



## Consumers' experiences of rights-based mental health laws: Lessons from Victoria, Australia

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### ABSTRACT

Many countries embarked on reforms of mental health law in the wake of the Convention on the Rights of Persons with Disabilities. These reforms have had varying levels of success. This paper considers the experience of consumers in the Victorian mental health system, drawing on an evaluation that asked consumers and clinicians about their knowledge and experience of rights under the Victorian Mental Health Act, 2014. The data show that consumers were not informed of their rights, were not involved in decisions about treatment, were not able to access safeguards, and could not exercise their rights. The explanations for this include limited staff time, unclear delegations of responsibility, a lack of knowledge, training, and support for rights, and a preference for 'best interests' approaches. The paper identifies tangible reforms that would maintain rights for consumers, including competent refusal of treatment, legislative and regulatory reforms, and training and resourcing. Consumers in this study found that the rights-based framework in the Mental Health Act, 2014 had such an insignificant effect on clinical mental health practice in Victoria that their rights appeared to be illusory.

### 1. Introduction

The Convention on the Rights of Persons with Disabilities (CRPD), signed in 2007, has prompted global shifts in mental health law. Scotland ([Scottish Mental Health Law Review, 2021](#)), England and Wales ([Department of Health and Social Care, 2021](#)), and Ireland ([Mental Health Reform, 2021](#)) are currently reviewing mental health legislation, while India has introduced the *Mental Healthcare Act 2017* to meet its CRPD obligations ([Duffy & Kelly, 2019](#)). Efforts to produce fit for purpose mental health laws are being challenged to engage with a new set of questions that prioritise non-discrimination ([Davidson, 2020](#)) while upholding mental health consumers' autonomy, dignity, and self-determination ([Brown, 2016](#)). Legislative strategies that have become associated with CRPD-based reform include support for decision-making ([Gooding, 2017](#)), better use of support persons ([Series, 2015](#)), advocacy services ([Ridley et al., 2015](#)), consensual proxy decision-making ([Pathare, Shields, Nardodkar, Narasimhan, & Bunders, 2015](#)), and better use of instruments such as psychiatric advance directives ([Flynn, 2019](#)). In tandem, attention has been drawn to the need to radically reduce restrictive practices ([Gooding, McSherry, & Roper, 2020](#)) and

routine compulsory treatment in the community ([Brophy, Ryan, & Weller, 2018](#)).

Evolving debates about the proper form of mental health law mark a new phase in mental health law reform discourse. Traditionally, mental health laws conferred unrestricted authority on psychiatrists to make treatment decisions on a 'best interests' basis ([Brown, 2016](#)). In the second half of the 20th century, rights-based mental health laws surrounded medical discretion with procedural safeguards, introducing, for example, strict criteria for compulsory mental health treatment and administrative tribunal review ([Weller, 2010](#)). Internationally, the principles of rights-based law reform have been widely promoted by the World Health Organisation (WHO) and the CRPD Committee. These rights-based principles led to consideration of non-discriminatory substitute decision-making laws, where a person's capacity, not their diagnosis, was the central consideration ([Gooding, 2017](#)). These principles also led to supported decision-making laws, where a person would be supported to exercise their capacity, rather than have their capacity assessed and denied ([Gooding, 2017](#)). The recent WHO (2021) publication *Guidance on community mental health services: Promoting person-centred and rights-based approaches* progresses this reform agenda.

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Mental health law reform is inevitably constrained by the social, economic, and political contexts in which reform is attempted. In many developed jurisdictions, rights-based law reform has intersected with periods of de-institutionalisation (Gostin, 2008), reduced government funding, and increased demand for mental health services, resulting in crisis-driven systems in which resources are progressively funnelled into acute psychiatric care rather than preventive care. Public mental health systems around the world are reporting poor treatment outcomes for mental health consumers (Giuntoli et al., 2019), persistent breaches of consumer rights (BC Office of the Ombudsperson, 2019), and increased reliance on coercive and restrictive forms of treatment and care (Dixon, Wilkinson-Tough, Stone, & Laing, 2020; Gill, Allan, Clark, & Rosen, 2020; Hashmi, Shad, Rhoades, & Parsaik, 2014; Knott et al., 2020; Rains et al., 2019). Poor outcomes raise questions about the efficacy and impact of rights mental health law reform. One way of understanding the impact of mental health law is to consider the experience of individuals who are subject to such laws.

This article provides an account of consumers' experience of rights-based law reform in Victoria, Australia, where an innovative legislative framework was introduced in 2014. The promise of the *Mental Health Act, 2014* (Vic) (the Act) was so great that Victoria was hailed as a 'true leader' in mental health law reform (Cannold, 2014). Only four years later, the Victorian government called a Royal Commission into Victoria's Mental Health System (Royal Commission) to investigate the failure of Victoria's mental health system. Amongst its sweeping recommendations, the Royal Commission advised that the *Mental Health Act, 2014* be abolished and replaced with a new *Mental Health and Wellbeing Act*. This paper considers some of the recommendations of the Royal Commission in light of consumers' experience in the mental health system.

The paper is divided into six parts. The following section, part two, describes the approach taken to the collection of the data. Part three provides a summary of the *Mental Health Act, 2014*. Part four examines consumers' experiences of rights under the *Mental Health Act, 2014*. The dominant theme in this analysis is that consumers described their rights under the Act as illusory. Part five describes several factors that appear to limit the realisation of statutory rights, including a lack of knowledge on the part of staff and clinicians. Part six provides a discussion of the key findings and makes recommendations for future law and system reform. This analysis shows that the rights framework in the *Mental Health Act, 2014* had, for the consumers who participated in this study, little or no impact on the way mental health services engaged with consumer rights. While it is difficult to draw a complete picture of why and how legislation fails, this paper argues that the rights framework in the *Mental Health Act, 2014* failed in its objectives because it was weak, contradictory, and disconnected from human rights principles. What is required is a firm grasp on human rights principles, adequately resourced services including independent non-legal advocacy, robust legislation, strong implementation, ongoing training, and dedicated attention to the social determinants of mental health.

## 2. Methodology and materials

The analysis in this article draws on previously unpublished data collected in 2017 and 2018 during an evaluation of Victoria's Independent Mental Health Advocacy (IMHA) service (Maylea et al., 2019; Weller et al., 2019).<sup>1</sup> The evaluation took a participatory approach, using principles of co-design and coproduction (Burge, 2016; Roper, Grey, & Cadogan, 2018) to guide methodological choices and the research process. Six members of the ten-person evaluation team had lived experience as consumers of mental health services, with three

<sup>1</sup> Victoria's mental health system is on the brink of significant reform, as discussed below, however no major changes to the system have occurred since data collection.

having experienced involuntary treatment under the *Mental Health Act, 2014*. A further sub-committee consisting of five consumers from IMHA's *Speaking from Experience* advisory group provided guidance and direction for the evaluation, including the research design, data collection, and analysis.

The evaluation sought to examine to what extent the IMHA service provided effective, efficient, and sustainable non-legal advocacy for consumers on or at risk of being placed on compulsory treatment orders. This included assessing the extent to which IMHA supported people to exercise their rights. The evaluation team drew on evidence from consumers, mental health professionals, mental health lawyers, IMHA advocates and service staff, and broader sector stakeholders. Groups were selected using a purposive sampling method. During interviews and focus groups, all consumers and clinicians were asked about their knowledge and experiences of rights under the *Mental Health Act, 2014*.

The evaluation team invited prospective participants in the community using IMHA's contact database and in the inpatient setting by visiting mental health inpatient units. Nine focus groups were held in both regional and metropolitan Victoria, in both inpatient and community settings, while 51 interviews were conducted face-to-face or over the phone. In total, 59 consumers (40 in the community and 19 across five inpatient units) and 61 mental health professionals participated.<sup>2</sup> These 59 consumers are not a random sample, having been recruited because they had used IMHA previously or were available to participate in a focus group on the day the evaluation team attended the inpatient unit. This has likely introduced some bias into the findings as people who experience rights breaches are more likely to seek out IMHA, and those who complain of rights breaches are more likely to be referred to IMHA (Maylea et al., 2019). For this reason, these qualitative data do not indicate the prevalence of rights breaches but contribute to the understanding of how rights breaches are experienced.

Interviews and focus groups were recorded and professionally transcribed before being transferred into NVivo qualitative analysis software for analysis. Participant responses were disaggregated based on their responses. The questions asked if participants had been informed about their rights, whether mental health services breached their rights, and the complaints individuals had made. The raw data were independently coded and then recoded using axial coding, ensuring double handling of data from both consumer and academic perspectives. A heavy emphasis has been placed on using quotes in their full length with minor edits for readability and to ensure anonymity. In doing so, we aim to privilege consumer voices that are often marginalised in mental health research (Groot, Haveman, & Abma, 2020).

Quotes are identified using terms "FG" followed by a number (e.g. "FG11") for consumer focus groups, "MHP" followed by a number (e.g. "MHP32") for interviews with mental health professionals, and "C" followed by a number (e.g. "C3") for interviews with consumers.

The authors of this paper, including three academics and two consumers, are a subgroup of the original evaluation team, supported by a research assistant who was not part of the original evaluation team.

Ethics approval for the original research was granted by RMIT University #20970 and #20975-06/17, and Melbourne Health Human Research Ethics Committee #17/MH/394.

## 3. Mental health law reform in Victoria

The *Mental Health Act, 2014* (Vic) was the product of a lengthy law reform process following Australia's ratification of the CRPD. Australia adopted the CRPD in 2008, albeit with a declaration indicating Australia's intention to retain substituted decision-making regimes would

<sup>2</sup> A further 33 lawyers, advocates, and stakeholder body representatives participated in focus groups or interviews, and 300 survey responses were received. However, these data were not included in the analysis for this paper, which focuses on the consumer experience.

be retained as a “last resort and subject to safeguards” (*Convention on the Rights of Persons with Disabilities Declaration 2009*, Sch 2). Australia’s Declaration contradicts subsequent statements by the CRPD Committee that non-consensual (substituted decision-making) forms of psychiatric treatment are discriminatory and contrary to the CRPD principles (*Committee on the Rights of Persons with Disabilities, 2014*). According to the CRPD Committee, people with disabilities must be supported to exercise their legal capacity, understood as the ability to have and exercise rights (*McSherry, 2012*), rather than have their rights restricted based on mental capacity (*Gooding, 2017*). Australia has declined to remove the Declaration despite repeated requests from the Committee on the Rights of Persons with Disabilities.

Australia’s federal system of government means that mental health law reform is the constitutional responsibility of state governments (*Scully, 2009*). In Victoria, the development of the *Mental Health Act, 2014* was lengthy and bipartisan. It was informed by contemporary rights debates and the human rights principles in the *Charter of Human Rights and Responsibilities Act, 2006* (Vic).<sup>3</sup> However, it is pertinent to note that the content of the legislation was largely settled by the time the Committee on the Rights of Person with Disabilities published its CRPD General Comment 1 on Article 12 in 2013. It is unsurprising then that some features of the legislation fall short of more recent interpretations of what is required by the CRPD.

The *Mental Health Act, 2014* explicitly sought to create a rights-based framework that would support consumers to make or participate in their own treatment decisions while receiving care that was the least restrictive as possible. The statutory mechanisms utilised to achieve these goals were the inclusion of binding statutory mental health principles (s 11), limited treatment criteria (s 5), advance statements (ss 19–22), nominated persons (ss 23–26), the opportunity to seek second psychiatric opinions (ss 78–89), and the inclusion of specific obligations related to psychiatrists’ decision-making (ss 68–71). Competent refusal for electroconvulsive therapy was introduced (s 93) but not for other treatment decisions (s 71). There is clear legislative guidance to seek informed consent (s68ss 68–70), however, s 71 states that if a patient does not have capacity to give informed consent (s71s 71(1)(a)(i)) or has capacity but does not give informed consent (s71s 71(1)(a)(ii)), the psychiatrist may make the treatment decision for the patient, provided he or she is satisfied that there is no less restrictive way for the patient to be treated (s71s 71(3)).

Instead of a capacity-based approach, the 2014 legislation attempted to shift practice to a supported decision-making approach, albeit firmly within a substituted decision-making framework. The responsibilities of the Mental Health Tribunal (formerly the Mental Health Review Board) were enhanced (ss 152–155), and an independent Mental Health Complaints Commission (MHCC) was established (s 228). The statutory safeguards and consumer rights were to be communicated to consumers via a “statement of rights” (s 12) and explained to the person by psychiatrists in a manner that the person can understand (s 13). The rights framework was supported by the Independent Mental Health Advocacy (IMHA) service, which provided non-legal advocacy to consumers who were subject to or at risk of being placed on compulsory mental health treatment orders (*Maylea et al., 2019*).

Under the legislative scheme introduced in 2014, clinicians and service providers must respect and promote the rights, dignity and autonomy of people who receive mental health services (s 11(1)(e)). The practical expression of principle was the inclusion of a legislative obligation to provide information to those admitted to mental health facilities. The Act requires psychiatrists to ensure that people receiving treatment are given a statement of rights (s 12 and s 69(2)(f)) accompanied by an oral explanation and an opportunity to ask questions (s 13 (a) and s 13(b)). If the person is unable to understand the information,

<sup>3</sup> At the time, Victoria was the only state or territory in Australia with human rights legislation (*Scully, 2009*).

the psychiatrist must make further attempts to explain the information when the person can understand (s 13(c)). The logic of legislation is that consumers who were informed of their rights would be better able to access the key features of the supported decision-making framework. These include the ability to articulate their views and wishes in an advance statement or with the support of nominated persons. By these means, it was hoped a consumer could fully participate in treatment decisions and, if they wished, seek the views of another clinician.

As indicated by both the need for a Royal Commission and by that Royal Commission’s report, these legislative changes have not resulted in the intended outcomes. In Australia, a country with some of the highest rates of involuntary admissions in the world (*Rains et al., 2019*), Victoria is well above the national average for rates of seclusion events, mechanical restraint events, and involuntary admissions (*AIHW, 2021*). Victoria is a politically progressive state of nearly seven million people with a robust health service and a well-functioning economy, but this is not reflected in its mental health system. The following data further highlights the failure of the reform effort: consumers in our study were rarely provided with information about rights and rarely supported to participate in treatment decisions.

#### 4. Consumers’ experiences of the Mental Health Act

Amongst the group of 59 consumers who participated in a focus group or interview for the IMHA evaluation, we identified 108 instances of consumers describing how they did not understand their rights or had their rights ignored by treating clinicians. Breaches of statutory rights were reported across all five inpatient services visited for focus groups and in every consumer interview.<sup>4</sup> The most common occurrences were failures to inform consumers of their rights and failures to involve consumers in treatment decisions.

##### 4.1. Failures to inform consumers of their rights

Consumers in our study reported multiple and persistent failures of clinicians to provide statements of rights, as is explained in the following focus group discussion, where the group were asked if they received a statement of rights:

*Consumer 2: Some of us did, but most of us didn’t.*

*Consumer 4: No. Some of us, I didn’t.*

*Consumer 6: I didn’t.*

*Consumer 1: I got nothing.*

*Interviewer: Okay, so just for the record, so one of you of the six got a statement of rights.*

*Consumer 1: Nothing.*

*Consumer 2: None one of, I don’t think any of us did, but I know someone else out, who did...*

*Interviewer: Oh, so none of you here?*

*Consumer 3: No none of -*

*Interviewer: Got a statement of rights... Okay, it is in the Act, it’s in the Mental Health Act -*

*Consumer: We know it is. (FG5)*

Another group was asked whether they knew about specific rights and entitlements under the legislation:

*Consumer 2: They chucked me in, and that was it.*

*Interviewer: ... What about other rights to do with your treatment here? Are you aware of other things that you’re entitled to? Could you name anything?*

<sup>4</sup> The nature of focus group data in the inpatient setting makes distinguishing individual speakers difficult. It is therefore not always possible to state precisely what proportion of people experienced rights breaches. Participants often spoke over each other, and some participants did not speak at all. This is a qualitative study and does not seek to establish the prevalence of rights breaches in these settings.

Consumer 1: I'm not too sure, to be honest.

Consumer 2: Yeah, I'm not too sure either.

Interviewer: Do you know what an advance statement is? Have you heard of that?

Consumer 1: No.

Interviewer: Advance statements are documents where you can write down what you want to happen to you. They don't have to follow them, but they have to read them.

Consumer 2: Right.

Interviewer: ... What about nominated persons? Have you heard of that?

Consumer 1: No.

Interviewer: ... What about second opinion service? Are you aware you're entitled to a second opinion?

Consumer 2: Yeah.

Interviewer: You've heard of that?

Consumer 2: Yeah.

Interviewer: Have you used it?

Consumer 2: No.

Consumer 1: No idea. No.

Interviewer: You weren't aware of that?

Consumer 1: No. (FG6)

Another consumer commented on the general absence of rights talk:

*Well, it seems that's something that doesn't get talked about, and that's probably because if you know your rights you're more empowered, you can say well, this has to be like this, and it's part of the policy and procedure that it's done like this, and that kind of inhibits the staff, you know, it gives them, it gives you more power to refuse things or maybe change things as you want, you know? (C1, FG3).*

Some clinicians who participated in the study stated that rights information was routinely provided to patients. For example:

*We actually offer different types of pamphlets, like rights and responsibilities of [mental health service] as an organisation. If they're under the Mental Health Act – like if they're on an assessment order or temporary treatment order, we have particular statements of rights which we do give them. They're like small booklets. (MHP3).*

One clinician stated that he knew that consumers were meant to be informed of their rights but couldn't confirm that this was occurring in practice:

Interviewer: Does everybody get a copy of their statement of rights and information packs and things like that?

MHP32: I don't think so.

Interviewer: Who's supposed to be giving those out? Is that policy?

MHP32: Yeah, it's policy. Every patient admitted here needs to have the rules of [mental health service] and the policies and the services available. It's part of the beginning process. But I'm not sure. I'm not sure every person is getting it. Because people don't understand what their rights are and what advanced statements are.

Another clinician was unable to recall ever seeing an interview with a patient where rights were discussed:

*I have to say that I haven't seen, in any of the reviews with any of the doctors – I'm a junior doctor, but I haven't seen during the interview when the patient is addressed about these rights – like 'these are your rights; are you aware of them?' Maybe something that happened prior to admission, maybe in a level of admission that I'm not participating in. I don't know. (MHP42).*

Our data suggest that the provision of rights booklets is, at best, ad hoc and that explanations of rights by clinicians are rare or not meaningful to consumers. This finding is consistent with a report from the Victorian Mental Health Complaints Commissioner that noted persistent failures to provide and/or explain a statement of rights (Coulson-Barr, 2020).

#### 4.2. Failures to involve consumers in treatment decisions

People receiving mental health services under the [Mental Health Act, 2014](#) are entitled to be involved in all decisions about their assessment, treatment, and recovery and are entitled to be supported to make, or participate in, those decisions, and their views and preferences should be respected (s 11(1)(c)). This principle is reflected in various provisions in the legislation including in the requirement that psychiatrists 'have regard' to the person's wishes when making a treatment decision (ss 68–71). Consumers in this study were not consistently aware that they were entitled to be involved in treatment decisions:

Interviewer 1: ... if you're under an order then that means the doctors have control over the treatment, but they're required to involve you in that process, so what would help you be more involved in that process?

Consumer 1: If they talk to us about how we... because we didn't know we were involved in that process. I didn't, did you?

Consumer 2: No, I haven't been made aware either, that I could be involved.

Interviewer 1: You didn't know that you could be involved in deciding what treatment you were going on?

Consumer 1: Oh yeah, no, I had no idea.

Interviewer 2: So, you don't feel like you can discuss... So, if they said we're going to put you on this medication, you didn't feel like you could say, in the past I've been on this and this worked really well -

Consumer 1: No. ... we just went along with what they said...

Interviewer 2: They didn't explain what they're giving you?

Consumer 1: No, it was just here, here's your cup, swallow it. (FG7)

Some reported that their attempts to be involved in the decision were rebuffed:

*I tried to talk a couple of times the other day about the needle and stuff, and it feels like they just say what they want to come through because it's just me, there's no one else there they have to answer, to say that I was trying to stand up for my rights. (C2, FG7).*

Others reported that clinicians actively excluded them from the treatment decision while involving the consumer's family against their wishes:

*Sometimes you do feel like you don't know what's going on or you ask what's happening and you don't really get much answers but then yet they're talking to your family, which I've asked specifically not to contact my mum. They're still doing it. (C1, FG7).*

Overall, consumers felt estranged from the treatment decision process, describing their experience as being 'under the control' of clinicians rather than involved in a process. This finding is consistent with the observation of [Kokanović et al. \(2018\)](#) that mental health practitioners were some way from realising supported decision-making in practice.

#### 4.3. Failures to facilitate access to rights safeguards

In some instances, although consumers were aware of their rights, they remained dependent on services and clinicians to accept their requests and act on upon them. For example, one consumer reported persistent delays in accessing the second psychiatric opinion service:

*I said to my nurse I'd like a second opinion; I'm entitled to it, according to the Mental Health Act. She got a list of psychiatrists and was trying to organise a second opinion. Nothing happened while I was in there. ... So, then I had a meeting with my psychiatrist and he said I was discharged. I said what about my second opinion? ... But most second opinions aren't given until the person is discharged. It's not given while they're on the ward. And that's breaching the Mental Health Act. That's what I was upset about. Because the Act specifically says you're entitled to a second opinion. It even gives a time period. And I couldn't get one. (C3, FG1).*

Consumers consistently shared their feelings that administrative practices or ward routines routinely trumped statutory rights.

## 5. Barriers to rights practice

Several clinicians acknowledged there are significant barriers to implementing the rights framework, including limited staff time, delegation of tasks, and a lack of knowledge about rights. Some clinicians demonstrated genuine confusion about their legal responsibilities, while others questioned the value of rights-based approaches.

### 5.1. Overall assessment: Rights are illusory

The overwhelming experience of consumers in our study is that their statutory rights under the [Mental Health Act, 2014](#) are illusory. Several consumers described their experience as having no rights at all:

*... you don't have rights in there. You're powerless in there. What they say, you do. You've got no choice.* (C3, FG1).

*That's the trouble with the Mental Health Act, you have no rights.* (C1, FG2).

*I don't believe that I have any rights. The truth, I don't believe, regardless of how much they've supposedly changed the laws in 2014 I think it was a waste of time... I don't believe that I have any rights, honestly. Whatever rights I might have, the psychologists completely just disregard.* (C3).

*They basically, the psychologist ... You can be told about every right that you have. A psychologist, within one word, "It's my opinion; that's it", they can negate every one of your rights.*<sup>5</sup> (C2).

These findings are consistent with the observation by [Wyder, Bland, Herriot, and Crompton \(2015\)](#) that consumers equate being on a compulsory treatment order with having no rights. [Loft and Lavender \(2016\)](#) similarly found that consumers reported the mental health system as one that denied their personhood and rights. Some consumers reported confusion and bewilderment about the imposition of involuntary status:

*I was a voluntary patient when I first came in. After the second day I was an involuntary patient, so I don't know how the hell that happened.* (C3, FG3).

Others reported traumatic experiences and a deep sense of violation and betrayal:

*Because at this stage, the Mental Health Act is not being followed by [mental health service]. It's not being adhered to, and people are getting wrongfully admitted, are getting wrongfully medicated. [Fellow consumer] went into anaphylactic shock in there because they injected him. It was pretty severe. I had to witness that.* (C4, FG1).

One clinician recognised the weak rights protection afforded by the [Mental Health Act, 2014](#) and the underlying relationships of power:

*I very much anticipated the new Mental Health Act, and I don't think it went far enough. I don't think it went far enough to empower the consumer, in all honesty. There's too many overrides of the patient's rights in there. Even an advance statement – yeah, the doctor has to look at it. But they can still ignore it and do what they – they still hold the power. I think that when you get to human rights and all of those kind of thoughts, it didn't go far enough.* (MHP31).

Another clinician pointed to an implied need for subservience:

*I think that the Act itself, even though it's far more progressive than the governor's pleasure, still requires a fair amount of passive acceptance for a subject of the Act. That's replicated in some way in the relationship with the treating team. We have a sort of auspiced or deferred authority.* (MHP10).

Several published studies have similarly emphasised the relationships of power and powerlessness that pervade mental health systems ([Szmukler, 2014](#); [Roper et al., 2018](#)).

The practice of placing all consumers under strict control in the first 24 h was described by another clinician:

*When they come through the door, you can't smoke, you can't leave, you can't, can't, can't. We're a 'no' society versus the open society and we become an open society after 24 h. The first 24 h is really hard. The reason you've come to an acute inpatient unit is because you can't be cared for in the community and so we have no leave until you're seen by the consultant and that might be at 11 o'clock but you were admitted yesterday at 10 o'clock in the morning, that kind of stuff.* (MHP44).

The latter example illustrates the unquestioned priority given to clinical imperatives, ward practices, and 'rules' about obedience over rights-based mental health legislation.

### 5.2. Staff time

Several participants identified staff time as a major barrier to the realisation of the rights-based framework:

*A lot of our patients have a really hard time understanding the Mental Health Act and what their rights are. And sometimes we don't have the time to give them all the explanations that they need.* (MHP2).

These comments are consistent with the findings of the Royal Commission that "consumers are not properly supported to exercise their rights" ([RCVMHS, 2021c](#), p. 393).

Other staff commented on the difficulty in upholding consumer entitlements when staff were unavailable. The following comment refers to the right to day leave:

*I know from my practice that if people want leave and, like, we just can't facilitate them all the time and then it might feel like we're restricting someone's rights in terms of being entitled to leave that they've got written up, but if we can't escort them they can't then have it so then that may leave the consumer then feeling that they're not being appreciated, they're not as valued or whatever because they aren't getting what they're entitled to I guess.* (MHP17).

### 5.3. Delegation of responsibility

Another problem appeared to be psychiatrists delegating the responsibility to give rights information and explanations to nursing staff:

*The psychiatrist makes the decision, or the treating team makes the decision and then when people start to question it and 'why is this happening?', the nurses get their back up a bit because they feel they're being attacked or challenged for something they're not responsible for.* (MHP9).

### 5.4. Lack of knowledge

The delegation of responsibility about rights was compounded by a lack of knowledge amongst mental health professionals about the rights and entitlements of consumers:

*The staff have no idea what patient rights are, really. The majority of nursing staff don't know. ... The problem with that is that obviously it limits the number of times that this stuff gets brought up with patients,*

<sup>5</sup> This quote likely reflects confusion between the professions of psychology and psychiatry, as psychiatrists would ordinarily be the treatment decision-makers under the [Mental Health Act, 2014](#).

because the majority of staff don't really know. Because it's so complex. We talked about patients not really understanding their rights and stuff, it's because we don't actively communicate them to them very often, because it's such a complicated system. There aren't actually that many of us that really understand what the patient's rights are. (MHP11).

One clinician admitted to their limited knowledge:

*I think I've got a basic understanding of it so that if someone did come to me with a question I could probably be, like, 'Yeah, that doesn't really sound right, like, you could still do this or whatever'. But in terms of the ins and outs of it all, I wouldn't feel confident in explaining that to someone. (MHP17).*

One clinician described the limited rights that were afforded to voluntary patients:

*MHP32: Even patients on voluntary status have limited access to leave and all those things.*

*Interviewer: So, there are patients here who are voluntary who are being denied leave?*

*MHP32: Yeah, sometimes.*

Another thought the routine limitation of the rights of voluntary patients was part of a general 'duty of care':

*MHP57: We get patients here with dementia who might have restrictions on their leave, so they're – they're here under duty of care...*

*Interviewer: When you say they're here under duty of care, how is that kind of explained to you?*

*MHP57: I don't really know. It's sort of like they're voluntary, but you're treating them with a closer eye. I guess it's almost like saying they're voluntary, but yet still have limitations to that. Just because of their cognition or their memory.*

*Interviewer: If they wanted to walk out, they'd be able to?*

*MHP57: I'd – wouldn't have a clue. I'd probably almost say no.*

Guidance from the [Office of the Chief Psychiatrist \(2018\)](#) confirms that restriction of the rights of voluntary patients is not appropriate.

### 5.5. Lack of training and support for rights

Some clinicians noted the lack of appropriate training made available to them. A consultant psychiatrist reported:

*I've been working for six months. I haven't had almost like a formal training in the Mental Health Act or the role of IMHA or anything like that or even any kind of correspondence or any kind of information. (MHP26).*

Others who called for greater education were supportive of rights:

*I think a lot of education needs to be done at the professional level. Not for the consumers, but for the treating team. The professional needs to know the implication of the Act and how it is important. This is not a jail; this is a hospital, and we need to promote the rights. ... Promoting the rights of the patient is important, because we need it implement the legislation. Everyone needs to be on the same page. (MHP32).*

Those who supported rights often recognised the need to improve rights-based service delivery. One nurse unit manager acknowledged:

*The patients have rights, and we need to be working toward a recovery-oriented service delivery. And we still aren't. We are in a better way than we used to be, but there's still a long way to go. (MHP31).*

### 5.6. Clinicians prefer 'best interests' approaches to care

Several clinicians seemed unaware of the statutory provisions, expressing the view that a 'best interests' approach is the primary paradigm for guiding care.<sup>6</sup> One clinician saw the expression of rights as an obstacle to appropriate care:

*I could never understand why when the patients – it was in the best interests of the patient, for their care, that everything would be challenged in regards to treatment, how we dealt with that person, the medication they were on, their rights, why haven't they had this, why haven't they had that, without looking at the big picture... And I thought we were all here to work – I feel that we are all here to work for the patients' best outcome in regards to their treatment. But when people are sort of putting obstacles up all the time it makes it really hard. (MHP7).*

Another questioned the legitimacy of perspectives that contradicted best interests:

*Well, it's probably not a good position then to have because if you've got one person that's pushing for something that's not in the best interests of the patient and we're doing the opposite, then that's a sort of a mixed response to treatment, isn't it? (MHP5).*

Others postulated that a limited acknowledgement of rights might be clinically beneficial:

*So, some things might not be in someone's best interest clinically, like they want leave so they can go and smoke. Smoking is bad for you. You shouldn't be advocating that, but at the same time you've got to balance that against their rights to do something that's a legal activity. I think if you give someone their rights, even though it might not technically be in their best interest in an ideal situation, then it gives them the strength to care a bit more about examining that for themselves. (MHP9).*

These comments point to a significant deficit in understanding amongst clinicians about the purpose and effect of rights frameworks. The observation that some clinicians privilege 'best interests' approaches is consistent with similar observations made in relation to clinician attitudes toward advance statements ([Swanson, Van McCrary, Swartz, Van Dorn, & Elbogen, 2007](#)) and compulsory treatment ([Gooding, 2015; Lamont, Stewart, & Chiarella, 2020; Tan, Doll, Fitzpatrick, Stewart, & Hope, 2008](#)). It is also consistent with research that shows that clinicians frequently display a lack of understanding or regard for mental health law ([Gooding, 2015; Lamont et al., 2020; Ryan, 2018; Wand & Wand, 2013](#)).

On the other hand, comments from some clinicians revealed a broader or more general understanding of human rights. For example, one clinician expressed annoyance at what he regarded as the irrelevance of the rights in the [Mental Health Act, 2014](#):

*I need somewhere I can discharge the guys... I need someone on the outside to advocate for the patients and to get them a bed. Not to tell me what the Mental Health Act is or tell them what the Mental Health Act is, I need a bed. (MHP11).*

This comment is important because it expressed the frustration of providing clinical care when there is limited availability of suitable step-down accommodation beyond the hospital. Another clinician explicitly recognised the limitation as a restriction of human rights:

<sup>6</sup> The authors note a distinction between 'best interests' in an Australian clinical context, which is usually understood as an 'objective' assessment by a clinician aimed at reducing symptomology, and the way the term is used in other jurisdictions, such as England and Wales, where the term is more often used to describe a subjective assessment of what the person themselves would understand as their best interests.

*We've got patients here that could be out in the community tomorrow if but for a suitable service, a suitable accommodation could be found. That's a failure of the system. That's not a failure of the patient. The system is not providing adequate services; therefore we're keeping people in a more restrictive environment than they would otherwise need. To me, that's a breach of the Mental Health Act. (MHP9).*

## 6. Discussion

It is clear from our study that not all Victorian mental health consumers experience the mental health system as one that respects rights. Some participants had not been included in discussions about treatment nor given the opportunity to express their views about their treatment preferences. They had not experienced support for decision-making. Rather, participants overwhelmingly identified repeated failures by services to inform them of their rights, to provide effective explanations, to support their participation in treatment decisions, or to facilitate access to rights safeguards, such as advance statements, nominated persons, or second opinions.

As noted above, the consumers who participated in this study are not a random sample, and as such, these data do not indicate the prevalence of rights breaches. Other data suggests, however, that these experiences are widespread. Similar experiences were widely reported to the Royal Commission from multiple sources, with submissions from consumers and consumer groups highlighting the theme of power/powerlessness (Victoria Legal Aid, 2020). The Final Report of the Royal Commission recognised the universality of these experiences:

*Dignity is often disregarded, and human rights are breached. Many people who do obtain access to mental health services are not treated with dignity or respect and are not involved in making decisions about their own treatment, care and support. (RCVMHS, 2021a, p. 18).*

The report also found:

*... supported decision-making principles and practices, where a person is enabled to make decisions, communicate and have their preferences respected, are not routinely used. (RCVMHS, 2021a, p. 4).*

The report also found:

*'Power imbalances' that disadvantage and marginalise people living with mental illness or experiencing psychological distress are (still) apparent. (RCVMHS, 2021a, p. 229).*

These findings are consistent with the analysis of the data in this study. The Royal Commission offered 488 recommendations as a blueprint for a transformed mental health system centred on a primary objective of achieving “the highest standard of mental health and wellbeing” and “the protection and promotion of human rights” (RCVMHS, 2021c, p. 37). This is to be achieved a new suite of governance structures, including a new Mental Health and Wellbeing Commission to provide oversight of government and mental health services (recommendation 44 and 53).

In addition to providing a legislative basis for the new statutory body, the Royal Commission has recommended that the new *Mental Health and Wellbeing Act* be framed with new objectives and principles accompanied by compliance mechanisms (RCVMHS, 2021b, p. 37). Compulsory mental health treatment is to be used only as a last resort (recommendation 55) (RCVMHS, 2021a). Treatment decision provisions are to be “simplified” and include a statutory obligation for psychiatrists to document how they have sought informed consent and supported a consumer to participate in treatment decisions (RCVMHS, 2021b, p. 428). The legislation will also embed an “opt-out” advocacy service, allowing all consumers to access a mental health advocate whenever they are placed on a treatment order (recommendation 56(2)). The new legislation is to be introduced by mid-2022 (recommendation 42), with

a subsequent review required by law within five to seven years (recommendation 43).

The analysis of the data set out in this paper suggests that the existing rights framework has been too weak to effect change. A stronger legislative response is required to promote consumers' rights and dignity and to enhance self-determination. The Royal Commission recommendations seek to strengthen the rights framework by recommending the inclusion of compliance measures. However, given the depth of disquiet reported by some consumers and the attitude of some clinicians, it seems unlikely that a compliance approach will bring the sustained and enduring cultural change that will be necessary to improve the quality of care provided to mental health care consumers. There is also a danger that a compliance approach will exacerbate the power imbalance between consumers and clinicians and increase clinician resistance to rights principles.

More importantly, the Royal Commission did not address fundamental flaws in the current *Mental Health Act* that directly undermine a human rights framework. The following section outlines four strategies that would strengthen respect for human rights in Victoria's mental health care system. These recommendations include recognising the right to competent refusal for mental health care; ensuring consumers' entitlements to decision-making support and binding advance directives; more closely aligning legislation with human rights frameworks; ensuring access to independent, rights-based advocacy; ensuring appropriate powers for the new regulatory bodies; robust implementation and training and appropriate resourcing.

This paper and these recommendations focus on legislative reform, however, the authors acknowledge that consumer's rights will only be realised when legislative reform is undertaken in concurrence with broader systemic reform, such as a shift to community-based services (WHO, 2021). These broader shifts have been identified as required by the Royal Commission, however, without real change to the underlying legislation, the experiences of consumers of Victoria's mental health system seem unlikely to change.

In making the recommendations below, we also recognise that capacity-based decision-making frameworks are generally regarded as inconsistent CRPD, which requires all people to be supported to maintain their capacity to make their own treatment decisions (Flynn, 2019). In the pragmatic context of Victorian law reform, however, we argue that recognising the right to competently refuse treatment is a necessary first step toward a CRPD compliant legislative framework. The right to competent refusal should be supported by embedding support to maintain capacity, with a view to achieving full CRPD compliance as soon as possible.

The remainder of this section details recommendations for ongoing legislative reform to address the issues identified above. These are specific to the Victorian legislative context but have broad relevance for any mental health reform agenda.

### 6.1. Enable competent refusal of treatment

Modern mental health laws should ensure the right of competent patients to refuse mental health treatment (Callaghan & Ryan, 2014). Except for provisions relating to electroconvulsive therapy, the *Mental Health Act, 2014* does not respect the right to those with mental capacity to refuse mental health treatment. Section 71(1) (ii) permits an authorised psychiatrist to make the treatment decision if a patient “has the capacity to give informed consent, but does not give informed consent to treatment”.

Protection of the right to give informed consent or refuse treatment is a general feature of law in all developed legal systems (Szmukler, 2014). At present, the denial of capacity-based entitlements in Victorian mental health law contrasts with the Victorian *Power of Attorneys Act, 2014*, the *Medical Treatment Planning and Decisions Act, 2016*, and the *Guardianship and Administration Act, 2019*, each of which are activated by determinations of a person's mental capacity. The difference in

treatment based on disability is discriminatory. The [Victorian Equal Opportunity and Human Rights Commission \(2014\)](#) argues that a failure to protect competent refusal of treatment is incompatible with the CRPD and with the right to equal treatment before the law, which is protected by the [Charter of Human Rights and Responsibilities Act, 2006](#) (Vic).

### 6.2. Permit binding advance directives and formal decision-making support

Consumers' rights could be further protected by ensuring that they could make formal advance directives, access formal decision-making support, and appoint a decision-maker of their choice. These entitlements are available to Victorians in the physical healthcare system. Other than for mental health patients under the [Mental Health Act, 2014](#) (s 48), the [Medical Treatment Planning and Decisions Act, 2016](#) permits those with the mental capacity to make binding advance directives and values directives (ss 9–24). The [Medical Treatment Planning and Decisions Act, 2016](#) allows for the appointment of support persons (ss 31–25) and the appointment of decision-makers who are bound to make decisions following the “known preferences and values of the person making the appointment” (s 29(c)(ii)). This right should also be made available to people using mental health services.

### 6.3. Embed human rights language in the legislative frameworks

We recommend that human rights language, principles, and instruments are actively embedded in the new legislation. The [Charter of Human Rights and Responsibilities Act, 2006](#) (Vic) establishes a ‘dialogue’ model that is intended to enable governments to properly consider the 20 protected human rights when drafting new legislation. The Charter has been widely criticised for its weak enforcement regime and its failure to produce a robust dialogue about human rights within governments ([Boughey & Fletcher, 2018](#)). The language of s 38, however, could be a useful basis for new mental health principles:

*It is unlawful for a public authority to act in a way that is incompatible with a human right or, in making a decision, to fail to give proper consideration to a relevant human right. (s 38(1)).*

For example, the mental health principles in the new Act could include a requirement that services and clinicians demonstrate proper consideration of Charter rights when making (or failing to make) a decision that impacts on a consumer's rights, and that a failure to do so would make the decision unlawful.

Another strategy is to use the language of human rights. States are party to international conventions and are thus required to respect, protect, and fulfil human rights. Human rights language could therefore complement direct references to specific international human rights instruments. The [Guardianship and Administration Act, 2019](#), for example, refers to the CRPD in its list of primary objectives:

*The primary object of this Act is to protect and promote the human rights and dignity of persons with a disability by—having regard to the Convention on the Rights of Persons with Disabilities, recognising the need to support persons with a disability to make, participate in and implement decisions that affect their lives. (s 7).*

We recommend the inclusion of the CRPD in the new legislation. As above, we note that this would not make the legislation CRPD-compliant but would assist in foregrounding human rights in the implementation of the new Act.

### 6.4. Universal access to independent advocacy

The findings of the independent evaluation of IMHA clearly demonstrate the value of rights-based independent advocacy ([Maylea et al., 2019](#)), something recognised by the Royal Commission, which

recommended an opt-out model to ensure universal access to advocacy ([RCVMHS, 2021c](#), p. 424). The evaluation also found that IMHA's co-designed approach built on relationships with services and consumers, including consumer groups, was a foundation to its success.

Concerningly, however, the Royal Commission did not recommend that advocacy should be provided by IMHA or even that it be independent or rights-based. Instead, it indicated that rather than being a single, co-designed, coordinated statewide service, multiple providers might provide multiple models of advocacy. This position reflects a fundamental misunderstanding of the nature of effective advocacy in mental health. It allows the possibility that clinical mental health services might provide advocacy services internally and thus not be independent or that advocates may use a best interests model of advocacy rather than a rights-based approach. Such approaches would undermine the value of independent rights-based advocacy and jeopardise the foundations which have contributed to IMHA's success.

### 6.5. Empower regulators to enforce rights

We support the Royal Commissions' suggestion that a new regulator be equipped with enough power to use sanctions for non-compliance with minimum standards ([RCVMHS, 2021c](#), p. 233). The goal of such regulatory powers should be to ensure that the use of compulsory mental health treatment is used as a last resort. Successful regulation requires clear statutory objectives matched with powers to meet these objectives ([Ayres & Braithwaite, 1992](#)). Commonly used enforcement mechanisms include warning and prohibition notices to cease conduct and penalties or infringements ([Freiberg, 2017](#)). In addition, we recommend that a failure to comply with principles in the new legislation should give rise to a potential cause of action and allow for judicial oversight.

### 6.6. Implementation strategy, mandatory mental health law training, and professional development

Perhaps most importantly, we recommend that new legislation be accompanied by a robust implementation strategy that promotes a shared understanding of the legislative framework amongst consumers, services, and clinicians. Our research identified a lack of understanding of rights-based care and supported decision-making practice and a tendency to fall back on best interests approaches.

Rights-based practice is not possible without a workforce that understands and is supported to implement human rights principles ([Katterl & Maylea, 2021](#)). Preferences around treatment and care expressed by consumers of mental health services are shaped by a person's understanding of their situation and the options available to them ([Knight et al., 2018](#)). Clinicians and treatment teams have a central role in informing people of their rights and what courses of treatment might mean in practice. Training must be mandatory for any clinician exercising a function under the new *Mental Health and Wellbeing Act* and co-delivered with consumers. The training should include units that assess a clinician's understanding of mental health law. Such an approach is broadly consistent with mandatory training in England and Wales (*Mental Health Act 1983* (UK)), s 114 and would reflect the Royal Commission's prioritisation of rights-based care as a key pillar of new workforce development ([RCVMHS, 2021c](#), p. 522).

### 6.7. Appropriate resourcing

Finally, we recommend that the mental health system is appropriately resourced. The underfunding of Victorian mental health services is well documented ([RCVMHS, 2021a](#); [Victorian Auditor General's Office, 2019](#)). In May 2021, the Victorian government announced a \$3.8 billion investment in a new mental health and wellbeing system to implement the Royal Commission's recommendations ([Victorian Government, 2021](#)).

Some of the clinicians in this study referred to wider social problems

that impact on the ability of the mental health system to attend to the rights of consumers. Prominent within the data was the current crisis in affordable housing. A rights-affirming mental health system would require adequate funding of and integration with systems that interface with the mental health system and support a person's mental health and wellbeing, such as housing. Governments will need to, for example, fund public and social housing (Castan Centre for Human Rights Law & Inner Melbourne Community Legal, 2021), prevent and respond to discrimination (Paradies et al., 2015), reduce inequality (both financial and gender-based) (Yu, 2018), address family violence and sexual violence, and respond to the unacceptable rates of incarceration of those with mental health problems and other disabilities in the criminal justice system (Gregory, 2021). A failure to take a wider view of the social determinants of health and wellbeing and drivers of poor mental health will ensure that the mental health system continues to take up the burden from other failed systems.

## 7. Conclusions

Our findings suggest that the rights-based framework in the *Mental Health Act, 2014* had so little effect on clinical practice in Victoria that consumers found their rights to be illusory. We found that the rights outlined in the *Mental Health Act, 2014* were poorly understood and often ignored. Lack of resources and staff time was underpinned by clinicians' troubling refusal to countenance the intended benefits and effects of a rights-respecting framework. The next steps are clear. In addition to legislative reform, broader systemic reform is also required, and legislative reform must both support and inform this broader process. The WHO (2021) report *Guidance on community mental health services: Promoting person-centred and rights-based approaches* lays out a road map for legislative and other responses required to progress the rights of mental health consumers toward CRPD compliance and a better mental health system. The Royal Commission has made a commitment to shaping a mental health system that is premised on respect for human rights, but the task of crafting mental health legislation sufficient to support such a system remains ahead of us.

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