12 of the ICESCR requires that health care and public health facilities and services be available, accessible, acceptable and of good quality. Availability refers to the availability of all facilities, goods and services, including health systems, hospital clinics, trained medical professionals and medicines and to the underlying determinants of health such as food, shelter, safe and potable drinking water and adequate sanitation.[13] Accessibility includes the overlapping dimensions of access without discrimination, physical and economic access including affordable and accessible health related information.[14] Acceptability refers to respect for medical ethics, cultural sensitivities and a person's willingness to accept the treatment.[15] Quality refers to the availability of appropriately skilled medical personnel, scientifically approved and unexpired drugs, hospital equipment, safe and potable water and adequate sanitation.[16]

9 States parties to the ICESCR are required to integrate gender perspectives in health-related policies; implement a national strategy for promoting women's health; abolish harmful traditional practices; provide a safe and supportive environment for adolescents; integrate health for older persons; address the health needs of people with disabilities, including people with mental health issues; and adopt measures with respect to the health of indigenous people, including the provision of resources for the design, delivery and control of such services.[17] Discrimination with respect to access to the underlying determinants of health, including discrimination on the basis of disability, is forbidden.[18]

The Convention on the Rights of Persons with Disabilities

10 Of relevance to the provision of mental health care is Article 25 of the CRPD:[19]

> **Article 25 – Health**
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> States Parties recognize that persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability. States Parties shall take all appropriate measures to ensure access for persons with

[12] See Forman, L. et al, 'Conceptualising Minimum Core Obligations Under the Right to Health: How Should We Define and Implement the "Morality of the Depths"' (2016) 20(4) *International Journal of Human Rights* 531.
[13] General Comment 14, [12a].
[14] General Comment 14, [12b].
[15] General Comment 14, [12c].
[16] General Comment 14, [12d].
[17] General Comment 14, [20]-[27].
[18] General Comment 14, [18].
[19] For a comprehensive analysis of Article 25, see Weller, P. (2018) 'Health' in Bantekas and Anastasiou (eds) *The United Nations Convention on the Rights of Person with Disabilities commentary*, OUP.

disabilities to health services that are gender-sensitive, including health-related rehabilitation. In particular, States Parties shall:

(a) Provide persons with disabilities with the same range, quality and standard of free or affordable health care and programmes as provided to other persons, including in the area of sexual and reproductive health and population-based public health programmes;

(b) Provide those health services needed by persons with disabilities specifically because of their disabilities, including early identification and intervention as appropriate, and services designed to minimize and prevent further disabilities, including among children and older persons;

(c) Provide these health services as close as possible to people's own communities, including in rural areas;

(d) Require health professionals to provide care of the same quality to persons with disabilities as to others, including on the basis of free and informed consent by, inter alia, raising awareness of the human rights, dignity, autonomy and needs of persons with disabilities through training and the promulgation of ethical standards for public and private health care;

(e) Prohibit discrimination against persons with disabilities in the provision of health insurance, and life insurance where such insurance is permitted by national law, which shall be provided in a fair and reasonable manner;

(f) Prevent discriminatory denial of health care or health services or food and fluids on the basis of disability.

11 The salient obligations in Article 25 are that health care services, including services related to a person's disability, must be provided on an equal basis with others; that services must be provided on the basis of free and informed consent; that the discriminatory denial of health care and services is prohibited; and that States parties must provide training for health professionals in both the public and private sectors. In my view, the obligations enshrined in the CRPD should be formally recognised in Victorian law.

12 Determining precisely how such obligations are to be appropriately applied in a mental health setting requires thoughtful and genuine collaboration between all stakeholders, including people with experience of mental health issues. What is clear is that a human rights-based analysis of the right to the highest attainable standard of health and mental health does not support the provision of unwanted medical or psychiatric treatment that is administered against a person's will.

13 Despite the availability of information on the right to health, it is often poorly understood, even amongst human rights scholars. In part, this is because of the indeterminate nature of the right, its dynamic incorporation of civil, political, economic, social and cultural rights,

and its rapid expansion. Moreover, the right to health has been discussed more frequently in relation to developing nations than in the context of Western democracies with well-resourced and sophisticated health systems. The assumption that developed nations adequately provide for people with disabilities, including people with psycho-social disabilities, was challenged by the findings of the World Programme of Action, which led to the proclamation of the United Nations Decade of Disabled Persons (1983-1992).[20] That program documented widespread human rights violations experienced by people with disabilities and gave rise to the CRPD.[21]

14 To address this poor understanding, community-wide training and education should be provided on the right to health.

The Charter of Human Rights and Responsibilities

15 In Victoria, the *Charter of Human Rights and Responsibilities Act 2006* (the **Charter**) recognises the importance of human rights and the relevance of international human rights instruments. Relevantly, the Charter protects equality before the law; the right to life; protection from torture and cruel, inhuman or degrading treatment; freedom of movement; privacy and reputation; freedom of thought, conscience, religion and belief; freedom of expression; cultural rights; liberty and security of person; and humane treatment when deprived of liberty.[22] The Charter prohibits public authorities from acting incompatibly with a human right or making decisions without giving proper consideration to a relevant human right.[23] The Charter recognises that human rights may be limited or balanced against other rights, in certain circumstances, as set out in section 7. Charter jurisprudence clearly states that the first step in that balancing process requires consideration of the full scope of the rights in question. In understanding the full scope of human rights, it is relevant to consider international law and the judgments of domestic, foreign and international courts and tribunals.[24] In a recent decision concerning decisions to provide electroconvulsive therapy made under the *Mental Health Act 2014 (Vic)* (**Act**),[25] Justice Bell drew a close connection between the right to health and the relevance of Charter rights for decision-making under the Act, including:

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[20] The General Assembly proclaimed the 1983-1992 United Nations Decade of Disabled Persons to provide a timeframe during which governments and organisations could implement the activities recommended in the World Programme of Action.

[21] Lindqvist, B., *Final Report of the Special Rapporteur of the Commission for Social Development on Monitoring the Implementation of the Standard Rules on the Equalization of Opportunities for Persons with Disabilities on his Second Mission 1997-2000*, 38th session, Provisional Agenda Item 3(b), UN Doc E/CN.5/2000/3 (8-17 February 2000).

[22] *Charter of Human Rights and Responsibilities Act 2006 (Vic)* ('*Charter*') Pt 2–Human rights.

[23] *Charter* s 38.

[24] *Charter* s 32(2).

[25] *PBU & NJE v Mental Health Tribunal* [2018] VSC 564 ('*PBU*').

(a) the right to equality;

(b) the right to be free from cruel, inhuman or degrading treatment or punishment;

(c) the right not to be subject to medical treatment without free and informed consent;

(d) the right to privacy;

(e) the right to liberty and security of person; and

(f) the right, when deprived of liberty, to be treated with respect for the inherent dignity of the person.

16 I recommend the formation of a task force or research hub dedicated to identifying and promoting the 'right to health' obligations arising under the Charter.

17 Disappointingly, there is little evidence of proactive engagement with these broader human rights concepts by policy makers, those with governance responsibilities, managers and clinicians. As noted above, a general understanding of human rights is lacking.

18 Another key barrier to the task of giving substance to the rights that are recognised in the Mental Health Act is the limited allocation of resources and effort directed to human rights focused research, education and training. The process of creating a human rights compliant mental health system must include a process for giving full and proper consideration to the scope of human rights and their application in the mental health system. To that end, a task force or research hub should be created in order to identify and promote the proper application of human rights principles in the Act.

Degree of alignment between a public health approach and a human rights framework

19 A 'right to health' approach is broader but consistent with a public health approach. It provides a conceptual framework that looks beyond immediate health system responses to the legal, social and economic conditions that constitute the underlying social determinants of health. It supports a preventive public health approach. It also supports systems modelling to identify and respond to need while limiting the occurrence of unintended or perverse consequences of piecemeal reform.

20 The right to health framework provides an opportunity to recognise and take account of all aspects of the burden imposed by mental health issues. Second, it promotes mental health policy that comprehensively recognises poverty, marginalisation and disadvantage as drivers of mental health care need. This need includes access to proper housing, secure income and employment. Improving the socio-economic conditions that shape a person's mental health will have a direct impact on the mental health and well-being of the community and the work undertaken in the mental health sector. To achieve this, I

recommend the establishment of a multi-disciplinary research body dedicated to identifying social policies and interventions that support mental health and well-being.

Ways of promoting the rights of people living with mental illness

21 A 'right to health' approach would support the rights of people living with mental illness by demanding responses that value health, justice and equitable and accountable health systems. Such an approach would also demand the eradication of laws that stigmatise or discriminate against marginalised populations, especially where such laws are harmful and exacerbate existing health disparities.

22 With respect to the question of promoting the rights of people with mental illness within the mental health system, a 'right to health' perspective demands robust governance and accountability structures that ensure a just and equitable mental health system, innovative legal strategies that respond to the broad range of needs of people with mental illness and also meet their specific needs in navigating the mental health system, and recognise each person's entitlement to appropriate, safe and effective mental health care.

(a) **Establish robust governance structures**: a human rights compliant mental health system requires creative and robust governance. At present, the Mental Health Complaints Commissioner, the Office of the Chief Psychiatrist and the Mental Health Tribunal each perform an oversight role. However, none of these bodies are empowered to actively drive change in the system or work towards achieving a culture in the mental health system that is engaged with human rights, acknowledges health justice and is cognisant of the legal determinants of health. Consideration could be given to the establishment of a body with an express mandate to oversee and sustain the transformation of the mental health system.

The following ideas are examples of the kind of work that could be undertaken by such a body:

(1) It could monitor and research the impact of policy decisions and system change decisions, both within the mental health sector and beyond, that affect the capacity of the mental health system. Many of the current difficulties facing the sector have been contributed to by decisions made in other policy areas, such as decisions about the availability of public housing. Rather than reacting to these impacts there needs to be active engagement with the broad range of policy decisions that impact on the ability of mental health sector to provide appropriate services. A recurrent difficultly is the interface between the drug and alcohol services and the mental health services.

(2) It could consider and make recommendations about the interactions between the civil mental health system, the drug and alcohol system, the aged care system, the guardianship and administration system and the interface of these systems with the criminal justice system.

(3) It could monitor and promote a targeted preventive stance in the funding and delivery of mental health services.

(4) It could monitor the implementation of service approaches to ensure that innovation is properly prioritised (provided it is consistent with human rights principles) in the delivery of mental health services. The body's stance should be one that harnesses the creative efforts of all those who are currently seeking to infuse the mental health system with human rights principles.

(5) It should have strong representation from those with lived experience and a mandate to support the inclusion of those with lived experience at all levels of policy development and service provision throughout the mental health system.

(b) **Create justice and health partnerships**: many of the individuals who access public mental health services struggle with disadvantage, poverty and unemployment. Many are homeless. Many engage in illicit drug use. Many have a range of legal needs that are rarely acknowledged, let alone addressed, in the current system despite the obvious relevance of such stressors to the trajectory of a person's mental illness. Such legal needs may relate to issues raised by fines, debts, family payment issues, criminal charges, family violence matters, family law proceedings, child custody matters, permanent residency and migration issues and more. Establishing justice and health partnerships in the form of specialist/generalist legal services located at mental health facilities would assist in addressing these unmet legal needs. This would be one way of having a concrete response to those broader socio-economic issues that are all too evident in certain service areas.

(c) **Expand the existing independent mental health advocacy (IMHA) service**:[26] IMHA is a service providing non-legal representational mental health advocacy for people who are at risk of or subject to compulsory treatment. Some IMHA advocates are peers who have lived experience. IMHA supports human rights by using empowerment and recovery principles to equip individual consumers with

[26] Weller P, Alvarez-Vasquez S, Dale M, et al (2019) 'The need for independent advocacy for people subject to mental health community treatment orders', *International Journal of Law and Psychiatry*, Vol 66 (Sep-Oct 2019), 101452.

the skills to improve their ability and confidence to advocate for themselves. IMHA is valued by those who have used the service and is also well regarded by services and clinicians. The service assists people with discharge, supports participation in decision-making about medication, and supports consumers appearing before the Mental Health Tribunal.[27] A right of access to IMHA's services could be mandated in legislation.

(d) **Actively implement evidence-based programs across all services**: the right to health requires that services be accessible, acceptable and appropriate. A significant amount of work has been undertaken in the sector to create new and effective approaches to the delivery of mental health services, all of which take a holistic, contextual and person-centred approach to mental health care. Prominent examples are:

(1) the Safewards program;

(2) trauma-informed care;

(3) recovery-oriented practice;[28]

(4) strategies to eliminate seclusion and restraint in all facilities; and

(5) strategies to support decision-making in line with the CRPD.[29]

The evidence is that such approaches improve outcomes for people experiencing mental health problems. It is important that such programs are promoted, resourced and provided with translational support to ensure that they become mainstream practice. Evidence that such programs have been implemented could be mandated in service contracts and would assist in quality control audits.

(e) **Introduce women only wards**: recent research published by the Mental Health Commission and RMIT University has documented the unacceptable occurrence

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[27] Evaluation of the Independent Mental Health Advocacy Service (IMHA); <https://www.imha.vic.gov.au/sites/imha.vla.vic.gov.au/files/imha-rmit-evaluation-of-the-independent-mental-health-advocacy-service-03-2019.pdf>.

[28] Meadows G, Brophy L, Shawyer F et al (2019), 'REFOCUS-PULSAR recovery-oriented practice training in specialist mental health care: a stepped-wedge cluster randomised controlled trial', 2019, *Lancet Psychiatry* Vol 6(2) 103-114; Edan V, Brophy L, Weller P, Fossey E, Meadows G (2019), 'The experience of the use of Community Treatment Orders following recovery-oriented practice training' *International Journal of Law and Psychiatry* Vol 64 (May-June 2019), 178-183; Shawyer F, Enticott J C, Brophy L, Weller P et al (2017), 'The PULSAR Specialist Care protocol: a stepped-wedge cluster randomized control trial of a training intervention for community mental health teams in recovery-oriented practice' *BMC Psychiatry* 17(1) 172; Enticott J, Shawyer F, Brophy L, Russell G, Fossey E, Inder B, Mazza D, Vasi S, Weller P, Wilson-Evered E, Eden V, and Meadows G (2016), 'The PULSAR primary care protocol: A stepped-wedge cluster randomized controlled trial to test a training intervention for general practitioners in recovery-oriented practice to optimize personal recovery in adult patients', *BMC Psychiatry*, 16(451) pp 1 – 16.

[29] Weller, P. (2008) 'Supported Decision–making and the Achievement of Non–discrimination: The Promise and Paradox of the Disabilities Convention', *Law in Context*, Vol 26(2) pp 85-110.

of gender-based violence in mental health facilities.[30] One way to reduce many such instances would be to introduce women only wards. Since most area mental health services have more than one ward, it would be possible to organise inpatient units on the basis of gender in all mental health areas.

Ways in which mental health laws and other human rights frameworks can assist in reducing the use of compulsory treatment

23 The Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health,[31] Dainius Pūras, has recognised that the right to health in international human rights law is to be understood within the framework of the CRPD. He argues that immediate action is required to radically reduce medical coercion and to:

> "facilitate the move towards an end to all forced psychiatric treatment and confinement. In that connection, States must not permit substitute decision-makers to provide consent on behalf of persons with disabilities on decisions that concern their physical or mental integrity; instead, support should be provided at all times for them to make decisions, including in emergency and crisis situations."[32]

24 In its 2017 report, the Special Rapporteur called for the adoption of five deliberate, targeted, and concrete actions:

(a) Mainstream alternatives to coercion in policy with a view to legal reform;

(b) Develop a well-stocked basket of non-coercive alternatives in practice;

(c) Develop a road map to radically reduce coercive medical practices, with a view to their elimination, with the participation of diverse stakeholders, including rights holders;

(d) Establish an exchange of good practices between and within countries;

(e) Scale up research investment and quantitative and qualitative data collection to monitor progress towards these goals.[33]

25 In my view, each of these actions should be adopted and pursued in Victoria.

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[30] This research was published in a report titled 'Preventing gender-based violence in mental health inpatient units', available at <https://www.anrows.org.au/publication/preventing-gender-based-violence-in-mental-health-inpatient-units/>. See also Weller, P. (2016) 'The Contradictions of Gender: mental health research, policy, law and human rights', *Griffith Law Review*, Vol 25(1) pp 87-103.
[31] The Special Rapporteurs are independent experts appointed by the Human Rights Council to examine and report back on a country situation or a specific human rights theme.
[32] Pūras, D. 2017, *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health* at [65], available at <https://www.ohchr.org/EN/HRBodies/HRC/RegularSessions/Session29/Documents/A_HRC_29_33_ENG.DOCX> [Accessed 18 August 2020].
[33] Ibid at [66].

Legal mechanisms to reduce the use of compulsory treatment

26 The question of how to directly reduce the use of compulsory mental health treatment is a complex one. One argument currently being put forward in response to this issue is that mental health legislation should be abolished. Those who support this approach argue that it is possible for mental health systems to operate without compulsory treatment laws. They point to an example provided by the experience of Germany, where there was a period during which no compulsory treatment laws were in force. There was apparently no significant negative impact on the operation of the mental health system.[34] The German example underscores the broader point that it is possible for effective mental health systems to operate under different legal regimes.[35] The relationship between compulsion and practice also requires more in-depth research.[36]

Rights based mental health laws

27 In developed Western countries, the legislative response to the consumer rights arguments of the 1970s was to introduce rights based mental health laws.[37] The key features of such laws are limited to civil commitment criteria and oversight of clinical decision-making by mental health tribunals. The first wave of rights based mental health legislation (which was introduced in the 1980s) was not directly focused on the reduction of compulsory mental health treatment. Rather, the objective of these laws was to protect rights. As I have argued in earlier work, the human rights principles underpinning this legislative model tend to be 'lost in translation'.[38] It is now evident that the original model of rights based mental health laws served to identify and regulate the provision of mental health treatment without the consent of the person. In that sense, it created or 'named' the problem of compulsory treatment.

28 A second wave of rights based mental health law reform, which took place in Australia from 2010 onwards, was more directly aimed at reducing rates of compulsory mental health treatment, despite that policy goal not being explicitly expressed in the relevant legislation. Several jurisdictions in Australia have amended the original rights-based

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[34] Martin Zinkler (2016) Germany Without Treatment in Psychiatry- a 15 Month Real World Experience, *Laws* 2016 5(1) 15.https://doi.org/10.3390/laws5010015.

[35] Weller, P. (2018) 'Therapeutic Jurisprudence and Procedural Justice in Mental Health Practice: responding to vulnerability without coercion', in *Critical Perspectives on Coercive Interventions, Routledge Frontiers of Criminal Justice*, Oxon, United Kingdom, pp. 212-224 ISBN: 9781138067370. Weller, P. (2013) "Towards a genealogy of coercive care" in Ian Freckelton and Bernadette McSherry (eds) *Coercive Care,* Routledge.

[36] Weller P (2019) 'Mothers and mental illness: breaking the silence about child loss' *International Journal of Law and Psychiatry*, 2019, Vol. 67 (2019) 101500. Brophy L, Ryan C, and Weller P, (2018) 'Community Treatment Orders: the evidence and ethical implications', in *Critical Perspectives on Coercive Interventions, Routledge Frontiers of Criminal Justice,* Oxon, United Kingdom, pp. 30-43 ISBN: 9781138067370;

[37] See McSherry B and Weller P (eds) *Rethinking Rights–Based Mental Health Laws* (Hart Publishing, 2010).

[38] Weller, P. (2010) 'Lost in translation: human rights and mental health law' in McSherry B and Weller P (eds) *Rethinking Rights–Based Mental Health Laws*, (Hart Publishing, 2010) pp 51-72.

model to include (a) determinations of capacity as an element of the civil commitment criteria; and/or (b) a range of alternative decision-making mechanisms, such as advance directives and supported decision-making mechanisms. Proponents of this second wave of rights based mental health laws (which one might term a 'rights plus' model) often claim that they are compliant with the CRPD, or at least recognise that these laws are more closely aligned with the CRPD than the prior iterations. Whether or not that is this case requires further analysis.

29 The introduction of capacity based and supported decision-making laws in Australia has not reduced the levels of compulsory mental health treatment as was intended, save perhaps in Western Australia.[39] It is not clear why this is the case. The impact of different mental health laws warrants further investigation. It seems likely that the question of whether different models of mental health legislation play a role in the reduction of compulsory mental health treatment will depend on the specific features of the legislation, how it is implemented, the role that is given to oversight bodies, the interaction between the legislation and other related legal frameworks, and the influence of other recurrent features of the mental health system. For example, the introduction of rights based mental health laws, coupled with the withdrawal of substantive funding in the mental health sector, appears to have given rise to a crisis-driven mental health system with increased levels of compulsory medical treatment.[40] Possible explanations for the failure of new laws to change the rates of compulsory mental health treatment may include significant anomalies in the available data (for example when a person is the subject of a compulsory treatment order but is willing to receive the treatment specified in the order); variations in the interpretation of mental capacity; variations in the way other elements in the statutory criteria for civil commitment are interpreted and applied; and different understandings about the application of human rights principles in those states and territories that have adopted human rights legislation (Victoria, the ACT and Queensland). For example, it is evident from the Victorian Supreme Court decision of *PBU* that the interpretations of the concept of mental capacity adopted by the clinicians and the Mental Health Tribunal in that case differed from that which was ultimately articulated by the Supreme Court. [41]

30 Targeted research is needed to properly investigate the relationship between different legal structures and the rates of compulsory mental health treatment.

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[39] Christopher Ryan, Presentation at the ANZAPPL conference, Singapore, Nov 2019.
[40] Weller, P. (2011) 'The Convention on the Rights of Persons with Disabilities and the social model of health: new perspectives' (2011) *Journal of Mental Health Law*, pp 74-83.
[41] PBU & NJE v Mental Health Tribunal [2018] VSC 564.

The degree of international consensus on compulsory treatment

31 There is a clear consensus amongst international bodies about the need for change in mental health systems. At present there are some differences in the statements issued by international human rights bodies in response to the CRPD and specifically in respect of the question of whether it is permissible to detain and treat individuals with acute mental health problems. There is also considerable consensus.

32 There are several points to be borne in mind in evaluating the statements of international human rights bodies. First, the statements of such bodies are nuanced. That is, a close and contextual reading reveals less difference than is sometimes represented in the commentary.

33 Second, some of the differences in approach can be accounted for by the different perspectives of various international bodies. For example, the statements differ depending on whether a body's focus is on forensic or civil mental health detention, whether and how questions of mental capacity are interpreted and applied, whether and how questions about substitute decision-making are addressed and whether discussion of a possible exception to the general principles is included in the statements.

34 Third, notwithstanding these differences, it is clear that (a) an international consensus is emerging over time, and (b) there is absolute agreement that a great deal needs to change. There is also general agreement that new models need to be generated with detailed explications of how such laws, policies and practices will 'work' in a given jurisdiction.

35 With respect to points of consensus, all of the statements reflect the position in international human rights law that discrimination on the basis of disability is forbidden. Many of the statements refer to the concept of proportionality: that human rights principles require interventions to be proportionate to the harm being averted, and that they be measures of last resort. Moreover, it is generally recognised that the rights of people with disabilities, including those with mental health problems, should be respected, that the use of compulsory mental health treatment should be limited, and that mental health treatment should be provided on the basis of free and informed consent. In the absence of free and informed consent, decisions must respect the 'rights, wills and preferences' of the person. There is currently active international debate about the particular meaning of that phrase, a debate which is part of a broader international effort to engage with human rights based mental health law reform.[42] The need for reforms to existing mental health

[42] See for example George Szmukler (2019)'"Capacity", "best interests", "will and preferences" and the UN Convention on the Rights of Persons with Disabilities', *World Psychiatry* 18(1) p. 34-41; Eilionóir Flynn (2019) 'The rejection of capacity assessments in favour of respect for will and preferences: the radical promise of the UN Convention on the Rights of Persons with Disabilities'.*World Psychiatry*, 2019, Vol.18(1) p 50-51.

legislation to align with human rights principles has prompted several jurisdictions with similar legal frameworks to Australia to review and develop new models of mental health law. The legislative frameworks in Ireland, Northern Ireland, Scotland, England and Wales are currently at various stages in the reform process.

36 It is hoped that all stakeholders in the Victorian mental health system will be encouraged to engage in an open and collaborative discussion that will support the development of our own human rights-based legislation.

Ways in which the principles and human rights safeguards in the Mental Health Act 2014 could be improved

37 A 'right to health' approach should also guide the transformation of mental health legislation. Mental health laws should expressly recognise the principles of equality, proportionality and reciprocity.

The principle of equality

38 The principle of equality requires that if multiple legislative frameworks apply to people with disabilities, including those with mental health problems, each legislative framework must provide at least the same suite of rights and protections as are provided under other legislative frameworks.[43] This means that an analysis of mental health laws must be conducted with reference to the operation of laws, principles and practices that are applied in general health settings. Attention must be paid to the operation of capacity-based laws, supports for decision-making[44] and alternative decision-making arrangements.[45]

39 The key question is, on what basis are we treating people with mental health issues differently from others, and can that different treatment be justified by a human rights analysis?

40 Although the current form of the Act contains some innovative solutions compared with its predecessor, it is now significantly out of step with the legislative frameworks that apply to others, particularly those set out in the new *Guardianship and Administration Act 2019* and the *Medical Treatment Planning and Decisions Act 2016*.

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[43] Weller, P. (2017) 'Health Law and Human Rights: Towards Equality in the Human Right to Health' in Freckelton and Petersen (eds) *Tensions and Traumas in Health Law* (Federation Press, 2017).
[44] See Weller, P. (2016) 'Legal Capacity and Access to Justice: The Right to Participation in the CRPD' *Laws,* Vol 5(1), 13 pp 1-13.
[45] For a full discussion of international trends in advance directives, see Weller, P. (2013) *New Law and Ethics in Mental Health Advance Directives: The Convention on the Rights of Person with Disabilities and the Right to all through*).

41 One area of difficulty is the question of whether it is legitimate to treat individuals with mental capacity against their will. Such practices are clearly indefensible under a human rights framework. To provide compulsory medical treatment to a person with mental capacity is a violation of their right to self-determination and personal liberty.

42 A second area of difficulty is how we support those who lack mental capacity in ways that ensures that they are given the opportunity to provide informed consent to any proposed treatment.

43 A third area of difficulty is how to design laws that appropriately account for the limited situations where it may be necessary to make decisions according to the 'rights, will and preferences of the person.'[46] Significant resources should be allocated to the design of appropriate laws and the implementation of them. Transformation of decision-making practices as they relate to management of the mental health system should be at the heart of this transformative vision.

The principle of proportionality

44 A second principle that derives from the human rights framework is the principle of proportionality. This principle requires that any interventions mandated by legislation should be proportionate to the danger or harm to be averted. At present, the Act refers to the 'least restrictive option'. The least restrictive option is a lower standard than that required by the principle of proportionality.

45 At present, the calculation of the least restrictive option operates on an assumption that a safe environment is provided in an inpatient facility. The fact that there are regular instances of forced treatment, assault and sexual assault among individuals who are subject to seclusion and restraint should be included in the calculation of harm.

46 The principle of proportionality also provides a basis that would better facilitate the transition of individuals from compulsory treatment to voluntary treatment than the risk frameworks currently in place.

The principle of reciprocity

47 The principle of reciprocity involves the notion that the exercise of power by the state to detain and treat people in mental health facilities imports a parallel obligation to ensure that those facilities are safe, appropriate and that appropriate care is provided. Accordingly, any instances of forced treatment, assault or sexual assault occurring in relation to individuals subject to seclusion and restraint would amount to a failure of the

[46] Weller, P. (2017) 'Substitute Decision Making' in Farrell, Karpin, Devereaux and Weller (eds) *Health Law: Frameworks and Context*, Cambridge University Press.

State to provide a safe environment. Similarly, the requirement that treatment be appropriate means that treatment must be tailored to meet the needs of individuals, including their need for trauma-informed care, recovery-oriented principles and gender-based accommodation.

48 The principles of proportionality and reciprocity may also be capable of being employed together to provide a more effective framework for regulating the entry of individuals into the acute mental health system and the transition of those who have been subject to compulsory mental health treatment to voluntary forms of mental health treatment.

49 For example, at present it appears that the risk based civil commitment criteria operate inconsistently at different points in time. Individuals report that they are turned away from mental health services because they are not sufficiently unwell to meet the civil commitment criteria. On the other hand, when they wish to leave hospital, the risk-based criteria are applied in a way that prevents them from leaving or transitioning to voluntary care. This state of affairs is exacerbated by the apparent use of community treatment orders to ensure some level of service provision is available to individuals who may not otherwise receive attention or care from over-burdened mental health services.[47]

50 I recommend the establishment of a dedicated research program to investigate the relationship between laws, legal frameworks and system characteristics with respect to the use of compulsory mental health treatment.

Overview of the Mental Health Act 2014

51 The Act was the product of a bipartisan law reform process. It was widely regarded as introducing an innovative, rights-based framework which was influenced by the CRPD. Human rights dimensions of the Act manifest in the objectives and principles of the legislation, in its protection of the rights set out in Part 3, and in the supported decision-making framework it establishes for patients who receive treatment under the provisions of the Act. In my view, many of the features of the Act remain sound.

52 The most lauded and innovative features of the Act include:

(a) a comprehensive list of objectives (s 10) and mental health principles (s 11);

(b) the requirement to seek informed consent (s 70(1)), the presumption of capacity to provide informed consent (s 70(2)), and the inclusion of contemporary definitions of mental capacity (s 68) and informed consent (s 69);

[47] Brophy L, Ryan C, and Weller P, (2018) 'Community Treatment Orders: the evidence and ethical implications', in *Critical Perspectives on Coercive Interventions, Routledge Frontiers of Criminal Justice,* Oxon, United Kingdom, pp. 30-43 ISBN: 9781138067370; Edan V, Brophy L, Weller, P, Fossey E, Meadows G, (2019) 'The experience of the use of Community Treatment Orders following recovery-oriented practice training' *International Journal of Law and Psychiatry* Vol 64 (May-June 2019), 178-183.

(c) a suite of measures aimed at facilitating supported decision-making, which include the requirement to provide and explain a statement of rights (ss 12, 13) and provisions for advance statements (ss 19-22) and nominated persons (ss 23-27); and

(d) the requirement that the treating clinician and the Mental Health Tribunal (in determining the least restrictive option available) take into account the patient's views and preferences, including their views and preferences as expressed in any advance statement, the views of any nominated person and the views of a guardian, parent or other carer (see, for example, s 55(2)(a)-(f) and s 71(4)(a)-(f)).

53 Unfortunately, the promise of these key features, especially the supported decision-making framework, has not yet come to fruition. With respect to advance statements, the uptake of advance statements has been small and the influence or role of supported decision-making in most instances appears to be negligible. Specialist services such as the Mental Health Legal Centre have been providing support for the development of advance statements, however the reach of such services is limited. There appears to be uncertainty about the legal status of these documents, and doubt as to their utility, among clinicians. When the concept of advance statements was incorporated into the Act, a strong criticism made by consumer groups was that the non-binding nature of these statements fell short of their expectation of a binding advance directive.

54 Similarly, the nominated person scheme has not been widely adopted. There appears to be confusion amongst carers, family members, consumers and clinicians about the role and value of such a person.

55 The potential impact of the innovative features of the Act concerning capacity, informed consent and the requirement that the wishes of persons receiving treatment be taken into account has been limited by a failure to implement these features in a robust way. While there have been some shifts in practice since the legislation came into force, the legislative innovations have not been transformative. Traditional models of clinical decision-making and practice persist.

56 The failure of these innovative structures to transform mental health practice can be attributed to several factors. First, there was inadequate leadership to articulate and promote a robust interpretation of the legislation as a transformative tool. Second, insufficient resources were dedicated to implementing the new framework and providing comprehensive education and support to mental health clinicians and other stakeholders to ensure that the legislative framework could operate effectively. Third, the reduction in funding and resources throughout the mental health system after the legislation was introduced made it almost impossible for staff to work in the ways that are envisaged and

facilitated by the legislation. There is no room for innovation when the mental health system has been reduced in its ability to provide anything other than an acute crisis response. Fourth, no clear responsibility was given for the promotion of some of the key rights protection tasks set out in the legislation, such as the provision of a statement of rights, the appointment of a nominated person or the writing of an advance statement. Finally, the failure to effect change can be attributed (in part) to limitations in the legislative framework itself.

A human rights analysis of the Mental Health Act 2014

57 A human rights analysis of the Act raises a number of issues including the authorisation of treatment for persons with mental capacity, a decision-making scheme that provides less robust protection of the rights of individuals receiving treatment than is available to those in the general health system, a flawed scheme of regulation for seclusion and restraint and a failure to include positive legislative obligations to provide appropriate, safe and proportionate interventions.

Authorising treatment for those with mental capacity

58 The most pressing issue arising from a human rights analysis of the Act is the scope for contravention of the rights of persons with mental capacity. Generally, the law respects the right of persons with mental capacity to consent to or refuse medical treatment. The current wording of section 71 contravenes that principle.

59 The conflation of a failure to give informed consent with an inability to give informed consent was identified as a central problem in the civil commitment criteria of the *Mental Health Act 1986*. The reforms of 2014 were supposed to overcome this fundamental problem. Unfortunately, the wording of section 71 replicates and perpetuates the intrusion upon recognised human rights.

Inadequate protection of rights

60 A second issue arising from a human rights analysis of the Act is its failure to provide a framework of decision-making equivalent to that which is available to those who seek or receive general health care. In Victoria, the legislative frameworks providing for decision-making for individuals seeking health care in the general health system have been transformed by the *Medical Treatment Planning and Decisions Act 2016* and the *Guardianship and Administration Act 2019*. The principle of equality demands that the following amendments to the Act be considered:

(a) extending the facility for binding advance directives to those who are subject compulsory mental health treatment;

(b) enabling people to appoint a substitute decision-maker who is authorised to provide informed consent to any proposed medical treatment; and

(c) enabling people to appoint a decision-making supporter.

61 The degree to which restrictive interventions, such as seclusion and restraint, are regulated under the Act also requires careful consideration. Some commentators argue that the inclusion of the current framework of safeguards has legitimised and encouraged the use of such restrictive practices. It is clear from some emerging research that it is possible to eliminate the use of such practices.[48] If the current regulatory framework is retained, the use of such practices should be reportable to oversight bodies and to any nominated person(s).

62 Provisions in the Act that impose positive obligations on services should be extended to include obligations to provide safe, appropriate, acceptable and proportionate treatment and care in accordance with human rights principles and obligations.

Benefits and drawbacks of having separate legislation for the oversight of compulsory treatment

63 The adoption of a separate piece of legislation applying only to those who are thought to require urgent mental health intervention, would require justification within a human rights framework. Ultimately, whether it is determined that the use of exceptional laws is acceptable depends on the content and operation of the proposed legislative framework.[49] It may be, for example, that separate mental health legislation would provide a positive framework for protecting, defending and promoting the rights of people with mental health problems. A separate legislative framework may also be helpful in ensuring the provision of appropriate services and designating in law the obligation to provide reasonable accommodation to those with disabilities, as is required of States parties to the CRPD.

64 If mental health legislation is understood as a beneficial framework, it might be questioned why these benefits ought to be confined only to those with acute mental health problems. For example, rights based mental health laws have developed several mechanisms and strategies that protect the rights of people with mental health problems. These include limitations and frameworks of oversight for the provision of compulsory treatment, such as a review function performed by the Mental Health Tribunal. A human rights approach

[48] McSherry B., Brophy L., Hamilton B., Roper C., Tellez J., "Reducing seclusion and restraint" (2017) April (41) *The Health Advocate* 34-35.
[49] Weller, P. (2017) 'Mental Capacity and States of Exception: Revisiting Disability Law with Giorgio Agamben' *Continuum* Vol 31(3) pp 1-11.

would require the extension of such safeguards to all instances where compulsory mental health treatment is authorised, such as for decisions made under the *Disability Act 2006*.

65 On this basis, a human rights approach may also recognise the need for legislation that encompasses all those who access mental health services.

66 A recognised danger of separate legislation is that it contributes to the stigma and discrimination experienced by those with mental health problems and contributes to the reluctance of the more vulnerable members of the community to seek mental health care.[50]

67 Another danger is that the mental health system might become isolated from other areas of health services provision which are nevertheless essential to providing a holistic person-centred approach to each individual's own problems and circumstances. For example, the medical problems of people with mental health issues continue to be grossly overlooked. Similarly, the interface of existing mental health services with alcohol and drug related services is extremely poor. The problem of housing for many marginalised people who access mental health services has also remained unaddressed.

68 A related danger arising from the isolation of the mental health system is its failure to readily adopt new practices, approaches and responses that have long since become accepted practice in the mainstream health system. A corollary of this isolation is a general reluctance to engage in innovation and reform.

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date 27/08/2020

[50] Weller, P. (2019) 'Mothers and mental illness: breaking the silence about child loss', *International Journal of Law and Psychiatry*, Vol 67 101500.