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Review of the Mental Health Act 1986

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Submission to the Community Consultation Panel's review of the Mental Health Act 1986

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Part A - Executive summary & recommendations

1. Executive Summary

1.1 The Public Interest Law Clearing House (**PILCH**) welcomes the opportunity to contribute to the review by the Community Consultation Panel (**Panel**) of the Mental Health Act (**Consultation**). We commend the Victorian Government and the Community Consultation Panel on its initiative to undertake the Consultation.

1.2 The Consultation provides a valuable opportunity to more closely align the *Mental Health Act 1986* (Vic) (***MHA***) with the Victorian *Charter of Human Rights and Responsibilities Act 2006* (Vic) (***Charter***) and Australia's international law obligations in respect of human rights and mental health law.

1.3 The operation of the MHA, by its nature, impacts some of the most vulnerable, disadvantaged and marginalised persons in our community and impinges upon a number of fundamental human rights, including the right to life, the right to liberty and security of the person, freedom from cruel inhuman and degrading treatment and the right to a fair hearing. The careful balancing of these fundamental rights and community interests, required by the MHA is best achieved by utilising the existing international human rights law framework. That framework provides a sophisticated and nuanced system of laws and principles that can assist in identifying competing rights and interests, prioritising rights, and achieving the delicate balance inherent in decisions about mental health, deprivation of liberty and involuntary treatment.

1.4 With this approach in mind, in this Submission, PILCH has attempted to focus on those aspects of the mental health system (by reference to the questions set out in the *Review of the Mental Health Act 1986 Consultation Paper – December 2008*) that might expose the hypothetical vulnerable consumer to an unjustified contravention of her rights and where PILCH is able to draw on its particular experience and knowledge as community lawyers. Those areas are: external review of involuntary treatment orders and proceedings before the Mental Health Review Board (***MHRB***); and monitoring of, and complaints about consumer care and treatment.

1.5 A fundamental means of protecting human rights under the new Act[1] will be to ensure that external reviews are conducted in a forum which provides a fair hearing and abides by the rules of procedural fairness. The availability of effective, timely review by an independent and impartial review body is an important safeguard against unjustified or unlawful interference with human dignity and bodily integrity, through the imposition of an involuntary treatment order. Our Submission recommends that the right to a fair hearing in external reviews should be strengthened by (in summary): shortening the time periods for external review; improving the mechanisms for ensuring the independence of the MHRB; guaranteeing legal representation for all persons appearing before the MHRB; and

[1] Where it is used in this Submission, the expression "new Act" has the same meaning as that expression has in the Consultation Paper – see, for example, paragraph 2.1 of the Consultation Paper.

improving procedural fairness before the MHRB by putting in place mechanisms to increase access to the consumer's medical files, amending processes for non-disclosure applications and assisting consumers to obtain a second opinion on their psychiatric condition.

1.6 Advocacy, monitoring of care and treatment decisions and investigation and complaints procedures within the mental health system are also vital in enabling consumers to protect and exercise their rights. These requirements may be met both through the involvement of the consumer's 'nominated carer' (if the consumer wishes to nominate one) and the establishment of a statutory body whose role it is to safeguard consumers' rights and welfare, through visiting persons on involuntary treatment orders, providing information and explanation about the external review process, assisting consumers to access legal representation, investigating standards of care and operating a complaints system. An effective and accessible complaints system will protect consumers' rights by bringing unjustifiable rights violations to light and promoting compliance with human rights law obligations.

1.7 PILCH's recommendations are set out in paragraph 2 below. We consider that these recommendations will advance the position of the most vulnerable consumer who is least able to assist herself, and will strengthen the MHA safeguards to ensure that she does not slip through the cracks and, for instance, be unlawfully deprived of her liberty, or denied a reasonable treatment choice.

2. Recommendations

2.1 PILCH submits that the Panel should recommend that:

(1) Proposed reforms to MHA must be consistent with Australia's international human rights obligations and the Charter.

(2) A review of the MHA is likely to engage the following rights under the Charter:

(i) Right to recognition and equality before the law;

(ii) right to life;

(iii) protection from torture and cruel, inhumane and degrading treatment;

(iv) freedom of movement;

(v) right to privacy and reputation of person;

(vi) right to liberty and security of person;

(vii) right to humane treatment when deprived of liberty; and

(viii) right to a fair hearing.

Any limitations or restrictions on these rights must be consistent with section 7(2) of the Charter and the *Siracusa Principles on the Limitation and Derogation Provisions in the International Covenant on Civil and Political Rights*. They should

take into account all relevant factors, including the nature of the right being limited, whether the limitation fulfils a pressing need and pursues a legitimate aim and whether there is any less restrictive means available of achieving that aim.

(3) The new Act should confirm that the right to a fair hearing under section 24 of the Charter applies to proceedings before the MHRB.

(4) Time periods for external reviews of ITOs should be shortened so that:

(i) Automatic initial reviews occur within 3 days after the making of an ITO;

(ii) reviews occur within 7 days after a request for a review; and

(iii) thereafter, external reviews are held every 3 months in relation to ITOs and every 6 months in relation to community treatment orders.

(5) The MHRB should publish a practice note outlining the appropriate conflict-management procedures that apply where a MHRB member has previously treated or personally knows a consumer appearing before that board member.

(6) The MHRB should be relocated to a governmental portfolio outside the Department of Human Services, such as the Department of Justice, in order to increase the perception of the MHRB's independence from the executive.

(7) Greater use should be made of single member boards in order to cope with an increase in case volume and in frequency of MHRB sittings. However, single member boards should not be constituted by a psychiatrist sitting alone.

(8) Upon being placed on an ITO, a consumer should be advised of her right to access her file and should be provided with support and assistance to do so. The MHRB should be required to adjourn hearings if the consumer has not reviewed her file but would like to do so. Consumers should be provided with support when reviewing their file and be able to access an explanation of its contents from an independent source. Consumers from a non-English speaking background should be able to access the services of an interpreter to help them examine their file.

(9) The MHRB should be required to enquire whether the consumer has had an opportunity to review her file and adjourn the matter if the consumer has not reviewed her file but would like to do so.

(10) Consumers should be provided with legal representation whenever an application for non disclosure is made to the MHRB and the consumer's lawyer should be granted access to the material where a non-disclosure order is made.

(11) Prior to appearing before the MHRB, consumers should be provided with information, assistance and funding to enable them to source a second psychiatric

opinion. The independent psychiatrist providing the second opinion should be given access to the consumer's file.

(12) Legal representation paid for by the state should be available to all persons appearing before the MHRB.

(13) A Mental Welfare Commission should be established to:

(i) Undertake monitoring, information provision and support for consumers who have been placed on an ITO;

(ii) conduct investigations and reporting into standards of care; and

(iii) establish and conduct a complaints mechanism.

The Mental Welfare Commission should visit all consumers placed on an ITO and would assist consumers to access free legal representation, their file, second opinions and complaints mechanisms. The Commission's annual reports should be submitted to parliament and published on its website.

(14) The MHRB should only conduct a review or appeal in the absence of the consumer (or his or her representative) in very limited circumstances.

(15) A scheme under which the consumer may nominate a person to receive information about her treatment and care, modelled on the 'primary carer' scheme in the *Mental Health Act 2007* (NSW), should be included in the new Act.

(16) A consumer's nominated person should, with the consumer's consent, be able to appeal ITOs and to advocate at external reviews on the consumer's behalf.

(17) A consumer's nominated person should, with the consumer's consent, be provided with information about the consumer's treatment, including notification within 24 hours that the consumer has been involuntarily detained.

(18) An independent and multidisciplinary statutory body, modelled on Scotland's Mental Welfare Commission, should be established to replace the monitoring functions currently undertaken by the Chief Psychiatrist and community visitors. The MWC should also undertake investigations into consumers' care, educate consumers about the involuntary treatment process and their rights under the new Act (including their appeal rights) and facilitate consumer's access to legal representation.

(19) The Mental Welfare Commission should prepare annual reports for submission to Parliament and publication on its website.

(20) A Mental Health Services Commissioner should be appointed by the new Victorian MWC and the MHS Commissioner's office should form part of the MWC. The

MHS Commissioner should be the central body for complaints in relation to mental health services in Victoria and should be empowered to make decisions about complaints, to issue legally enforceable compliance notices and to conduct its own investigation where there are concerns that a consumer's medical care and welfare is at risk or where there are broader concerns about the standard of practice of a practitioner or a facility.

(21) The MWC should be empowered to visit all consumers upon being placed on an ITO and to advise consumers of their right to nominate a 'primary carer' who can also support them and of the available complaints mechanisms. The MWC should also be empowered to assist consumers to lodge complaints.

Part B – About this submission

3. About PILCH

3.1 PILCH welcomes the opportunity to make a submission to the Panel.

3.2 PILCH is a leading Victorian, not-for-profit organisation which is committed to furthering the public interest, improving access to justice and protecting human rights by facilitating the provision of pro bono legal services and undertaking law reform, policy work and legal education.

3.3 PILCH coordinates the delivery of pro bono legal services through six schemes:

- the Public Interest Law Scheme (**PILS**);
- the Victorian Bar Legal Assistance Scheme (**VBLAS**);
- the Law Institute of Victoria Legal Assistance Scheme (**LIVLAS**);
- PILCH Connect (**Connect**);
- the Homeless Persons' Legal Clinic (**HPLC**); and
- Seniors Rights Victoria (**SRV**).

3.4 In 2007-2008, PILCH facilitated pro bono assistance for over 2,000 individuals and organisations and provided hundreds of others with legal information and referrals. PILCH also encouraged and promoted pro bono work amongst Victorian lawyers, not just within private law firms but also those working in government and corporate legal departments. In the last year, PILCH also made numerous law reform submissions on questions of public interest. Much of this work has assisted in securing human rights and access to justice for marginalised and disadvantaged members of the Australian community.

3.5 PILCH's objectives are to:

- improve access to justice and the legal system for those who are disadvantaged or marginalised;
- identify matters of public interest requiring legal assistance;
- refer individuals, community groups, and not for profit organisations to lawyers in private practice, who are willing to provide their services without charge; and
- encourage, foster and support the work and expertise of the legal profession in pro bono and/or public interest law.

4. Approach and Scope of this submission

4.1 PILCH considers that this review of the MHA is of paramount importance because of the impact the MHA has on some of the most vulnerable, disadvantaged and marginalised persons in our community. In particular, the provisions of the MHA allowing for the lawful deprivation of liberty and involuntary treatment of persons who, by definition, are less able to advocate for themselves, deal with some of the most challenging and serious policy issues to confront a democratic society that values the rule of law. These issues engage three of the most fundamental human rights: liberty and security of the person; the right to

freedom from cruel, inhuman or degrading treatment; and the right to a fair hearing which is fundamental to the effective protection of other human rights. Thus the treatment of and protection of persons who are suffering a mental illness and have been deprived of their liberty or their ability to make decisions about their own treatment, is a litmus test of a free, democratic and fair society.

4.2 As the European Court of Human Rights explained in its important decision on the right to freedom from cruel, inhuman and degrading treatment and psychiatric patients:

> *The Court considers that the position of inferiority and powerlessness which is typical of patients confined in psychiatric hospitals calls for increased vigilance in reviewing whether the Convention has been complied with. While it is for the medical authorities to decide, on the basis of the recognised rules of medical science, on the therapeutic methods to be used, if necessary by force, to preserve the physical and mental health of patients who are entirely incapable of deciding for themselves and for whom they are therefore responsible, such patients nevertheless remain under the protection of Article 3 (art. 3), whose requirements permit of no derogation.*
>
> *The established principles of medicine are admittedly in principle decisive in such cases; as a general rule, a measure which is a therapeutic necessity cannot be regarded as inhuman or degrading. The Court must nevertheless satisfy itself that the medical necessity has been convincingly shown to exist.* [2]

4.3 In our view, a fair balancing between the protection of persons suffering mental illness and the competing community interests is best achieved by a rights based approach to mental health law and policy and by utilising the existing human rights law framework in developing the appropriate legislative responses. In this connection, PILCH endorses the Panel's stated aim of ensuring that the '*new Act appropriately protects human rights in light of the Charter [of Human Rights and Responsibilities] and Australia's international human rights obligations*.'[3]

4.4 PILCH believes that a human rights approach to mental health reform is necessary to ensure that rights are protected and promoted in a meaningful way. This concern is particularly relevant in the field of mental health, as people with a mental illness may experience a denial of human rights in practice, if not in law, due to discrimination and social disadvantage. Further, the human rights framework provides a sophisticated and nuanced system of laws and principles that can assist in identifying competing rights and interests, prioritising rights, and achieving the delicate balance inherent in decisions about mental health, deprivation of liberty and involuntary treatment (discussed further below at section 5).

4.5 With PILCH's knowledge and experience as community lawyers in working to increase access to justice for marginalised and disadvantaged individuals and communities, it is well

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[2] *Herczegfalvy v Austria*, application no 10533/83 (24 September 1992) at [82] (ECtHR).

[3] Review of the Mental Health Act 1986 Consultation Paper – December 2008, p13

placed to consider whether the process and institutions established by the MHA provide sufficient protection. In order to test the processes and institutions to ensure protection for the most vulnerable and those who are unable to advocate for themselves, our submission considers the MHA from the perspective of the hypothetical most vulnerable consumer who is least able to assist herself. Our objective is to look for weaknesses in the system, processes and institutions which might allow the hypothetical vulnerable consumer to slip through the cracks and, for instance, to be unlawfully deprived of her liberty, deprived of her liberty for an unreasonable period of time, or denied a reasonable treatment choice.

4.6 In line with this approach we have chosen to comment only on those questions or areas of the MHA that might expose the hypothetical vulnerable consumer to an unjustified contravention of her rights and where PILCH is able to draw on its particular experience and knowledge. Therefore, this submission focuses on the following questions outlined in the *Review of the Mental Health Act 1986 Consultation Paper – December 2008* (**Consultation Paper**):

(1) PART C - Questions 1-2;

(2) PART D - Questions 45-47;

(3) PART E - Questions 25 and 51-52; and

(4) PART F - Questions 56 -59.

4.7 PILCH has drawn upon the Consultation Paper, relevant legislation, the Charter, Australia's international human rights obligations and its own institutional, and the authors' experience and expertise.

Part C –A human rights framework

5. Why a human rights framework? (Questions 1 & 2)

5.1 The Consultation Paper has recognised that any amendment to the MHA should be compatible with the Charter and consistent with Australia's international human rights obligations. It also recognises that recent human rights developments, including the ratification of the *Convention on the Rights of Persons with Disabilities*[4], have created an impetus for a review of the MHA. The Panel seeks to gain input on the best way to implement human rights obligations.[5]

5.2 It has been recognised that a human rights based approach provides access to a clear legislative framework, based on proportionality, under which competing rights may be identified and conflicts between them negotiated.[6] Human rights contain a mechanism for

[4] *Convention on the Rights of Persons with Disabilities* entered into force 3 May 2008, ratified by the Australian Government on 17 July 2008

[5] See paragraph 2.5.3 of the Consultation Paper.

[6] Department for Constitutional Affairs (UK), *Review of the Implementation of the Human Rights Act* (July 2006), 21.

weighing the rights of individuals against each other, or against the rights and interests of the community as a whole.

5.3 In comparative jurisdictions, such as the United Kingdom, a human rights approach has been found to be advantageous in discouraging a "one size fits all" response to complex issues. Instead, the human rights framework has been found to encourage approaches which are capable of adjustment to recognise the circumstances and characteristics of individuals.[7] The complexity and range of situations which are encountered under mental health legislation demand such subtlety and flexibility.

5.4 The Department of Constitutional Affairs in the United Kingdom has recognised that the implementation of the UK's Human Rights Act has led to '*better policy outcomes, by ensuring that the needs of all members of the UK's increasingly diverse population are appropriately considered. It promotes greater personalisation and therefore better public services…'.*[8] In the UK it has also been recognised that '*human rights offer an effective framework for making decisions which take into consideration the needs of individual service users*'.[9]

5.5 Accordingly, a consideration of Australia's international and domestic human rights obligations and the extent to which human rights may be limited in certain circumstances is a necessary starting point for the Consultation.

6. Australia's international human rights obligations

6.1 Australia is a party to various international human rights conventions that are relevant to this review, including:

(1) the International Covenant on Civil and Political Rights (***ICCPR***);[10]

(2) the International Covenant on Economic, Social and Cultural Rights (***ICESCR***);[11]

(3) the International Convention on the Rights of Persons with Disabilities (***ICRD***);[12] and

(4) the Convention on the Rights of the Child (***CROC***).[13]

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[7] Department for Constitutional Affairs (UK), *Review of the Implementation of the Human Rights Act* (July 2006), 4.

[8] Department for Constitutional Affairs (UK), *Review of the Implementation of the Human Rights Act* (July 2006), 1.

[9] British Institute of Human Rights *The Human Rights Act – Changing Lives (Second Edition),* 25.

[10] *International Convention on Civil and Political Rights,* entered into force 23 March 1976, ratified by the Australian Government on 13 August 1980.

[11] *International Covenant on Economic, Social and Cultural Rights,* entered into force 3 January 1976, ratified by the Australian Government on 10 March 1976.

[12] *Convention on the Rights of Persons with Disabilities* entered into force 3 May 2008, ratified by the Australian Government on 17 July 2008

[13] *Convention on the Rights of the Child* , entry into force 2 September 1990, ratified by the Australian Government on 16 January 1991.

6.2 These instruments require all arms of government to act to protect, respect and fulfil a range of human rights and include multiple provisions which have relevance in a mental health context, including:

(1) the right to freedom from cruel, inhuman or degrading treatment or punishment and to freedom from medical or scientific experimentation without consent (see, for example, article 7 of the ICCPR and article 15 of the ICRD);

(2) the right to liberty, to not be arbitrarily or unlawfully deprived of liberty and to take proceedings before a court if deprived of liberty (see article 9 of the ICCPR and article and article 14(1)(b) of the ICRD). The ICRD notes that persons with disabilities should enjoy liberty on an equal basis with others (article 14(1)(a));

(3) the right to be treated with dignity and humanity if deprived of liberty (see article 10 of the ICCPR);

(4) the right to the highest attainable standard of physical and mental health, (see article 12 of the ICESCR). Essentially the 'right to health' entails an obligation on governments to take specific steps to protect and promote health. It includes the right of people with mental disabilities to services that are available, accessible, acceptable and of appropriate and good quality;[14]

(5) the right to liberty of movement and freedom of choice of residence. These rights should only be subject to such restrictions as are provided by law and are necessary to protect national security, public order, public health or morals or the rights or freedoms of others (see article 12 of the ICCPR);

(6) freedom from arbitrary or unlawful interference with privacy (see article 17 of the ICCPR);

(7) the right to a fair hearing contained in article 14 of the ICCPR provides, '…everyone shall be entitled to a fair and public hearing by a competent, independent and impartial tribunal'. The right to a fair hearing is also a norm of customary international law. International jurisprudence establishes that the basic requirements of a fair hearing include:

(i) equal access to and equality before the courts;

(ii) the right to legal advice and representation;

(iii) the right to procedural fairness, including a hearing without undue delay;[15]

(8) the right of persons with disabilities to experience autonomy and independence and to make their own choices (see article 3 of the ICRD);

[14] CESC General Comment 14 at para 12

[15] General Comment 32, [7]. See also *Yves Morael v France* UN Doc CCPR/C/36/D/207/1986 and *Ruben Turibio Munoz Hermoza v Peru* UN Doc CCPR/C/34/D/203/1986, which held that a fair hearing in civil proceedings required justice to be rendered without undue delay.

(9) an obligation to enable persons with disabilities to live independently and participate fully in all aspects of life (see article 19 of the ICRD);

(10) an obligation to ensure that persons with disabilities enjoy an equal right to live in the community and to facilitate this, including ensuring that persons with disabilities have the opportunity to choose their place of residence and are not obliged to live in a particular living arrangement and by providing in-home and community support services;

(11) an obligation to take measures to enable persons with disabilities to attain and maintain maximum independence (see article 9 of the ICRD); and

(12) the ICRD also contains measures stating that disabled persons must be afforded opportunities to participate fully in work, education and public life. Enjoyment of rights may also be limited by involuntary treatment or institutionalisation.

6.3 PILCH refers to the Submission to the Panel's review of the MHA made by the Human Rights Law Resource Centre (**HRLRC**) which provides further detailed discussion of the content of the rights listed above. PILCH endorses the HRLRC Submission in this regard.

7. Mental Health Principles

7.1 The Panel should also consider the *United Nations Principles for the Protection of Persons with Mental Illness and Improvement of Mental Health Care*[16] (***Mental Health Principles***).

7.2 In particular, the following aspects of the Mental Health Principles may be relevant:

(1) a right to the best available mental health care, which must be part of the health and social care system (Principle 1);

(2) a right to be treated with humanity and dignity (Principle 1);

(3) a right to exercise all civil, political, economic, social and cultural rights as recognised in the Universal Declaration of Human Rights, the ICESCR, the ICCPR, and in other relevant instruments, such as the Declaration on the Rights of Disabled Persons and the Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment (Principle 1);

(4) a right to live and work, as far as possible, in the community (Principles 3 and 7). Where treatment takes place in a mental health facility, a patient shall have the right, whenever possible, to be treated near his or her home or the home of his or her relatives or friends and shall have the right to return to the community as soon as possible (Principle 7);

(5) a right to be treated in the least restrictive environment and with the least restrictive or intrusive treatment appropriate to the patient's health needs and the need to protect the physical safety of others (Principle 9);

[16] Adopted by General Assembly resolution 46/119 of 17 December 1991

(6) the treatment of every patient shall be directed towards preserving and enhancing personal autonomy (Principle 9);

(7) no treatment shall be given to a patient without his or her informed consent, except:

(i) If the patient is an involuntary patient and an independent authority is satisfied that the patient lacks capacity to give informed consent and that the proposed treatment plan is appropriate;

(ii) a personal representative empowered by law to consent to treatment for the patient consents on the patient's behalf; or

(iii) a qualified mental health practitioner authorised by law determines that the treatment is urgently necessary in order to prevent immediate or imminent harm to the patient or to other persons. Such treatment shall not be prolonged beyond the period that is strictly necessary for this purpose. (Principle 11);

(8) where any treatment is authorised without the patient's informed consent, every effort must be made to inform the patient about the nature of the treatment and any possible alternatives and to involve the patient as far as practicable in the development of the treatment plan (Principle 11(9));

(9) physical restraint or involuntary seclusion of a consumer shall not be employed except in accordance with the officially approved procedures of the mental health facility and only when it is the only means available to prevent immediate or imminent harm to the consumer or others (Principle 11(11));

(10) a consumer who is restrained or secluded shall be kept under humane conditions and be under the care and close and regular supervision of qualified members of the staff. A personal representative, if any and if relevant, shall be given prompt notice of any physical restraint or involuntary seclusion of the consumer (Principle 11(11));

(11) a consumer in a mental health facility shall be informed as soon as possible after admission, in a form and a language which the consumer understands, of all his or her rights under the Mental Health Principles and domestic law. The information given must include an explanation of those rights and how to exercise them (Principle 12); and

(12) the consumer shall be entitled to choose and appoint a counsel to represent him or her, including representation in any complaint procedure or appeal. If the consumer does not secure such services, a counsel must be made available without payment by the consumer to the extent that the consumer lacks sufficient means to pay (Principle 18).

8. The Victorian Charter

8.1 The Charter provides a domestic framework to protect a range of civil and political rights which are derived from the ICCPR.

8.2 The Charter requires that human rights are taken into account when developing, interpreting and applying Victorian legislation. In particular:

(1) Bills must be assessed for consistency with the Charter and a Statement of Compatibility tabled with the Bill when it is introduced to Parliament;

(2) all legislation must be considered by the parliamentary Scrutiny of Acts and Regulations Committee for the purpose of reporting as to whether the legislation is compatible with the Charter;

(3) public authorities, including public and private bodies undertaking functions of a public nature, must act compatibly with human rights and also give proper consideration to human rights in any decision making process (section 38); and

(4) so far as possible, courts and tribunals must interpret and apply legislation consistently with the Charter and should consider relevant international, regional and comparative domestic jurisprudence in doing so (section 32).

8.3 The following rights under the Charter are likely to be engaged by the review of the MHA:

(1) right to recognition and equality before the law (section 8);

(2) right to life (section 9);

(3) protection from torture and cruel, inhumane and degrading treatment (s 10) including the right not to be subjected to medical or scientific experimentation or treatment without full, free and informed consent (section 10(c));

(4) freedom of movement (section 12);

(5) right to privacy and reputation of person (section 13);

(6) right to liberty and security of person (section 21);

(7) right to humane treatment when deprived of liberty (section 22); and

(8) right to a fair hearing (s 24).

9. Limitations upon human rights

9.1 It is well established that some human rights are absolute while other human rights may be limited in certain circumstances and subject to certain conditions. The general principles relating to the justification and extent of limitations are contained in the *Siracusa Principles on the Limitation and Derogation Provisions in the International Covenant on Civil and Political Rights* (**Siracusa Principles**).

9.2 Most relevantly, the Siracusa Principles state that:

(1) No limitations or grounds for applying them may be inconsistent with the essence of the particular right concerned;

(2) All limitation clauses should be interpreted strictly and in favour of the rights at issue;

(3) Any limitation must be provided for by law and be compatible with the objects and purposes of the ICCPR;

(4) Limitations must not be arbitrary or unreasonable;

(5) Limitations must be subject to challenge and review;

(6) Limitations must not discriminate on a prohibited ground;

(7) Any limitation must be 'necessary', which requires that it:

(i) Is based on one of the grounds which permits limitations (namely, public order, public health, public morals, national security, public safety or the rights and freedoms of others);

(ii) Responds to a pressing need;

(iii) Pursues a legitimate aim; and

(iv) Is proportionate to that aim.

9.3 Importantly, international human rights jurisprudence establishes that, in and of themselves, financial considerations will almost never constitute a legitimate aim or justify a limitation on human rights, although they may be relevant to determining whether there is any less restrictive means reasonably available to achieve the purpose that a limitation seeks to achieve.[17]

9.4 Section 7(2) of the Charter reflects the Siracusa Principles, providing that:

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

9.5 Relevant factors to be considered when applying section 7(2) are:

(1) The nature of the right;

(2) the importance of the purpose of the limitation;

(3) the nature and extent of the limitation;

(4) the relationship between the limitation and its purpose; and

(5) whether there is any less restrictive means reasonably available to achieve the purpose that the limitation seeks to achieve.[18]

[17] See *Newfoundland (Treasury Board) v NAPE* [2004] 3 SCR 38; *Reference re Remuneration of Judges of the Provincial Court of Prince Edward Island* [1997] 3 SCR 3.

[18] Charter, sections 7(2)(a)-(e).

9.6 The Charter does not create any non-derogable rights. However to maintain consistency with article 4(2) of the ICCPR domestic law should not allow derogation from certain human rights. These absolute rights include the right to life (article 6 of the ICCPR and section 9 of the Charter), freedom from torture, cruel, inhumane and degrading treatment (article 7 of ICCPR and section 10 of the Charter) and the right to recognition as a person before the law (article 16 of the ICCPR and section 8 of the Charter).

9.7 By its nature the operation of the MHA is likely to place limitations upon human rights protected by the Charter and by international human rights law. The review of the MHA must ensure that those limitations are drafted and applied in accordance with section 7(2) of the Charter and the Siracusa Principles.

10. Application of the Charter to the MHA

10.1 The MHA, like all Victorian legislation, is subject to the Charter. This means that, so far as possible, the MHA must be interpreted in a way that is compatible with human rights.[19] Further, any proposed bill to amend the MHA will be assessed for consistency with the Charter.

10.2 In addition, 'public authorities' who administer the MHA or are granted authority under the MHA must act in accordance with the Charter and give consideration to Charter rights in their decision making.[20]

11. Public authorities

11.1 A key question is which entities involved in mental health law and policy in Victoria are 'public authorities' under the Charter and are therefore required to act in accordance with human rights.

11.2 The Charter recognises two types of public authorities: those who are bound by the Charter generally ("core" public authorities) and those who are only bound when exercising particular functions ("functional" public authorities). Most public authorities (such as those described in sections 4(1)(a), 4(1)(b), 4(1)(d), 4(1)(e), 4(1)(f), 4(1)(g) and 4(1)(h) of the Charter) are core public authorities and are required to exercise all of their functions in compliance with the Charter.

11.3 Functional public authorities and are bound only when they are exercising functions of a public nature, when the entity is exercising those functions on behalf of the State or a public authority, and not at other times. This distinction is intended to ensure that the Charter applies to third parties who have been contracted to exercise public functions.

11.4 The following bodies involved under the MHA appear to be 'public authorities':

(1) Victoria Police (pursuant to section 4(1)(d) of the Charter)

(2) an approved mental health service (pursuant to sections 4(1)(a) and 4(1)(b) of the Charter);

[19] Section 32 of the Charter.

[20] Section 38 of the Charter.

(3) the Chief Psychiatrist (pursuant to section 4(1)(b) of the Charter);

(4) authorised psychiatrists appointed under section 96 of the MHA (pursuant to section 4(1)(b) of the Charter); and

(5) registered medical practitioners (when performing functions pursuant to the MHA, in accordance with paragraphs 4(1)(b) and (c) of the Charter).

11.5 While the MHRB could be considered a 'public authority' within the meaning of section 4(1) of the Charter, paragraph 4(1)(j) of the Charter states that a court or tribunal is not considered to be a 'public authority' except when it is acting in an administrative capacity. Our view is that the MHRB falls within this exclusion and therefore is a 'court or tribunal' when exercising its judicial functions, but a 'public authority' when exercising its administrative functions. Therefore, the obligations on public authorities set out in section 38 of the Charter apply to the MHRB in respect of its administrative functions but not when it is exercising judicial functions.

11.6 Further, PILCH considers that in order for section 6(2)(b) and section 24 (the right to a fair hearing) of the Charter to be effective, those provisions must impose substantive obligations on courts and tribunals. Therefore, in respect of its judicial functions, the MHRB is required to comply with the right to a fair hearing. Section 24 applies to a 'party to a civil proceeding'. Our view is that this phrase extends to proceedings in a court or tribunal which involve the determination of rights and obligations between the parties, including proceedings before the MHRB.

Recommendation 1

Proposed reforms to MHA must be consistent with Australia's international human rights obligations and the Charter.

Recommendation 2

A review of the MHA is likely to engage the following rights under the Charter:

a) Right to recognition and equality before the law;
b) Right to life;
c) Protection from torture and cruel, inhumane and degrading treatment;
d) Freedom of movement;
e) Right to privacy and reputation of person;
f) Right to liberty and security of person;
g) Right to humane treatment when deprived of liberty; and
h) Right to a fair hearing.

Any limitations or restrictions on these rights must be consistent with section 7(2) of the Charter and the Siracusa Principles. They should take into account all relevant factors, including the nature of the right being limited, whether the limitation fulfils a pressing need and pursues a legitimate aim and whether there is any less restrictive means available of achieving that aim.

Part D –External review and appeals

12. Review and appeals of involuntary treatment

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

12.2 As noted in the Consultation Paper, review mechanisms are central to most contemporary mental health systems in Western democracies and provide a paramount safeguard against the unlawful deprivation of liberty or denial of a reasonable treatment choice. This is recognised in international and comparative jurisprudence and commentary on mental health law and practice. For instance, the World Health Organisation document 'Mental Health Care Law: Ten Basic Principles'[21] provides:

(1) 'There should be a review procedure available for any decision made by official (judge) or surrogate (representative, e.g. guardian) decision-makers and by health care providers'; and

(2) 'In the case of a decision affecting integrity (treatment) and/or liberty (hospitalization) with a long-lasting impact, there should be an automatic periodical review mechanism.'[22]

12.3 The right to a fair hearing is a central requirement of any such review body. Elements of the right to a fair hearing are reflected in our common law. The right of an accused to receive a fair trial is a fundamental element of our criminal justice system[23] and the concept of natural justice is an important requirement of administrative law. The High Court has held that when a statute confers power on a public official to destroy, defeat or prejudice a person's rights, interests or legitimate expectations, the rules of natural justice regulate the exercise of that power unless they are excluded by plain words of necessary intendment.[24]

Application of section 24 of the Charter to the MHRB

12.4 In Victoria, the common law requirements described above have been supplemented by the right to a fair hearing contained in section 24 of the Charter.

12.5 Whilst the MHRB itself has stated that it considers that it is required to comply with section 24 of the Charter,[25] and PILCH shares this view, there is some uncertainty about this.[26]

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[21] World Health Organisation, Geneva, 1996

[22] See Principles 7 & 8 respectively.

[23] *Dietrich v The Queen* (1992) 177 CLR 292 at 299

[24] *Annetts v McCann* (1990) 170 CLR 596 at 598

[25] 09-003 [2008] VMHRB 1 (8 July 2008)

PILCH submits that it is essential that the body empowered under the new Act to review ITOs be required to comply with the right to a fair hearing.

12.6 In comparative domestic jurisdictions (such as the United Kingdom and the European Court of Human Rights) the right to a fair hearing has consistently been applied to proceedings before mental health review bodies. Further, the Mental Health Principles apply the elements of the right to a fair hearing to mental health review bodies (see Principles 17 & 18).

12.7 Therefore, in order to avoid uncertainty and the possibility of technical legal arguments about the applicability of section 24, PILCH recommends that the new Act confirm that the right to a fair hearing in section 24 of the Charter applies to proceedings before the MHRB.

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

(1) Time periods for reviews;

(2) constitution of the review body;

(3) legal representation before the review body; and

(4) access to information and ability to prepare for review hearings.

Each of these is discussed below.

13. Time periods for reviews (Question # 45)

13.1 Currently, an initial review of an ITO must be conducted by the MHRB within 8 weeks of the order being made.[27] Periodic reviews must occur at intervals not exceeding 12 months thereafter[28] and an appeal may be made to the MHRB at any time against an ITO.[29] Such an appeal must be heard 'without delay'.[30]

Right to a fair hearing

13.2 In our view the current periods for external review of ITOs are unacceptably long and as such are in breach of section 24 of the Charter and contrary to international jurisprudence on the right to a fair hearing.

[26] See paragraphs 11.6 and 12.4 of this Submission in which we discuss the application of section 24 to the MHRB.

[27] MHA, section 30(1)

[28] MHA, section 30(3)

[29] MHA, section 29

[30] MHA, section 29(4)

13.3 One of the key elements of the right to a fair hearing, as established by international law, is expeditiousness.[31] It is clear that justice must be rendered without undue delay and failure to do so may be a contravention of the right.[32] Whether a hearing is considered to be expeditious will depend on the circumstances of the case, including:

(1) the type and complexity of the case;

(2) the conduct and diligence of both sides of the dispute; and

(3) the conduct and diligence of the court.

A lack of resources or under-funding of the legal system generally will not be considered a legitimate excuse for undue delay.[33]

13.4 Victoria's existing 8 week review period is one of the longest in Australia.[34] The UK Court of Appeal (relying on decisions of the European Court of Human Rights which held that 8 weeks was too long) held that 8 weeks was too long for a review and reviews should be held as soon as reasonably practicable, given the circumstances of the case, and should not be routinely delayed.[35] The Mental Health Principles also state that the initial review should take place 'as soon as possible' and periodic reviews should be available 'at reasonable intervals'.[36]

13.5 John Lesser, the current President of the MHRB, has noted that the average length of inpatient stays is now between 10 to 14 days.[37] Therefore, under the current system, many consumers will not have their involuntary status reviewed at all, as they will be discharged before the 8-week period expires.

Right to liberty

13.6 The current periods for external review also represent an ongoing restriction upon the right to liberty, a fundamental human right which is protected by section 21 of the Charter and the right to freedom of movement, which is protected by section 12 of the Charter. Article 9(4) of the ICCPR recognises the importance of external review of detention in guarding

[31] See, for example, HRC Draft General Comment No 32.

[32] *Munoz Hermosza v Peru* (203/86) at [11.3].

[33] *Procurator Fiscal v Watson and Burrow*s [2002] UKPC D1, 55, where the House of Lords stated that it is generally incumbent on states to organise their legal systems so as to ensure that the reasonable time requirement is honoured.

[34] Review periods in other states and territories: Queensland (6 weeks), Tasmania (28 days), Northern Territory (7 days), NSW ('as soon as practicable'), WA (8 weeks) and South Australia (45 days).

[35] *R v MHRT London South, ex parte C* (2001) Lloyds Re Med 340.

[36] See Principles 17(2) and 17(3) respectively.

[37] John Lesser (2007) Review and Decision Making for Persons with a Serious Mental Illness: Achieving Best Practice – a Cross-Jurisdictional Evaluation of Involuntary Mental Health Review and Decision Making Systems, 11.

against unlawful limitations upon a person's right to liberty and security of the person. It provides:

> *Anyone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings before a court, in order that that court may decide without delay on the lawfulness of his detention and order his release if the detention is not lawful.*

13.7 The right to liberty is not an absolute right but may be constrained only in circumstances where the deprivation of liberty is legal, reasonable and proportionate in the circumstances.[38] Therefore, it is important that review bodies are pro-active in reviewing and continually assessing deprivations of liberty. If this is not the case, the safeguards against arbitrary or unlawful deprivation of liberty are weakened. Further, where a person is initially detained for a limited period for a specific purpose, there must be an appropriate justification to continue to detain the person after the purpose no longer applies[39] and that '*procedural safeguards are important in protecting against an initially lawful and reasonable detention becoming arbitrary. In the context of detention for reasons of mental illness, regular reviews of a person's condition will be important*'.[40]

13.8 In the United Kingdom, it has been held that a delay in review hearings by the Mental Health Review Tribunal breached the applicants' absolute right to a speedy hearing under Article 5(4) of the European Convention on Human Rights.[41] Article 5(4) requires that the lawfulness of the detention of a consumer should be decided "speedily". In *R (KB) v MHRT*, it was noted that to the extent that failures to provide speedy hearings were due to staff shortages or the pressure of work placed upon the Tribunal's existing staff, this was the responsibility of central government. In other cases dealing with psychiatric detention decisions and their compatibility with article 5(4), the European Court of Human Rights has held that a delay of 8 weeks is a violation of article 5(4).[42]

13.9 PILCH submits that the current period for external reviews also contravenes the spirit of the protections offered by section 21(5) of the Charter. Section 21(5) states that a person who is detained on a criminal charge must be either released or promptly brought before a court. Although involuntary orders are not criminal charges, they can involve a similar involuntary deprivation of liberty. PILCH feels that, in developing a 'best practice' approach to mental health, similar considerations should be taken into account.

13.10 Similarly, international jurisprudence on the period for review of administrative detention (such as immigration detention) suggests that the appropriate period is 2-3 days after being detained, depending on the circumstances in each case.[43]

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[38] Alistair Pound and Kylie Evans *An Annotated Guide to the Victorian Charter of Human Rights and Responsibilities*, 151.

[39] See *Spakmo v Norway* (Communication No 631/1995).

[40] Pound and Evans above n 37, 152.

[41] *R (KB) v MHRT* (2002) EWHC Admin 639.

[42] *E v Norway* (1990) Eur Ct HR (Application No 11701/85).

[43] Human Rights Law Resource Centre, *The Right to Liberty and Freedom from Arbitrary Detention* (27 November 2008).

13.11 PILCH submits that, in light of the serious nature of ITOs and the impact that they have upon fundamental rights such as the right to liberty, freedom from cruel, inhuman and degrading treatment and the right to freedom of movement, the current 8 week period for the initial review is unreasonable and incompatible with human rights protected by the Charter and international human rights law. In addition the comparatively long interval in Victoria between automatic periodic reviews (i.e. up to 12 months) and the practice of hearing requested reviews 14 – 30 days after the request (and in rural and regional areas this delay might be longer),[44] is not acceptable and not compatible with international human rights law, nor the Charter.

13.12 PILCH recommends that under the new Act, consumers subject to ITOs must be reviewed by an external body:

(1) within 3 days after the making of an involuntary order;[45]

(2) within 7 days, after a request for a review; and

(3) thereafter, external reviews to be held every 3 months in relation to inpatient orders and every 6 months in relation to community treatment orders (***CTO***).[46]

14. Constitution of the review body (Question # 46)

14.1 A key element of the right to a fair hearing is the requirement that the hearing be before a competent, independent and impartial court or tribunal. This element is reflected in section 24 of the Charter which provides for a hearing before a 'competent, independent and impartial court or tribunal'.

There are 3 aspects to the requirement of independence and impartiality:

(1) Independence from the consumer;

(2) independence from the executive; and

(3) independence from the treating mental health service.

Independence from the consumer

14.2 Clearly it is not appropriate for a MHRB member to preside over a hearing in relation to a consumer he or she knows personally or has treated. Whilst the usual practice is for the MHRB member to recuse him/herself in these circumstances, there is no practice note or written policy publicly available on dealing with such conflicts. PILCH recommends that a practice note be developed and published on how conflicts will be dealt with.

Independence from the executive

14.3 MHRB members are not considered employees of the Department of Human Services (***DHS***) and their decisions are made independent of, and cannot be reviewed or

[44] MHRB, 2006 *Annual Report*, September 2006, 27.

[45] Review of the Mental Health Act 1986 Consultation Paper – December 2008, 51.

[46] *Mental Health and Related Services Act 1998* (NT), s 123.

superseded by, the executive. However, there are some aspects of the current MHRB appointment and funding arrangements that raise concerns about the perception of independence of the MHRB. For instance, the MHRB is funded by the DHS, the appointment of members is controlled by the Health Minister and the clinicians whose decisions are reviewed by the MHRB are employed by the Health Minister.

14.4 There is some comparative domestic jurisprudence on the independence of tribunals from the executive, which suggests that tribunals such as the MHRB should be located within a governmental department other than that which has responsibility for the subject matter of the tribunal.[47]

14.5 PILCH suggests that the relocation of the MHRB to another governmental portfolio, such as the Department of Justice, would increase the perception of independence of the MHRB from the executive.

Other matters

14.6 PILCH recommends that, if the external review periods under the new Act are shortened (as discussed above) then greater use of single member boards (with access to multidisciplinary input)[48] should be considered to deal with the potential increase in case volume and in frequency of MHRB sittings at each facility. However, PILCH strongly recommends that single member boards are not constituted by a psychiatrist member, but by the legal member. This is because there is a perception amongst consumers that the psychiatrist member of the MHRB is merely a 'rubber stamp' in respect of the treatment decisions of his or her peers.[49] Whereas, the legal member is likely to be perceived as having greater independence from the treating team.

14.7 A consumer or the consumer's "nominated person" should also have the ability to request that a person of the same gender or ethnicity is co-opted on to the MHRB.[50]

15. Access to information and ability to prepare for review hearings

Procedural fairness

15.1 The MHA requires the MHRB to comply with the rules of natural justice.[51] This requirement is compatible with the right to a fair hearing, one element of which is the right to procedural fairness. This element seeks to ensure equality between parties to a hearing

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[47] *In R (on the application of Brooke and another) v Parole Board and another and R (on the application of O'Connell) v Parole Board and another* [2007] All ER (D) 39.

[48] S Delaney, "An Optimally Rights Recognising Mental Health Tribunal – What can be learnt from Australian Jurisdictions?", 20, http://www.communitylaw.org.au/clc_mentalhealth/cb_pages/mental_health_act_reform.php (accessed 10 February 2009).

[49] Vivienne Topp, Martin Thomas and Ing Varson, "Lacking Insight: Involuntary patient experience of the Victorian Mental Health Review Board", 39 – 42.

[50] *Mental Health (Compulsory Assessment and Treatment) Act 1992* (NZ), s 103.

[51] MHA section 24(1)(b).

in respect of the conduct of the hearing. For instance, each party must be given equal opportunity to respond to evidence put forward and to present their own evidence.[52] In PILCH's view, the importance of procedural fairness to a fair hearing is heightened in the context of the imposition of an ITO, a serious interference with human dignity and bodily integrity.

15.2 The Mental Health Principles address a number of procedural fairness matters:

(1) Consumer's right to present an independent opinion (Principle 18(3));

(2) right to access to consumer's records, reports and documents before the review body except in special cases where it is determined that a specific disclosure to the consumer could cause serious harm to her health or put at risk the safety of others (Principle 18(4));

(3) consumer's right to attend, participate in and be heard in, any hearing before the mental health review body (Principle 18(5)); and

(4) consumer's right to written reasons for the decision (and considerations relevant to a review body's decision to make reasons public) (Principle 18(8)).

15.3 Currently, PILCH believes that a number of aspects of the MHRB hearings process are incompatible with the requirement for procedural fairness, including:

(1) Access to the consumer's medical file and other relevant information;

(2) non-disclosure orders in respect of a consumer's medical file; and

(3) the ability of consumers to obtain a second opinion.

Access to consumer files

15.4 Timely and unfettered access to consumer files and other relevant procedural information is essential to consumers' receiving a fair hearing. Whilst the MHA provides for consumers to have access to their files,[53] in practice it seems that this is not always effected.[54] The Mental Health Legal Centre reports that:

(1) Some consumers are not aware of their right to access their file;

(2) some consumers are not allowed sufficient time to review their file;

(3) some consumers' lawyers are granted only limited access to the file; and

(4) many consumers are unable to understand the contents of their file and are not provided assistance with interpreting the file.

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[52] See for instance: *Gertruda Hubertina Jansen- Gielen v The Netherlands* UN Doc CCPR/C/71/D/846/1999; *Van Orshoven v Belgium,* 20122/92 [1997] ECHR 33 (25 June 1997).

[53] MHA s 26(7).

[54] Topp, Thomas and Varson, above n 47, 42-44.

15.5 A significant proportion of consumers on ITOs interviewed by the Victorian Auditor-General reported being unaware of their right to access information considered by the MHRB. Of those who were aware of their right of access, a common source of complaint related to difficulties actually getting access.[55]

15.6 Denying consumers access or providing consumers with inadequate access to their file is inconsistent with consumers' rights under section 24 of the Charter. It is also inconsistent with the MHRB's obligation to act in accordance with the rules of natural justice.

15.7 Without reviewing and understanding her file, a consumer is unlikely to be in a position to rebut the material put in support of the ITO or to present her best case. Clearly, in order for the right to access one's file to be meaningful, these difficulties with access need to be addressed.

15.8 PILCH recommends that, under the new Act, when a consumer is first advised of her hearing date, the consumer should also be advised of her right to access the file and assisted to contact the person who can arrange this. Further, consumers should be provided with support when reviewing the file and an explanation of its contents from a source independent from the treating team. In relation to consumers from non-English speaking backgrounds, the MHRB should be required to ensure that these persons (who often feel intimidated and bewildered[56]) obtain the assistance of an interpreter to help them review and understand their file prior to their hearing date.

15.9 PILCH submits that consumer access to files would be enhanced by implementing the proposal in Part E, section 19 of this submission regarding a Mental Welfare Commissioner (**MWC**) and by ensuring that all consumers appearing before the MHRB have legal representation (if necessary, paid for by the state). The MWC could be tasked with ensuring that consumers are aware of their right to access their file and assisted to do so and could provide an explanation of the contents of the file. Alternatively, if legal representation were provided at an early stage, consumers could rely on their lawyer to provide that explanation.

15.10 Finally, PILCH recommends that at the hearing, the MHRB should be required to ask the consumer whether she has had an opportunity to review her file and adjourn the matter to the next sitting date (provided that that would not result in a lengthy delay) if the consumer has not reviewed her file but would like to do so.[57]

Non-disclosure applications

15.11 PILCH has concerns about non-disclosure applications provided for in section 24(1) of the MHA. Obviously the non-disclosure to the consumer of parts of her file is contrary to the common law requirement of procedural fairness and a limitation on the procedural fairness element of the right to a fair hearing. Whilst in some circumstances it may be appropriate

[55] Delaney, above n 46, page 23.

[56] Topp, Thomas and Varson, above n 47, 55.

[57] Ibid, 10-11.

and compatible with a human rights approach to prevent a consumer from gaining access to certain parts of her file, such applications should be granted only in exceptional circumstances and where appropriate safeguards are in place.

15.12 The MHA empowers the MHRB to make a non-disclosure order, in the absence of the consumer, where access to the material would cause serious harm to the consumer's health or to the health or safety of another person, or involves unreasonable disclosure of personal information of another person, or breaches a confidentiality provision imposed by the person who supplied the information.[58]

15.13 PILCH submits that where access to the material would cause serious harm to the consumer or another person, non-disclosure is likely to be proportionate and compatible with a human rights approach and with the right to a fair hearing and the right to liberty in the Charter. However, where the reason for non-disclosure is the privacy of another person or the confidentiality of the source of the information, non-disclosure is less likely to be compatible with a human rights approach and with the right to a fair hearing and the right to liberty in the Charter.

15.14 In either case, where a non-disclosure order is made, it is important that safeguards are in place, such as ensuring that the consumer has a representative to whom the relevant material can be disclosed. Since applications for non-disclosure are made in the absence of the consumer, if the consumer is not represented by a lawyer, it is impossible for the consumer to meaningfully challenge the non-disclosure application or to appeal a non-disclosure order to Victorian Civil and Administrative Tribunal.

15.15 This issue is addressed by Principle 18(4) of the Mental Health Principles which allows for non-disclosure only in '*special cases'* where disclosure '*would cause serious harm to the patient's health or put at risk the safety of others*'.

15.16 PILCH considers that the new Act should:

(1) Make an order for non-disclosure only where the disclosure would cause serious harm to the consumer's health or to the health or safety of another person; and

(2) Require that a consumer be provided with legal representation (if necessary, paid for by the state) whenever an application for non-disclosure is made and that where a non-disclosure order is made, the consumer's lawyer is granted access to the material.

15.17 This would ensure that: the consumer's arguments for disclosure are put forward at the preliminary hearing for non-disclosure; where an order is made, the consumer, through her lawyer, can respond to material not disclosed to her; and where appropriate, an appeal against the non-disclosure order may be made.

Second Opinions

[58] MHA s 24(1).

15.18 The ability of a consumer appearing before the MHRB, to obtain and present a second psychiatric opinion, is crucial to her ability to challenge the ITO. However, presently consumers have great difficulty in obtaining a second opinion for the following reasons:[59]

(1) cost – the cost of obtaining a report from an independent psychiatrist can be prohibitive for many consumers.

(2) lack of availability – there are insufficient independent psychiatrists who are prepared to provide second opinions, to meet demand. In addition, consumers who have been involuntarily detained find it difficult to access contact details of appropriate independent psychiatrists.

(3) lack of full information – an independent psychiatrist usually is not provided with access to the consumer's medical file and so may not be aware of all the matters to be raised at the MHRB hearing.

15.19 These impediments raise concerns about whether consumers who are unable to access a second opinion are being afforded procedural fairness and therefore, a fair hearing. In our view, consumers cannot be said to have been given an equal opportunity to respond to evidence put forward and to present their own evidence in rebuttal, where they are unable to afford a second opinion or do not know how to access one.

15.20 Therefore, PILCH recommends that under the new Act:

(1) all consumers appearing before the MHRB be:

(i) entitled to funding to source a second opinion; and

(ii) provided with information and assistance to enable them to access a second opinion; and

(2) an independent psychiatrist providing a second opinion in respect of a consumer appearing before the MHRB, be given access to the consumer's file.

16. Legal representation before the review body

16.1 The right to a fair hearing, as protected by section 24 of the Charter, encompasses a right to legal advice and representation and the right to equal access to, and equality before, the courts. For consumers appearing before the MHRB the key issue is whether they can afford and access legal representation.

16.2 The right to a fair hearing does not impose an obligation on the state to provide free legal assistance in all civil cases. However, international jurisprudence suggests that the provision of legal aid may be required where the lack of legal representation will impede the litigant's ability to access the court proceedings and participate in them in a meaningful way.[60] An individual's access to the justice system should not be prejudiced by reason of his or her inability to afford the cost of legal representation. Factors relevant to this

[59] Topp, Thomas and Varson, above n 47, 59 – 60.

[60] Human Rights Committee, Draft General Comment 32, [3].

assessment will be the complexity of the case and legal issues and the seriousness of the consequences of the proceedings.[61]

16.3 PILCH submits that because of the significance of hearings before the MHRB and their outcomes, the nature of the rights engaged by such hearings and the vulnerability of the consumers, the right to a fair hearing requires that all persons appearing before the MHRB should be provided with legal representation paid for by the state.[62] This approach would also be compatible with Principle 18 of the Mental Health Principles, which states that legal representation must be made available on a pro bono basis to the extent that the consumer lacks sufficient means to pay.

16.4 It is important that the provision of free legal advice and representation is provided in a way that maximises the consumer's ability to obtain assistance with the review hearing or to otherwise challenge her involuntary treatment. This means that the consumer must be provided with appropriate legal information, and provided with assistance to actually access free legal advice, immediately upon being made involuntary. This is very important as, without assistance to access legal representation, some consumers may not be in a position to take the necessary steps to obtain legal representation themselves.

16.5 This assistance may be best provided by the new independent multi-disciplinary monitoring body proposed in Part E of this Submission (the Mental Welfare Commission (***MWC***)). The MWC could be tasked with:

(1) visiting the consumer shortly after being placed on an ITO;

(2) providing information about:

(i) the external review (MHRB) process;

(ii) legal representation; and

(iii) the consumer's rights,

(3) explaining each of these things to the consumer; and

(4) assisting the consumer to access free legal representation and pursue her rights.

16.6 In addition, PILCH supports the legal representation model under the *Mental Health and Related Services Act 1998* (NT) (**NT Act**) where the Mental Health Tribunal must appoint a legal practitioner to represent a person at a review or appeal where the person is not represented, unless it is satisfied that in the circumstances of the case it is not necessary.

16.7 It is also critical that consumers are provided with legal advice at an early stage so that they can be advised about the MHRB process, the legal options available and their rights. Again, in many cases, providing this information without explanation is likely to be meaningless to many consumers. Early provision of legal assistance would also enable

[61] *Currie v Jamaica* UN Doc CCPR/C/50/D/377/1989; See also *Airey v Ireland* 6289/73 [1979] ECHR 3 (9 October 1979).

[62] Although a means test may also be appropriate.

consumers to properly prepare their case before the MHRB and, importantly, obtain a second psychiatric opinion (see paragraphs 15.18 to 15.20 above).

16.8 PILCH recommends that:

(1) legal representation paid for by the state be available (subject to a means test) to all persons appearing before the MHRB; and

(2) the proposed MWC be empowered to visit consumers shortly after being placed on an ITO to:

(i) explain the MHRB process;

(ii) advise of the right to free legal representation; and

(iii) assist the consumer to exercise that right.

17. Consumer participation in external reviews (Question # 47)

17.1 The issue of consumer participation in external reviews must be addressed in the new Act in order to help improve Victoria's current low levels of consumer attendance (and representation) at MHRB hearings. One way to do this is to ensure that all consumers are entitled to government funded legal representation.

17.2 Legal representation would assist in ensuring that consumers feel adequately informed and resourced to properly participate in MHRB hearings and therefore are less likely to be confused by, or feel intimidated by, the legal process and more likely to understand the benefits of participating in the external review.[63]

17.3 PILCH submits that the MHRB may only conduct a review or appeal in the absence of the consumer (or his or her representative) in very limited circumstances, for example, where the Board is satisfied that:

(1) the person made the decision not to attend of his or her own free will; and

(2) the person had a reasonable opportunity to attend the review or appeal or to have a representative appear on her behalf.[64]

17.4 PILCH submits that the above approach is consistent with section 24 of the Charter and promotes the right to a fair hearing.

Recommendation 3

The new Act should confirm that the right to a fair hearing under section 24 of the Charter applies to proceedings before the MHRB.

[63] See the Report of the Mental Health Legal Centre, 'Lacking Insight: Involuntary Patient Experience of the Victorian Mental Health Review Board' (October 2008) for a discussion of the difficulties consumers face in appearing before the MHRB and the impact this has on participation.

[64] *Mental Health and Services Act 1998* (NT), s. 131.

Recommendation 4

Time periods for external reviews of ITOs should be shortened so that:

(a) Automatic initial reviews occur within 3 days after the making of an ITO;

(b) reviews occur within 7 days after a request for a review; and

(c) thereafter, external reviews are held every 3 months in relation to ITOs and every 6 months in relation to community treatment orders.

Recommendation 5

The MHRB should publish a practice note outlining the appropriate conflict-management procedures that apply where a MHRB member has previously treated or personally knows a consumer appearing before that board member.

Recommendation 6

The MHRB should be relocated to a governmental portfolio outside the Department of Human Services, such as the Department of Justice, in order to increase the perception of the MHRB's independence from the executive.

Recommendation 7

Greater use should be made of single member boards in order to cope with an increase in case volume and in frequency of MHRB sittings. However, single member boards should not be constituted by a psychiatrist sitting alone.

Recommendation 8

Upon being placed on an ITO, a consumer should be advised of her right to access her file and should be provided with support and assistance to do so. The MHRB should be required to adjourn hearings if the consumer has not reviewed her file but would like to do so. Consumers should be provided with support when reviewing their file and be able to access an explanation of its contents from an independent source. Consumers from a non-English speaking background should be able to access the services of an interpreter to help them examine their file.

Recommendation 9

The MHRB should be required to enquire whether the consumer has had an opportunity to review her file and adjourn the matter if the consumer has not reviewed her file but would like to do so.

Recommendation 10

Consumers should be provided with legal representation whenever an application for non disclosure is made to the MHRB and the consumer's lawyer should be granted access to the material where a non-disclosure order is made.

Recommendation 11

Prior to appearing before the MHRB, consumers should be provided with information, assistance and funding to enable them to source a second psychiatric opinion. The independent psychiatrist providing the second opinion should be given access to the consumer's file.

Recommendation 12

Legal representation paid for by the state should be available to all persons appearing before the MHRB.

Recommendation 13

A Mental Welfare Commission should be established to:

a) Undertake monitoring, information provision and support for consumers who have been placed on an ITO;

b) conduct investigations and reporting into standards of care; and

c) establish and conduct a complaints mechanism.

The Mental Welfare Commission would visit all consumers placed on an ITO and would assist consumers to access free legal representation, their file, second opinions and complaints mechanisms. The Commission's annual reports should be submitted to parliament and published on its website.

Recommendation 14

The MHRB should only conduct a review or appeal in the absence of the consumer (or his or her representative) in very limited circumstances.

Part E –Monitoring patient wellbeing

18. Nominated person, or 'primary carer' scheme (Question # 25)

18.1 Under the MHA, a consumer does not have the right to nominate a person to receive information about her treatment and care. PILCH considers that this is an omission in the current system that frequently leaves carers without information about their loved ones, and consumers without support because their carer does not have the information necessary to enable them to provide that support.

18.2 Article 12(3) of the ICRD requires State Parties to take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity.

18.3 PILCH recommends that, in order to better protect a consumer's rights under article 12 the 'primary carer' scheme in the *Mental Health Act 2007* (NSW) (***NSW Act***) should be included in the new Act.

18.4 Under the NSW Act, a consumer has the right to nominate a person to be their 'primary carer', unless the consumer has a guardian or the consumer is under 18 years of age. As part of the nomination process, the consumer has the right to nominate persons to be excluded from receiving notices and information about her. The nominations remain in force for a period of 12 months.

18.5 PILCH recommends that under the new Act, the nominated person should be able to appeal ITOs and to advocate at external reviews on behalf of the consumer (with the consumer's consent). The nominated person should also be provided with a range of information about the consumer's treatment, including notification within 24 hours that the consumer has been involuntarily detained.

18.6 The ability to nominate persons whom the consumer does not want to receive information about them is consistent with the right to privacy contained in section 13(a) of the Charter. The fact that a nominated person will be made aware of any ITO and may play a role in advocating on the consumer's behalf is likely to assist in protecting against the arbitrary or unwarranted denial of liberty and may promote the elements of the right to a fair hearing, at the consumer's hearing before the MHRB.

19. Monitoring functions (Question # 51)

19.1 PILCH supports the establishment of a new independent, multidisciplinary body modelled on Scotland's Mental Welfare Commission (***MWC***), to replace the monitoring functions currently undertaken by the Chief Psychiatrist and community visitors under the MHA (as well as to undertake an external complaints function, as discussed below (see Part F) in our response to questions 56-57).

19.2 The Scottish MWC's role is to safeguard the rights and welfare of mental health consumers under the *Mental Health (Care and Treatment) (Scotland) Act 2003*. The Scottish MWC also has a wider role in promoting best practice in the development and use of mental health law and policy.

19.3 PILCH recommends that the new Victorian MWC should undertake the following monitoring functions:

(1) undertake regular visits of persons on ITOs, including a mandatory visit to all consumers upon admission to hospital on an ITO,[65] to ensure that consumers understand the involuntary treatment process and are aware of their rights under the new Act;

(2) be notified of all consumers placed on compulsory treatment orders, check the relevant documentation and have the ability to question the appropriateness of the order;

(3) co-ordinate the funded legal representation scheme (as described in our response to questions 47-49 in Part E above) and to ensure that where a consumer has requested representation at an external review, a lawyer is allocated to act for that consumer;

(4) provide a free telephone advice line for consumers;

(5) be required to contact all consumers following external reviews and (where the consumer is not discharged from an ITO) to ensure that consumers are aware of their appeal rights; and

(6) undertake investigations into a consumer's care, including the ability to interview consumers, members of the treating team and 'any person it considers appropriate', and to inspect any medical or other records relating to a consumer's care.[66]

19.4 By establishing a new centralised body such as the MWC to carry out monitoring, inspection and complaint functions, consumers will have greater confidence that a sufficiently independent body with mental health expertise is protecting their best interests. Further, the fulfilment of the monitoring functions described above is likely to strengthen the ability of consumers to be recognised before and obtain equal access to the law, a fundamental right which is protected under section 8 of the Charter.

20. Publication (Question # 52)

20.1 PILCH recommends that the proposed Victorian MWC is required to prepare annual reports on the discharge of its functions and to submit such reports to its responsible Minister and to Parliament,[67] and to publish the reports on its website.

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[65] As district inspectors are required to do under New Zealand's *Mental Health (Compulsory Care and Treatment) Act 1992* – see Ministry of Health, "Guidelines for the Role and Function of District Inspectors appointed under the Mental Health (Compulsory Assessment and Treatment) Act 1992", 4, http://www.moh.govt.nz/moh.nsf/pagesmh/2486 (accessed 12 February 2009).

[66] Mental Health (Care and Treatment)(Scotland)) Act 2003, ss 7-16.

[67] Mental Health (Care and Treatment)(Scotland)) Act 2003, s 18.

20.2 PILCH recommends that the reports be published on a service-specific basis and contain a list of follow-up actions for the service providers. Under the new Act, the mental health service provider should be required to provide a response to the report within a set timeframe (which will also be published on the monitoring body's website).

20.3 PILCH submits that imposing these reporting and publishing requirements will increase the accountability to its consumers of each mental health service provider whilst also assisting to improve overall consumer satisfaction and wellbeing.

Recommendation 15
A scheme under which the consumer may nominate a person to receive information about her treatment and care, modelled on the 'primary carer' scheme in the *Mental Health Act 2007* (NSW), should be included in the new Act.

Recommendation 16
A consumer's nominated person should, with the consumer's consent, be able to appeal ITOs and to advocate at external reviews on the consumer's behalf.

Recommendation 17
A consumer's nominated person should, with the consumer's consent, be provided with information about the consumer's treatment, including notification within 24 hours that the consumer has been involuntarily detained.

Recommendation 18
An independent and multidisciplinary statutory body, modelled on Scotland's Mental Welfare Commission, should be established to replace the monitoring functions currently undertaken by the Chief Psychiatrist and community visitors. The MWC should also undertake investigations into consumers' care, educate consumers about the involuntary treatment process and their rights under the new Act (including their appeal rights) and facilitate consumer's access to legal representation.

Recommendation 19
The Mental Welfare Commission should prepare annual reports for submission to Parliament and publication on its website.

Part F –Complaints procedures (Questions # 56- 59)

21. Introduction

21.1 PILCH submits that the current local and external complaints systems in Victoria are fragmented, confusing and difficult for consumers to access.[68]

21.2 An effective complaint system is likely to strengthen the protection of consumers' human rights. The right to access a complaints system is recognised in Principle 21 of the Mental Health Principles, which states that consumers "shall have the right to make a complaint through procedures as specified by domestic law." By referring to "domestic law", Principle 21 implies that complaint procedures should be codified clearly in legislation, as opposed to the existing system in Victoria, which is not documented in the MHA. Principle 22 of the Mental Health Principles is also supportive of the need for effective complaints procedures, stating that signatory countries must ensure that there are mechanisms in place to promote compliance with the Mental Health Principles, for the submission, investigation and resolution of complaints and for the institution of appropriate disciplinary or judicial proceedings for violations of consumers' rights.

21.3 Similarly, the World Health Organisation has noted that consumers, their family members and their personal representatives should have the right to complain about any aspect of their care and treatment.[69] It has noted that for a complaints procedure to be effective, the procedure for submission, investigation and resolution of complaints should be outlined in legislation and written in simple language. Consumers and their families should be clearly informed of its applicability, relevant time periods and how and where to lodge a complaint. The complaints procedure should also specify the next or higher level to which the matter can be referred if a successful outcome is not obtained.

22. Local complaint systems

22.1 PILCH endorses the concerns raised in the Consultation Paper about the current local level complaints system in Victoria, in particular in relation to its lack of accountability and transparency.[70]

22.2 PILCH recommends that the new Act contains similar internal complaints procedures to that of the NT Act. Under section 100 of the NT Act, the person-in-charge of an approved treatment facility must establish complaint procedures that are 'accessible, just and fair' and ensure that adequate information about local and external complaint procedures of the facility is provided to:

(1) the consumer;

[68] Consultation Paper, 68 and the authors' experience on the Mental Health Legal Centre advice line.

[69] World Health Organisation (2005) *WHO Resource book on mental health, human rights and legislation*, 70.

[70] Consultation Paper, 67-68.

(2) the consumer's representative; and

(3) the consumer's primary carer.[71]

22.3 The person-in-charge must also ensure that a person who makes a complaint:

(1) receives a written acknowledgement of the complaint as soon as reasonably practicable after the complaint is made; and

(2) is regularly updated as to the progress of any investigation or other action on the complaint.[72]

22.4 The person-in-charge must maintain a register containing a brief record of all complaints and, every 6 months, must prepare a report detailing the pattern of complaints and the changes made to prevent a recurrence of the activities that led to the complaints. This report must be forwarded to the appropriate authorities.

22.5 PILCH recommends that where the consumer either does not receive a timely or satisfactory response under the local complaints system as described above, then the consumer can request that a centralised external mental health complaints body (such as a Mental Health Services Commissioner (as discussed below)) investigates the complaint.

23. External complaints systems

23.1 In Victoria, although a consumer can attempt to make a complaint to a number of external bodies (including the Office of the Health Services Commissioner and the Office of the Public Advocate) there is no independent complaints body with expertise in mental health services.

23.2 In particular, from a consumer's perspective there is an inherent conflict between the Chief Psychiatrist's powers under the MHA to oversee and direct consumer treatment and to simultaneously investigate and resolve complaints about consumer treatment.

23.3 Accordingly, PILCH recommends that a Mental Health Services Commissioner (***MHS Commissioner***) should be appointed by the new Victorian MWC and the MHS Commissioner's office should form part of the MWC.

23.4 The MHS Commissioner should be given similar types of complaint functions and powers to those currently held by the Chief Psychiatrist (as well as those granted to the Health Services Commissioner under the *Victorian Health Records Act* 2001).

[71] *Mental Health and Related Services Act 1998* (NT), s 100(5).

[72] *Mental Health and Related Services Act 1998* (NT), s 100(6).

23.5 PILCH recommends that under the new Act, the responsibilities of the new MHS Commissioner should include:

(1) deciding, within a reasonable period of time, whether to entertain a complaint and to notify the complainant of the decision;

(2) resolving complaints either informally, by conciliation or by investigation;

(3) where there has been a serious contravention of the new Act, issuing legally enforceable compliance notices on an organisation requiring the organisation to take specific action (and report back on the action taken) within a prescribed period of time; and

(4) ensuring that at all times the complainant is kept informed about the status of his or her complaint, and about the MHS Commissioner's findings.

23.6 Where the consumer is dissatisfied with the response that she receives from the MHS Commissioner in relation to its complaint, consumers should also be given the right to request that (as a last resort) the complaint be referred to the Victorian Civil and Administration Tribunal for a hearing.

23.7 PILCH recommends that the MHS Commissioner should also be given the special powers currently held by the Chief Psychiatrist,[73] to conduct its own investigations where there are concerns that a consumer's medical care and welfare is at risk or where there are broader concerns about the standard of practice of a practitioner or a facility.

23.8 PILCH submits that if the above measures are implemented, the Victorian mental health complaints processes would become more transparent and accountable and would provide complainants with a greater sense of satisfaction that their grievances have not only been heard but have also been resolved.

24. Support for consumers making complaints

24.1 PILCH recommends that a key function of the new Victorian MWC should be for staff to provide ongoing education to consumers about their rights under the new Act, including in relation to making complaints.

24.2 PILCH recommends that the MWC staff are given the following responsibilities in relation to consumer complaints:[74]

[73] MHA, s 106.

[74] These responsibilities are similar to the roles of the community visitors under the current Act and the district inspectors under New Zealand's *Mental Health (Compulsory Care and Treatment) Act 1992.*

(1) visiting all consumers upon initial admission and ensuring that the consumers understand their rights, including their right to nominate a 'primary carer' who can also support them; and

(2) advising consumers what action they can take if their treatment and care does not comply with the law (for example, by way of visits and a free telephone hotline), and in particular, ensuring that consumers are aware of their right to lodge a complaint with the MHS Commissioner if they are unhappy with the way that their complaint has been dealt with under the local complaints system.

24.3 The advantage of MWC staff carrying out this support role is that consumers will hopefully recognise that MWC staff are not health care providers and are sufficiently independent from the clinical decision-making process (unlike the Office of the Chief Psychiatrist in the current system).

24.4 PILCH also recommends that under the new Act, a consumer's "primary carer" (as discussed above in response to question 25) can make a complaint on behalf of a consumer, at both a local level and to the MHS Commissioner, with the consumer's consent.

Recommendation 20

A MHS Commissioner should be appointed by the new Victorian MWC and the MHS Commissioner's office should form part of the MWC. The MHS Commissioner should be the central body for complaints in relation to mental health services in Victoria and should be empowered to make decisions about complaints, to issue legally enforceable compliance notices and to conduct its own investigation where there are concerns that a consumer's medical care and welfare is at risk or where there are broader concerns about the standard of practice of a practitioner or a facility.

Recommendation 21

The MWC should be empowered to visit all consumers upon being placed on an ITO and to advise consumers of their right to nominate a 'primary carer' who can also support them and of the available complaints mechanisms. The MWC should also be empowered to assist consumers to lodge complaints.