

Submission to the independent review of compulsory assessment and treatment criteria and alignment of decision-making laws

This is a submission from:

- **Victorian Transcultural Mental Health**, the lead transcultural and intersectional mental health service in Victoria.
- **The Victorian Foundation for Survivors of Torture Inc.**, which provides services to and on behalf of people of refugee backgrounds who have endured torture and other traumatic experiences; and
- **Victorian Refugee Health Network**, which facilitates greater coordination and collaboration amongst health and community services to provide more accessible and appropriate health services for people of refugee backgrounds.

We support the aims of the Royal Commission into Victoria's Mental Health System, to ensure that compulsory treatment is only used as a last resort and to make the mental health system better at supporting mental health consumers to make their own decisions about treatment, in their own way, in their own time.

We appreciate the invitation of the Independent Review Panel to contribute insights into the experiences of communities that may be disproportionately affected by coercive treatment and whose perspectives are often neglected.¹

Our agencies work with a number of these groups – people from culturally and linguistically diverse backgrounds, LGBTIQ+ people, people from rural and regional backgrounds, the young and the aged, and people with refugee backgrounds.

The central focus of the Independent Review Panel's terms of reference are the legal mechanisms, and we ask the Panel to examine one of these – the timing of referral to the non-legal mental health service – and consider whether this should be adjusted with a view to reducing the imposition of compulsory assessment and treatment.

The Panel's consultation paper observes that a broad strategy is required to respond effectively to the issues around compulsory treatment including considerations such as *"resourcing, workforce training and support, the traumatic effect of compulsory treatment, and ensuring that consumers can access support, care and treatment."*²

We strongly agree.

A broad strategy is essential to reducing compulsory treatment overall.

It is also essential to address the disproportionate application of compulsory assessment treatment, which is the focus of our submission.

We therefore request the Independent Review Panel to reiterate its view about the necessity for a broad strategy, in the report it provides to the Victorian Government.

¹ Independent Review Panel, *The independent review of compulsory assessment and treatment criteria and alignment of decision-making laws, Consultation Paper*, Introduction.

² *ibid*

The Mental Health and Wellbeing Act 2022 – legislative provisions to reduce inequity and enhance the response to diversity.

A number of provisions of the new Mental Health and Wellbeing Act can contribute significantly to reducing inequity in the use of compulsory assessment and treatment and other aspects of mental health services. They include:

- The objective of the Act to “*reduce inequities in access to, and the delivery of, mental health and wellbeing services*” (Objective 12(a)) – such inequities of access and delivery affect Victorians in rural and regional areas and are compounded for people of the backgrounds with whom we work.
- The requirement that services must “*recognise and respond to the diverse backgrounds and needs of the people who use them*” (12 (c)(v)).
- The requirement that when mental health clinicians and other providers are communicating with consumers, carers, family and others, they “*must take reasonable steps to explain the content of the communication and answer any questions as clearly and as completely as possible.*”³ It is helpful that the Act includes examples of “*reasonable steps*” which make it apparent that simply providing translated, written information will not suffice.⁴ The Act also specifies that people receiving mental health and wellbeing services must be given a statement of their rights (as must their support people) and that health staff “*must take all reasonable steps to ensure that the person...understands their rights are set out in the statement.*”⁵
- Mental health services and providers must consider the principles of “*diversity of care*”⁶; “*diversity*”⁷ and “*cultural safety.*”⁸

Requiring access to non-legal advocacy support when people are subject to compulsory assessment

The Royal Commission into Victoria’s Mental Health System strongly supported increased access to non-legal advocacy as a means to assist people who are subject to, or at risk of, compulsory treatment to exercise their rights.⁹ It therefore recommended the establishment in legislation of

*“An opt-out mechanism...to ensure all eligible consumers can connect with non-legal advocacy services. This must be accompanied by adequate funding to ensure effective implementation, guaranteeing that all consumers can experience the benefits of non-legal advocacy if they wish.”*¹⁰

The Mental Health and Wellbeing Act accordingly specifies that non-legal mental health advocacy service providers undertake a variety of functions, such as receiving notifications of requests for support from or on behalf of consumers, consistent with the Royal Commission’s recommendation.¹¹

The Act also provides that an authorised psychiatrist must notify a statutorily designated non-legal mental health advocacy service provider “*as soon as practicable after a treatment order is made.*”¹²

³ Part 1.2, (3)

⁴ Part 1.2 (7)

⁵ Part 2.2, section 39.

⁶ Part 1.5, section 17 – “A person living with mental illness or psychological distress is to be provided with access to a diverse mix of care and support services...to be determined, as much as possible” by that person’s needs and preferences including relationships, experience of trauma and other factors.

⁷ Part 1.5, section 25 - “The diverse needs and experiences of a person receiving mental health and wellbeing services are to be actively considered noting that such diversity may be due to a variety of attributes including...” gender identity, sexual orientation, sex, ethnicity, language, race, religion and culture.

⁸ Part 1.5, section 27 (1) “Mental health and wellbeing services are to be culturally safe and responsive to people of all racial, ethnic, faith based and cultural backgrounds.”

⁹ See in particular Volume 4, 32.9 and 32.9.1.

¹⁰ Volume 4 page 425.

¹¹ See in particular section 44.

¹² Section 199(2).

It is not apparent to us why the legislation does not require notification when an assessment order is made, which would be consistent with the perspective of the Royal Commission that people have access to non-legal advocacy when they are *at risk* of compulsory treatment. Given the key aim of reducing compulsory treatment, it would seem desirable to provide access to non-legal advocacy at an earlier stage.

We request the Independent Review Panel seek advice on the reason why the Act does not provide for the non-legal advocacy agency to be notified when an assessment order is made. If the grounds are not compelling, the Independent Review Panel should consider recommending that the Act be amended to provide for earlier notification.

Ensuring the legislative framework is effective in practice

The legislation outlined above provides a very positive framework to address the prevalence and apparently inequitable imposition of compulsory interventions.

However, in our experience and as communicated to us by consumers, carers, families and communities, key issues of concern about the provision of health services generally, not just mental health and compulsory assessment and treatment, arise not solely on account of deficient legislation but to defects in the operational aspects such as the planning, funding, delivery and oversight of services.

Some of the principles of good practice not applied in practice as a matter of course, are that health services should engage accredited interpreters, trained in mental health, for people who are not proficient in English.¹³ This deficiency may be for a variety of reasons, including inadequate funding and unavailability of accredited and trained interpreters; workload pressures; staff not having had access to professional development about working with interpreters.

As noted by a mental health professional in one of our agencies:

"I observe some of our clients being diagnosed and treated in ways that are not necessarily therapeutic. For example, trauma-informed assessment of psychosis needs to be part of the review to avoid over-medicating or other invasive treatments enacted - when done without the client's informed consent, it risks compounding the illness. In cases where clients have given consent, they don't see any improvement, because it is only the presentation of psychosis being tweaked by the treatment, rather than seeing the trauma context and assisting to build the client's capacity to recover."

We concur with the general considerations for a broad strategy named by the Independent Review Panel viz resourcing; workforce training and support; recognising the traumatic effect of compulsory treatment; and ensuring that consumers can access support, care and treatment.

Other issues identified by the Royal Commission that are also of considerable importance include:

- the lack of publicly released data¹⁴; and
- the lack of research to support mental health services to significantly reduce the use and duration of compulsory treatment, and identify which groups, if any, are more likely to be compulsorily treated.¹⁵

¹³ Mental Health Reform Engagement: Mental Health and Wellbeing Act, Submission from the Victorian Refugee Health Network July 2021.

¹⁴ The Royal Commission into Victoria's Mental Health System reported: "While some high-level data about compulsory treatment use is available, it is not separated to show variables such as demographics, geography, cultural background, service level or the rate or duration of Assessment Orders or Temporary Treatment Orders." Volume 4, Chapter 32, page 410. It concluded: "Improved data reporting is...important to building the evidence base about why and how compulsory treatment is used, which groups are disproportionately affected, including any social determinants." (Page 422.)

¹⁵ Ibid page 419.

As the Royal Commission stated:

“Efforts to reduce the rates of compulsory treatment use cannot be made in the absence of understanding of the social determinants of compulsory treatment, nor the varied influences on clinicians’ and services’ decision making. But with limited data and research, this is difficult to achieve.”¹⁶

Data and research are necessary to address the question posed by the Independent Review Panel, *“why do so few compulsory patients have a nominated support person in place?”¹⁷* The reasons are likely to differ between different groups reflecting factors such as their knowledge of the mental health system, English proficiency and multiple identity points leading to oppression overall (intersectionality¹⁸). An understanding of the barriers is necessary to plan and deliver effective strategies to address them.

For example, access to supported decision-making - one of the pillars of the strategy to reduce compulsory assessment and treatment - requires a high level of health literacy and effective communication so that people can make informed decisions. Amongst communities of refugee backgrounds, health literacy and English language proficiency vary considerably; frames of reference for mental health may not be Western legal and biomedical. Recently arrived members of communities from refugee background, both those experiencing mental health and wellbeing difficulties and their families, carers and supporters, face significant barriers to understand the panoply of law, policies, practices and services.

It is also pertinent to consider that refugees have commonly had traumatic experiences in the countries they fled, inflicted by authorities, who may have included medical personnel.

The roles of the Chief Psychiatrist and the Chief Officer for Mental Health and Wellbeing

A key determinant of the effectiveness of the legislative provisions in reducing compulsory assessment overall and inequity in their use, will be the detailed guidance for service providers developed by the Chief Psychiatrist and the Chief Officer for Mental Health and Wellbeing. The Chief Psychiatrist is empowered to prepare guidelines in relation to the decision-making principles for treatment and interventions¹⁹ and the functions of the Chief Officer for Mental Health and Wellbeing include *“improving understanding of the mental health and wellbeing needs of diverse communities and their use of mental health and wellbeing services to enable more equitable access to those services and the delivery of equitable outcomes across communities.”²⁰*

There are a number of areas where guidelines may be important to ensuring that the delivery of mental health and wellbeing services is consistent with the Act’s principles and objectives relating to the diversity of the Victorian population. This is the case generally as well as with respect to compulsory assessment and treatment particularly. Some examples follow.

The concept of the family

The Act provides a central place for *“family”* members e.g., one of the objectives is *“to recognise the role of families...in the care, support and recovery of people living with mental illness and or psychological distress”²¹*; the *“cultural safety principle”* provides that *“regard is to be given to the views of the...family”* of people living with mental illness or psychological distress.²²

¹⁶ Op cit page 420.

¹⁷ Consultation paper, question 6.

¹⁸ Intersectionality is a framework for conceptualizing a person, group of people, or social problem as affected by a number of types of discrimination and disadvantage, such as age, gender identity, sexuality, race. It takes into account people’s overlapping identities and experiences in order to understand the complexity of prejudices they face. The Mental Health and Wellbeing Act recognises the pertinence of intersectionality e.g. the Diversity Principle states that the “diverse needs and experiences of a person receiving mental health and wellbeing services are to be actively considered noting that such diversity may be due to a variety of attributes...” (section 25 (1)- see also 25(2).

¹⁹ Section 84.

²⁰ Emphasis added, Part 6.2, section 261.

²¹ Part 1.3 (g).

²² Part 1.5, 27.

But there is no authoritative definition of what constitutes a “family” in the Act or more generally. As the Australian Bureau of Statistics states, “(a) *wide variety of living arrangements exist in Australia, so family structures can be complex, dynamic and difficult to capture.*”²³ This is consistent with the breadth of understanding of family that is suggested by the “*diversity principle*” of the Mental Health and Wellbeing Act, that the relevant attributes of a person receiving services may include their gender identity, ethnicity and culture, among other things.

Clinicians and services may similarly require guidance and assistance to apply the cultural safety principle, which requires them to provide treatment and care consistent with cultural and spiritual beliefs and give regard to the views of family members and “*significant members of the person’s community.*” With respect to Aboriginal and Torres Strait Islander people, regard is to be given to their “*unique culture and identity, including connections to family and kinship, community, Country and waters.*”

Another example of the cultural safety principle regarding family that is not specifically mentioned in the Act is the concept of “*found family*” or “*chosen family.*” This concept recognises the role of close friends and supporters in an individual’s life, particularly those who have experienced rejection or are distanced from their family of origin. The concept is often employed by LGBTIQ communities where individuals have faced discrimination and rejection from their biological families.²⁴

Assessing capacity

The diversity principle and the cultural safety principle may also be very pertinent to the assessment of the capacity to give informed consent to treatment.²⁵ When they undertake assessments, health practitioners must have regard to attributes that could be pertinent such as a person’s proficiency in English affecting their ability to understand the information; a person’s culture and faith, which are pertinent to their understanding of their unwellness and what would be helpful and unhelpful to healing, and their response to conventional biomedical treatments.

Conclusion

A person who is subject to an assessment order is clearly at risk of being subject to compulsory treatment. The Independent Review Panel should therefore consider recommending that the Mental Health and Wellbeing Act be amended to provide for the non-legal mental health advocacy service provider to be notified when someone is subject to an assessment order.

We welcome the Independent Review Panel noting that while its central focus is the legal framework relating to compulsory treatment, a broad strategy is required to respond to the various issues around compulsory treatment.

We believe it appropriate for the Panel to reiterate the critical importance of Government and the Department of Health adopting an integrated and comprehensive strategy to ensure that, whatever new legal provisions are adopted, the use of compulsory treatment is reduced overall and that it is not imposed inequitably.

Contact:

Josef Szwarc

Senior Advisor, Policy & Advocacy

E: szwarcj@foundationhouse.org.au

M: 0410 529 217

²³ Understanding Family composition and Grandparent families, <https://www.abs.gov.au/statistics/detailed-methodology-information/information-papers/understanding-family-composition-and-grandparent-families#coding-limitations>.

²⁴ Jackson Levin, N., Kattari, S. K., Piellusch, E. K., & Watson, E. (2020). “We Just Take Care of Each Other”: Navigating ‘Chosen Family’ in the Context of Health, Illness, and the Mutual Provision of Care amongst Queer and Transgender Young Adults. *International journal of environmental research and public health*, 17(19), 7346. <https://doi.org/10.3390/ijerph17197346>.

²⁵ Part 3.2.