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Does New Mental Health Legislation in Victoria, Australia, Advance Human Rights?

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Abstract

In introducing the Mental Health and Wellbeing Bill of 2022 into Parliament in Victoria, Australia, the state government claimed that the new legislation "delivers on the vision for rights-based mental health and wellbeing laws." This paper examines the new legislation in light of both local human rights legislation and international human rights law. Drawing primarily on the United Nations Convention on the Rights of Persons with Disabilities and the Victorian Charter of Human Rights and Responsibilities Act of 2006, this paper argues that while the new legislation is not, in fact, rights based, it does represent some rights-related improvements over existing legislation. The paper concludes with a discussion of how rights-based legislation could be applied to the Victorian context, using the latest guidance from the World Health Organization and the United Nations.

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Introduction

The Convention on the Rights of Persons with Disabilities (CRPD) and its Optional Protocol were adopted by the United Nations General Assembly in 2006 and opened for signature on March 30, 2007. The CRPD obligates signatory countries to reform many conventionally used coercive practices in psychiatric treatment, care, and support, particularly the use of involuntary treatment, detention, seclusion, and restraint.[1] Spurred by the CRPD, many jurisdictions have reviewed, revised, or replaced their mental health legislation. For example, all Australian jurisdictions, New Zealand, Scotland, England and Wales, China, India, and Canada have attempted to improve rights protections for people subject to coercive practices under mental health legislation.[2] Others have taken more revolutionary steps to reduce or eliminate coercive practices altogether. Costa Rica, Peru, and Colombia, for example, have completed landmark reforms that attempt to achieve CRPD compliance.[3] Peru, in particular, has abolished guardianship based on disability, and its 2020 Mental Health Law does not allow treatment without consent other than in limited circumstances. The impact of these reforms is not yet clear.

For most jurisdictions, the CRPD has not led to such significant revisions. This paper considers the example of the Mental Health and Wellbeing Act of 2022 in Victoria, Australia, enacted in September 2022 and due to come into force in September 2023, when it will replace the existing Mental Health Act of 2014. The new act does not abolish any coercive practices, although the Victorian government has committed to the abolition of seclusion and restraint within 10 years. Instead, it establishes the groundwork for an improved mental health system rather than attempting legal compliance with international and local human rights law. Since this is Victoria's second attempt at legislative reform since the CRPD was ratified by Australia, it represents a useful case study for other jurisdictions that are similarly finding that the first round of post-CRPD reforms have not achieved as much as many had hoped.

Methodology

For this paper, I used a doctrinal analysis, drawing on a human rights-based disability approach.[4] This was done by examining the new law in light of the requirements identified by the CRPD and the Victorian Charter of Human Rights and Responsibilities Act of 2006. The CRPD was ratified by Australia in 2008, making it legally binding on Australian states, including Victoria. However, in Australia, international treaties are not a direct source of individual rights until incorporated into law.[5] The CRPD applies to all persons with actual or perceived disabilities, including psychosocial disabilities.[6] Victoria's human rights charter is also legally binding and, among other things, requires that all new legislation be accompanied by a statement of compatibility that notes whether the proposed legislation is compatible with the charter.

My analysis also draws on non-legally binding guidance provided by the World Health Organization (WHO) and the United Nations, primarily the *Guidance on Mental Health, Human Rights, and Legislation*.[7] Despite not being legally binding, these documents provide a useful tool for assessing the implementation of the rights contained in the CRPD in local legislation.

A doctrinal analysis is not inherently suited to the emancipatory, participatory, and inclusive methodologies that underpin a human rights-based disability approach.[8] To address this, my analysis focused on how the law might result in changes that people subject to that law might notice, rather than changes apparent to lawyers, clinicians, and policy makers. It also aligns with the emancipatory methodology in explicitly challenging and highlighting the way in which mental health legislation does not comply with human rights frameworks and in doing so discriminates against people who are given mental health diagnoses.

The Mental Health and Wellbeing Act of 2022

At 688 pages, it is not possible to identify all of the individual changes in the act compared to the prior legislation. This section briefly notes the sub-

stantive changes before highlighting the very few specific ones that will be experienced by people subject to the legislation. It is important to note that much of the law remains unchanged from the previous Mental Health Act of 2014, with the new one 1.8 times the length of the previous one and using roughly 43% of the same words and phrasing. The new act has many additions but few changes.

There are some substantial legislative changes, nearly all relating to recommendations of the Royal Commission into Victoria's Mental Health System. There are new principles and objectives, which may influence how the legislation is interpreted and operationalized.[9] Their potential human rights implications are discussed below.

There are also bureaucratic infrastructure changes, including regional boards that will initially have a planning role and are slated to later have commissioning powers. New regional and statewide multi-agency panels will hopefully better coordinate service provision. There are also some new statutory bodies, including a new Mental Health and Wellbeing Commission and a mental health research center. There is also a levy designed to raise new money specifically earmarked for the mental health system.

None of these changes will be immediately noticed by people forcibly treated and detained in mental health services, although along with other non-legislative reforms, the improved system will hopefully eventually directly impact their experience. There are some minor legislative changes that people may notice, discussed below, primarily the legislated right to a non-legal mental health advocate and new coercive powers for paramedics.

Nearly everything that people subject to the act might notice remains unchanged. As with the 2014 legislation, people can still be subject to electroconvulsive therapy against their will.[10] Unlike in the physical health system, people in the mental health system are still unable to make binding advance directives about their physical health care.[11] There are no substantial changes to the treatment criteria, to the Mental Health Tribunal, or to ensure that people with decision-making capacity can make decisions about their treatment.[12]

It may seem curious that the then minister for mental health, the Honorable James Merlino, in the second reading speech of the Mental Health and Wellbeing Bill of 2022, stated that the bill establishes a "rights-based approach to mental health" with "rights-based framing."[13] Merlino went on to acknowledge that "there is a lot more work to do before we have the mental health and wellbeing system that protects the rights and dignity of all consumers, their families and carers," and took the highly unusual step of announcing a review of the new legislation before it had passed through Parliament.[14] The rest of this paper uses a human rights analysis to highlight what this "more work" might be.

CRPD compliance

The CRPD provides the best enumeration of binding international human rights law that applies to people with psychosocial disabilities. While not all people with poor mental health or who experience mental distress will identify as disabled, the social model of disability adopted by the CRPD protects people who are disabled by discriminatory mental health legislation.[15]

This section examines the relationship between the CRPD, detention, and forced treatment before turning to other interactions between the legislation and the CRPD.

The CRPD, detention, and forced treatment

The application of the CRPD to mental health legislation that enables detention or forced treatment has been of some international debate, with much diversity within two broad camps.[16] The Australian government, in the first camp, has interpreted the CRPD to allow detention and forced treatment irrespective of a person's capacity, with the Commonwealth government noting the following interpretive declaration on signing the CRPD in 2007: "Australia further declares its understanding that the convention allows for compulsory assistance or treatment of persons, including measures taken for the treatment of mental disability."[17]

This position is maintained by force of legislative power, with nearly all jurisdictions around the

world upholding regimes of detention and forced treatment based on diagnosis. The United Nations Committee on the Rights of People with Disabilities (CRPD Committee) and the Australian Human Rights Commission have both asked Australia to withdraw this interpretive declaration.[18]

The other camp views the CRPD as prohibiting detention and forced treatment, either entirely or on the basis of disability. Human rights scholars and the CRPD Committee, the United Nations High Commissioner for Human Rights, WHO, and multiple United Nations spokespersons have called for the complete abolition of forced treatment based on disability, including mental health diagnosis.[19] This argument centers on article 5 of the CRPD, which rejects disability-based discrimination, and article 12, which upholds the right to equal recognition before the law, requiring that "persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life." When read with article 14, which states that "the existence of a disability shall in no case justify a deprivation of liberty," this can be viewed as a prohibition on laws that detain or forcibly treat based on disability. Article 25 is also relevant, as it requires health services to be provided "on the basis of free and informed consent." Some scholars and international human rights commentators have argued that forced treatment constitutes torture or cruel, inhuman, or degrading treatment or punishment, in contravention of article 15.[20] Article 17, which protects the integrity of the person, and article 22, which respects the right to privacy, are also relevant.

Some scholars and some other human rights bodies have called for a generic capacity-based approach, allowing the forced treatment and detention of people who are assessed as not being able to understand, retain, use, weigh, or communicate information about their treatment. This, or similar tests, are used to permit forced treatment for non-disability physical health conditions. Proponents of this approach argue that this would not rely on diagnosis or disability and would, in theory, apply equally to all people.[21] This group interprets the CRPD as allowing forced treatment on the same basis for all individuals—that is, on the basis of a lack of decision-making capacity. They also argue that people should be supported in exercising their decision-making capacity wherever possible and that forced treatment should be used only where support cannot be provided.

Those who interpret the CRPD as allowing for forced treatment for those who are assessed or cannot be supported in exercising mental capacity generally argue for improvements in service provision and improved rights for people while they are subject to forced treatment.[22] Others have called for a "will and preferences approach" as being more CRPD consistent than a capacity-based approach.[23] The new act attempts neither of these approaches, although other Victorian legislation, such as the Guardianship and Administration Act of 2019 and the Medical Treatment Decisions and Planning Act of 2016, incorporate elements of both. Both pieces of legislation maintain the right for people with the capacity to make decisions; and in cases where they cannot be supported in exercising capacity, their will and preferences are to be followed. The new act, as with the previous legislation, simply gives decision-making power to the treating psychiatrist, who can make whatever treatment decision they view as clinically appropriate.[24] There are exceptions for electroconvulsive treatment or neurosurgery, where a person who is assessed as having capacity can refuse those specific treatments.[25] For all other treatments, for people who are assessed as meeting the treatment criteria, their capacious refusal, advance directive, or other reflection of their will and preferences is not legally binding.[26] There is legislative guidance for psychiatrists, including a requirement that they be satisfied that no less restrictive treatment options are available.[27] Still, the ultimate decision-making power sits with psychiatrists, not with the person made subject to a treatment order or their own nominee. From this perspective, the new act is not CRPD compatible. Very few, if any, international human rights legal scholars have argued that legislation enabling forced treatment on the basis of disability for people with decision-making capacity can be CRPD compatible.

This impact on human rights is, to some ex-

tent, recognized by the Victorian government. An addition to the new act is a principle that states:

> *The use of compulsory assessment and treatment or restrictive interventions significantly limits a person's human rights and may cause possible harm including—*
>
> *a. serious distress experienced by the person; and*
>
> *b. the disruption of the relationships, living arrangements, education or employment of the person.*[28]

The word "limits" in this context is important since, as discussed below, Victorian law explicitly allows for the lawful "limiting" of human rights when reasonable and demonstrably justified.[29] The CRPD has no such caveat, requiring, in article 4, "the full realization of all human rights and fundamental freedoms for all persons with disabilities without discrimination of any kind on the basis of disability." Economic, social, and cultural CRPD rights, such as the right to inclusive education, are subject to progressive realization.[30] This reflects an understanding that economic, social, and cultural changes take time. The articles relevant to detention and forced treatment have no such qualification, and state parties must immediately take steps to realize these rights.[31] In the 15 years since Australia has ratified the CRPD, neither of Victoria's legislative reforms have attempted CRPD compliance regarding detention and forced treatment.

Other CRPD considerations

Despite the fundamental inconsistency relating to the continuation of detention and forced treatment based on disability, there are other elements of the new act that do progress the CRPD agenda, although in no way achieving compliance. There are too many elements of the act to consider all that are relevant here, so this section will focus on the key changes that may be of relevance to other jurisdictions, particularly in light of the recently released WHO guidance on mental health-related law in line with the CRPD, developed in collaboration with the Office of the United Nations High Commissioner for Human Rights.[32] This document is not legally binding but is based on CRPD principles and reflects the worldwide learning of practical attempts to implement CRPD rights.

Using the WHO/UN draft guidance to assess mental health law is somewhat paradoxical, as the document calls for the replacement of mental health law in mainstream law by, for example, prohibiting discrimination on the basis of mental health in antidiscrimination law, or advance consent in general health law. Complying with the WHO/UN draft guidance would require the repeal of the new legislation. Despite this, there are some elements of the new act that are consistent with the WHO/UN draft guidance and the CRPD. Selected elements are discussed here at the system, organizational, and direct-service levels.

System-level considerations. The primary concern at the system level is lawmakers' failure to ensure that people who would be subject to the act played a decisive role in its drafting and implementation—a practice recommended by both the CRPD and the CRPD Committee.[33] None of the royal commissioners who made recommendations concerning the new legislation have been subject to the legislation. The Royal Commission and the drafters did consult widely with people who are subject to the legislation and organizations that represent them, but virtually none of the recommendations made by these people or organizations are reflected in the law. For example, the Victorian Mental Illness Awareness Council, Victoria's peak body for mental health consumers, conducted a consultation process to feed into the drafting process, calling for a legislative ban on seclusion and restraint and legislative targets for reducing compulsory treatments.[34] These are not present in the new act, which instead requires mental health service providers to "aim to reduce" and "eventually eliminate" restrictive practices.[35] This contrasts with the independent review of the legislation, which includes a person with experience of forced treatment and multiple people who draw on their own experience of mental distress and of using mental health services.[36]

Also at the system level, the new act includes a "mental health and wellbeing surcharge," which legislates for a new tax to fund improvements to the

mental health and well-being system and underpins a range of other reforms, primarily additional mental health services and increased mental health practitioners in the workforce, many of them in the community.[37] This tax is intended to address "many years of underinvestment" and may assist in giving effect to a range of CRPD rights, including article 25, which provides for the right to the highest attainable standard of health.[38] This may also help realize article 19, which requires that "community services and facilities for the general population are available on an equal basis to persons with disabilities and are responsive to their needs." This is supported by the WHO/UN draft guidance, which calls for legislation to establish "earmarked funds" for mental health care.[39] It is important to note that Victoria's current administration, which has been in power since 2014, could have decided to increase funding at any time without the need for legislation, so it may be inappropriate to include these funding increases in a rights analysis of the legislation. It also remains to be seen if this increased funding will be used in a manner that promotes human rights.[40]

There are, at the system level, new principles and objectives, including the principle acknowledging the human rights impact of forced treatment. These build on and extend the principles and objectives from the previous legislation. The new principles and objectives are explicitly aimed at improving human rights, according to the minister for mental health:

> *A primary concern of many of the recommendations of the Royal Commission was to better ensure that legislative human rights protections were fully and properly implemented in practice. This has been achieved in the Bill by introducing greater detail with respect to the objectives and principles that are to guide decision-making by all persons exercising functions and powers with respect to compulsory assessment and treatment decisions and other significant decisions and functions under the Bill.*[41]

There are a range of relevant objectives and principles covering diversity, inequity, trauma, dignity, autonomy, supported decision-making, lived experience, and a range of other issues.[42] One new objective is "to protect and promote the human rights and dignity of people living with mental illness by providing them with assessment and treatment in the least restrictive way possible in the circumstances."[43]

Given the recognized failure of the principles and objectives in the previous legislation, it is difficult to see what tangible impact these new principles and objectives may have. Certainly, in tribunal decision-making and judicial review, principles and objectives feature substantially in decisions interpreting the act.[44] In day-to-day practice, however, noncompliance with mental health legislation is so widespread and so well documented that it seems unlikely that such changes will have measurable impacts.[45] As an example, two Australian studies, one from Queensland and another from South Australia, both found that the majority of administrative forms authorizing detention did not comply with legislative requirements, let alone reflect the interpretive objectives and principles.[46] In New South Wales, Australia, a study examining the impact of reformed legislative principles found that some concepts from legislative reforms were subsequently present in documented decision-making, but other legislative concepts were not.[47]

These principles are not legally binding, as the requirement is merely that mental health services now must "make all reasonable efforts to comply."[48] This is slightly stronger than the previous requirement that a "person must have regard."[49] There are also new decision-making principles, which decision-makers must give "proper consideration" to.[50] Still, there is nothing substantial in the new legislation to enforce the implementation of the new principles and objectives. It may be that the revamped complaints procedure, which allows complaints based on failure to comply with the principles, has some impact.[51] It seems likely that decision-makers, clinicians, and services seeking to employ a more human rights-oriented approach may be able to use the new objectives and principles in justifying their approach. For recalcitrant human rights violators, however, these new principles

and objectives are unlikely to be any more effective than the principles and objectives in the previous legislation.

Organizational-level considerations. At the organizational level, there are various changes that, if successfully implemented, may further the right to health as enshrined in article 25 of the CRPD. These include new regional mental health and well-being boards intended to increase community involvement, including by people with lived experience using mental health services.[52] The act also provides that a range of other new and existing entities will have increased staffing or representation of people with lived experience using mental health services.[53] These lived experience initiatives may be viewed as working toward article 4, which requires the involvement of people in implementing the CRPD.

There are also some new or reformed accountability and oversight bodies, concurring with the WHO/UN draft guidance's call for improved information systems and independent monitoring bodies. These include a new Mental Health and Wellbeing Commission, which incorporates the powers of the existing Mental Health Complaints Commission and has a few additional publication and other powers.[54] The act does not implement effective remedies or legal redress processes, as those who experience harm are either hampered from seeking redress under numerous immunity provisions or left to pursue negligence claims against the state through the courts.[55]

Direct-service-level considerations. At the direct-service level, people subject to detention and forced treatment will now be offered a professional advocate.[56] The new act does not introduce advocates, who have been in place without legislative powers since 2015, but it does provide them with new legislative backing and establishes an opt-out system.[57] These new powers include the right to, with consent, access the file and other information about the person they are advocating for and attend meetings with and seek information from the clinical team.[58] Mental health services must now give advocates reasonable assistance to perform their functions.[59] These advocates help people have more say about their treatment and ensure that their voice is heard in clinical decision-making. This supports the overall approach of the CRPD, but specifically article 12, which the CRPD Committee has ruled requires a supported decision-making approach rather than a substituted decision-making approach.[60] The substituted decision-making is retained by the act, but the support for decision-making is strengthened by the presence of an advocate.

Other changes, such as the new powers of apprehension for paramedics, aimed at reducing police involvement, may also have a positive impact on the individual experience but seem unlikely to promote CRPD compliance.[61] The right to liberty is no less infringed by a paramedic exercising force than a police officer.

Across all levels, there are many, many examples of CRPD violations that are permitted by the new legislation. CRPD takes an explicit broad, social perspective, which includes a focus on social and economic rights. Other than the aforementioned right to health, these social and economic rights are not foregrounded in the act. No meaningful attempts are made to address issues of education; housing; employment; participation in public, political, or cultural life; poverty, homelessness; or other loci of discrimination. The act does not guarantee supported accommodation, as required by article 19, or rehabilitation, as required by article 26. The WHO/UN draft guidance calls on legislators to use legislation for these purposes: to uphold rights rather than to limit or violate rights.

There are also many direct infringements, such as where article 22, which protects the right to privacy, is violated by the act, which permits the disclosure of personal and health information without the person's consent in ways not permitted for physical health patients.[62] Article 31 requires the collection and use of statistics and data, which the act "allows" but does not require.

Taken as a whole, the rhetoric of the new legislation is rights based, but it is difficult to see what improvements in rights a person subject to the leg-

islation will experience. Eventually, potentially, as a part of a longer-term reform agenda, the resultant improved mental health system may become more CRPD compliant. True CRPD compliance cannot be achieved by legislation alone and must be assessed on the basis of the experience of people who are subject to the legislation, not a legal analysis. As a piece of legislation, however, the new act is neither rights based nor CRPD compliant.

Human rights charter compliance

The Victorian Charter of Human Rights and Responsibilities Act contains many of the same human rights as the CRPD, most relevantly the prohibition of medical treatment without consent, equality before the law, freedom of movement, protection from torture and cruel, inhuman, or degrading treatment, and the rights to privacy, liberty, and freedom of expression.[63] For the reasons detailed above, the new act also infringes on these human rights. Considering compliance with the charter is important because, unlike the CRPD, the charter has local enforcement mechanisms and provides the best available way to influence future mental health reforms. Unlike the CRPD, however, charter rights can be limited by law when these limits are reasonable and demonstrably justified.[64] It is not possible to determine here if each of the many ways in the new act engages the charter may be reasonable and demonstrably justified, but it is shown below that some are not. This section considers if the lack of a capacity criterion, the lack of binding advance statements, and the absence of a "will and preferences" approach are reasonable and demonstrably justified.

The limitation on equality before the law, present throughout the act, is most egregious in the absence of a mental capacity criterion in the treatment criteria. Both the Guardianship and Administration Act of 2019 and the Medical Treatment Decisions and Planning Act of 2016 have mental capacity assessments, meaning that people with other kinds of disabilities and health issues have different sets of laws that apply to them.[65] This discrimination is recognized by the Victorian government.[66]

Under the charter, the test must be if this is reasonable and demonstrably justified. Western Australia's Mental Health Act of 2014 has such a mental capacity criterion, and the state also has some of the lowest rates of involuntary treatment in Australia.[67] Many other jurisdictions—including the Australian states of Tasmania and Queensland, as well as Norway—also prevent forced mental health treatment for people who have decision-making capacity.[68] Northern Ireland is implementing a law that would apply a capacity test equally for all impairments, not singling out mental health diagnoses.[69] Given the absence of any significant issues associated with a capacity criterion in other Australian jurisdictions, it seems that such a criterion may be considered "reasonable," and its absence does not appear to be demonstrably justified. It should be noted that in Norway, the introduction of a capacity criterion did not reduce the number of people being made subject to community treatment orders, so it may be that a capacity criterion is legislatively more human rights compliant without resulting in significant changes to practice.[70]

Similarly, Victoria's Powers of Attorney Act of 2014 and its Medical Treatment Decisions and Planning Act of 2016 allow for binding advance planning and delegated decision-making. The new act does not, allowing psychiatrists to overrule the person's preference or that of the delegated decision-maker if the psychiatrist views them as not clinically appropriate, requiring only that the psychiatrist "have regard" to the advance plan.[71] The Australian Capital Territory's Mental Health Act of 2015 provides for binding advance planning, with no clear issues arising from its implementation, so its absence in the Victorian legislation does not appear to be demonstrably justified.[72]

Both Victoria's Guardianship and Administration Act of 2019 and its Medical Treatment Decisions and Planning Act of 2016 also require that, in cases where a person has not made binding advance plans, their "preferences" should guide decision-making.[73] The new act does include an "autonomy principle":

> *The will and preferences of a person are to be given effect to the greatest extent possible in all decisions*

> *about assessment, treatment, recovery and support, including when those decisions relate to compulsory assessment and treatment.*[74]

The symbolism of the phase "will and preferences" in this principle is not reflected in the operation of the legislation. The phrase "will and preferences" does not appear elsewhere in the act, where, at most, substitute decision-makers must "have regard" and should be disregarded if not "clinically appropriate."[75] Additionally, no such caveats appear in Victoria's Guardianship and Administration Act of 2019 or its Medical Treatment Decisions and Planning Act of 2016. It seems manifestly unreasonable that people with other disabilities and health conditions may have their will and preferences respected but that the same does not apply to people detained and forcibly treated by mental health services.

An analysis of the act's charter compliance must also consider how the charter has been successful in protecting rights to date. An analysis of this kind of the previous legislation has shown that the current legislation has failed, and there is little in the new act that will enforce this requirement.[76] Non-legal advocates are now required to educate people about their rights under the charter, but there is no new enforcement mechanism for charter breaches committed by mental health services.[77]

The examples of human rights limitations provided are either unreasonable or not demonstrably justified. Despite this, the Victorian government has issued a statement of compatibility for the new act, claiming that the limitations are, in fact, reasonable and demonstrably justified.[78] There is no process of judicial, administrative, or other review of statements of compatibility, so this claim must lie untested.

Next steps

The new act may be taking some steps toward CRPD compliance by improving access to mental health services, particularly community-based services, and through improving accountability. Still, there are many more actions required to achieve a genuinely rights-based approach to mental health legislation. Unfortunately, these actions were not recommended by the Royal Commission into Victoria's Mental Health System and are therefore not on the government's reform agenda.

There is some hope for increased rights protections with the upcoming independent review of the new act.[79] The review panel will consider the forced assessment and treatment criteria and the alignment of mental health laws with other decision-making laws. This excludes the kinds of reform required for CRPD compliance but does include in scope the kinds of reforms necessary to move toward charter compliance. A mental capacity criterion, binding advance planning, and a requirement to uphold the person's will and preferences are all required to align the act with other decision-making laws. These are simple and effective reforms that have been implemented in other jurisdictions for some years and would assist in charter compatibility.[80] Much more is required to achieve genuine charter compliance, but these are essential steps toward that goal. There is a strong argument that interim legislation may be a useful step toward full CRPD compliance.[81]

As the above analysis shows, there is also a need to revisit the ways that rights can be limited under the charter, as in many cases the "reasonable and demonstrably justified" test in the charter is lower than what is required in international human rights law. The charter should be strengthened to maximize its utility in ensuring the full implementation of Australia's, and Victoria's, obligations under international human rights law.

The terms of reference and the scope of the independent review mean that it cannot make recommendations that would result in CRPD compliance. This would require a complete repeal of the act, as well as a range of other legislative changes, including ensuring equality and nondiscrimination, respecting personhood and legal capacity, and eliminating coercive practices.[82] As noted above, there is some disagreement in the international human rights law discourse as to what circumstances may allow for nonconsensual treatment, such as in emergencies or when a person cannot be supported to exercise capacity, but there is universal agreement

among human rights scholars that nonconsensual treatment cannot be based on disability or perceived disability.[83] The nondiscrimination theme that pervades the CRPD means that any such laws must apply equally to everyone. Similarly, laws that allow for detention, seclusion, and restraint must apply equally to all or be abolished. The debate as to how this should best be achieved will continue at both the local and international levels, but as this paper has shown, the latest iteration of Victorian mental health law reforms have failed the human rights compliance test even before they have been implemented.

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