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Making the Future Happen: Law Reform Lessons from the Victorian Royal Commission

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Abstract

As mental health law reform projects proliferate, especially in the wake of the United Nations Convention on the Rights of Persons with Disabilities, it becomes necessary to find ways to analyse these projects and to evaluate their successes and failures. This chapter argues that an important element in this respect relates to the process employed in developing law reform proposals which, it contends, has consequences for both the reform project's legitimacy and its potential to effect meaningful change. Drawing on the approach of the Royal Commission into Victoria's Mental Health System, the chapter seeks to identify the components of an appropriate law reform process. In order to do this, the chapter begins by exploring the differing impetuses for mental health law reform and identifying the variety of law reform processes which can be employed. It then examines how the Royal Commission approached its task. It concludes that the Royal Commission's approach provides valuable lessons for other jurisdictions, both in its law reform proposals and in its process.

Introduction

Professor Bernadette McSherry's scholarship on mental health law is marked by a focus on human rights as an instrument of change (McSherry and Weller, 2010; McSherry and Freckelton, 2013; McSherry and Maker, 2021). From this perspective, she asks important questions about how human rights norms can be woven into the fabric of mental health service delivery. Her work eschews the simple dichotomies which have tended to dominate in debates around Articles 12 and 14 of the United Nations Convention on the Rights of Persons with Disabilities ('CRPD') and instead identifies a more expansive and interconnected framework for human rights engagement (McSherry and Wilson, 2015; McSherry, 2017). This approach to human rights is reflected in the work of the Royal Commission into Victoria's Mental Health System (the 'Royal Commission'), of which Professor McSherry was one of the four Commissioners. This mammoth piece of work, comprising an Interim Report published in 2019 and a five-volume final report published in 2021 (the 'Royal Commission Report'), sets out an ambitious plan to 'redesign Victoria's mental health and wellbeing system' (Final Report Summary, 4). The rich and multi-faceted Royal Commission Report provides ample material for analysis from a wide range of perspectives, both within Victoria and internationally. Writing from an Irish perspective, I am especially interested in the Royal Commission Report's contribution to policy discourse beyond Victoria and in particular in how it can contribute to a better understanding of the processes of mental health law reform.

Although much more than a law reform project, law reform plays a central role in the Royal Commission Report. In this respect, the Royal Commission Report is one of many mental health law reform projects, conducted across different times and different jurisdictions. The pace and range of

reform has increased in the wake of the CRPD as states parties have worked to prepare for their initial reports to the Committee on the Rights of Persons with Disabilities ('CRPD Committee'). Although law reform projects of one kind or another have been part of mental health law from its earliest iteration as a distinct discipline (Unsworth, 1991), there has (to my knowledge at least) been limited comparative analysis of law reform in this sphere. There is clearly a great deal to be learned from how different jurisdictions approach the matter of reform. However, there are challenges in developing a basis for comparative analysis which is simultaneously sufficiently rigorous and sufficiently granular. The Concluding Observations of the CRPD Committee and the World Health Organisation (WHO) Mental Health Atlas (2020) provide helpful data. However, these are limited in what they cover. The CRPD Committee's Concluding Observations are restricted because the Committee's view that abolition of mental health law is the only CRPD-compliant approach limits its engagement with the range of law reform possibilities, while the WHO Mental Health Atlas provides only a high-level picture of legislative developments. Thus, these sources present only a partial picture of the impact of reforms of mental health law in the jurisdictions covered.

While recognising the value of broad – and deep – comparative work on mental health law reform, this chapter is more circumspect in its ambition. Using the Royal Commission Report as an entry point, it focuses less on the outcome of law reform and more on the process which led to these outcomes. This is on the basis that law reform processes are important in their own right and that the way we approach law reform has consequences both for the law reform project's legitimacy and its potential to effect successful change. While recognising that the context for the Royal Commission's work will not necessarily be replicated in other jurisdictions, the chapter nonetheless argues that the Royal Commission's approach to law reform provides a template for other jurisdictions, both in its proposals and in the process it employed. Before turning to the specifics of the Royal Commission at work, the chapter begins by contextualising mental health law reform. It identifies differing impetuses for law reform and then, focussing primarily on the UK/English experience, it looks more closely at the diverse law reform processes which can be employed. The second part of the chapter outlines the key law reform proposals in the Royal Commission Report, before identifying two central elements of the Royal Commission's process: its approach to the collection and presentation of evidence and its adoption of a system-wide analysis. The chapter concludes by identifying the lessons to be taken from the Royal Commission's approach.

Reforming Mental Health Law: Turns, Twists and Detours

Lady Hale, writing extra-judicially, described mental health law as an attempt 'to reconcile three overlapping but often competing goals: protecting the public, obtaining access to the services people need, and safeguarding users' civil rights' (2007: 19). The attempt to reconcile these goals has been at the heart of all of the mental health reforms discussed below. This section presents an overview of how these have worked, first identifying the different kinds of impetus for law reform and then exploring the processes employed.

Mental Health: The Impetus for Reform

Law reform projects do not simply happen but rather emerge in response to a wide range of political and/or legal imperatives. We need to understand these imperatives if we are to evaluate the processes employed and the reform choices made. One possible categorisation distinguishes between those reforms which are external to the jurisdiction, typically arising from requirements of international or regional human rights instruments, and those which emerge from within the jurisdiction, usually emerging when difficulties in the existing system reach a tipping point. These

categories are by no means watertight. As recounted by Gráinne de Búrca, international human rights standards can provide an important basis for domestic grassroots engagement (de Burca, 2021: 17), which in turn can help create a domestic impetus for reform. Moreover, jurisdictions influence each other; for example, as discussed below, the growing recognition of patient autonomy in the United States beginning the 1970s and the consequent civil rights-based judicial interventions in mental health law were highly influential on domestic law reform processes in other jurisdictions.

External Impetus

Externally imposed requirements for mental health law reform are relatively new. Legislative reform is a key element of the CRPD, and the CRPD Committee has consistently reinforced the significance of law reform in its General Comments and Concluding Observations. From a mental health perspective, two strands of law reform can be identified in the CRPD Committee's communications. The first concerns positive requirements on states parties to enhance the rights of persons with disabilities (Gooding, 2017; Wilson, 2021). These include the identification of a requirement on states parties to 'holistically examine' their laws to ensure the equal right to legal capacity (General Comment No. 1, 2014: para. 7) and to 'take action to develop laws and policies to replace regimes of substitute decision-making by supported decision-making, which respects the person's autonomy, will and preferences' (GC No. 1, 2014: para. 26). The second strand is focused on the repeal of existing laws, including those which allow for substitute decision-making (GC No. 1, 2014: para. 28) and mental health laws which allow for compulsory admission (Guidelines on Art. 14, 2015: para. 10) or treatment (GC No. 1, 2014: para. 42).

The first of these strands has been normatively uncontentious. States parties (and their law reform processes) have of course diverged as to how the obligation to support should be given effect (Donnelly, 2022) but the appropriateness of an obligation to develop decision-making supports has not been seriously questioned. The repeal (or abolitionist) element of the CRPD Committee's law reform agenda has attracted more controversy. Several states parties, including Australia; Canada; Egypt; Estonia; Georgia; Ireland; the Netherlands; Norway; Poland; Singapore; Syrian Arab Republic; and Venezuela, have issued reservations or declarations in respect of the CRPD Committee's identification of a requirement to repeal all substitute decision-making regimes. Of more direct relevance to this chapter are the critiques of an abolitionist approach to mental health law, especially in the absence of alternative safeguarding structures (Freeman, 2015; Wilson, 2021; 2022). Consequently, while many states parties have taken steps to reduce the use of compulsion, no state party has (yet) entirely repealed all aspects of compulsion under mental health law, (although Peru is sometimes cited as having come closest (Encalada, 2021)).

Moving to regional human rights instruments, the European Convention on Human Rights (ECHR) provides one example of external drivers of reform. The different legal character of the ECHR means that it is less overtly directional than the CRPD. Nonetheless, the ECHR was a key driver behind reform of Irish mental health law; the Irish Mental Health Act 2001 (MHA 2001) was introduced following the settlement reached in *Croke v Ireland* (2000), where it was agreed that the complainant would withdraw his case before the European Court of Human Rights (EtCHR) provided that the Irish State would reform the (highly problematic) Mental Treatment Act 1945. ECHR-compliance was also the force behind the introduction of the Deprivation of Liberty Safeguards (DoLS) in England and Wales (Mental Capacity Act 2005, ss. 4A; 4B; 16A). These were introduced following the decision of the ECtHR in *HL v United Kingdom* (2004) that the absence of any formal legal procedures meant that HL's admission (as an adult lacking capacity) to a psychiatric facility was in breach of the liberty protections set out in Art. 5 of the ECHR.

While an external impetus can lead to law reform, it is less clear that it will lead to successful law reform (Hathaway, 2002). There is a risk of formulaic reform, introduced to comply with external requirements without the depth of engagement required to make the reforms meaningful. Ezgi Taşcıoğlu's critique of the engagement of the Turkish government with the CRPD provides a useful example. Taşcıoğlu shows that while the government amended the Turkish Disability Act no. 2378 in 2014, following Turkish ratification of the CRPD, practices on the ground remained largely unchanged (2022: 199-201). She points out the limitations of the state reporting process under the CRPD in achieving real change in the absence of domestic commitment to change (2022: 207-210). The DoLS saga in England and Wales (Law Commission, 2017; Harding, 2021) offers another angle on the limitations of compliance-driven law reform. The DoLS introduced in the wake of *HL v United Kingdom* (2004) were highly technical, legalistic, expensive and largely ineffective in delivering real protection. Peter Bartlett (2014) sums up the impact of DoLS on practice as follows:

> No doubt buttressed by the technical legal wording of the resulting legislation, the result is that care providers, insofar as they think about the DoLS at all, seem to perceive it as a technical legal problem, with a technical legal solution – not something that can actually benefit P in any tangible way'.

These examples show that, while external reform requirements can be effective in instigating law reform, if these are to change domestic practices, deeper engagement with underlying social, political and cultural contexts is needed. As de Búrca has argued, 'the longer success of human rights campaigns often depends on the level of underlying social support and wider mobilization' (2021: 30). In light of this, we can turn to domestic impetus for reform.

Domestic Impetus

Domestic impetus for law reform emerges when it becomes sufficiently apparent to the political system that existing legal frameworks are no longer workable. The reasons for this may include broader social change; effective lobby groups; increased costs; public fears; public scandals and/or damning evidence from various forms of oversight bodies (Unsworth, 1987). While these factors will play out differently in each jurisdiction, the repeated engagements with mental health law reform in the UK/England over the last half century or so make this an informative choice for a (truncated) tour of the many and varied domestic impetus for reform.

Kathleen Jones famously described English mental health law as a pendulum swinging between two extremes of legalism and medicalism (Jones, 1972). While this dichotomous characterisation may lack nuance (Wilson, 2021: 36), its basic taxonomy remains useful. The return to 'medicalism' in the Mental Health Act 1959 (MHA 1959) is therefore a useful starting point for consideration. The MHA 1959 came about following the Report of the Royal Commission on the Law Relating to Mental Illness and Mental Deficiency (1957) (the Percy Report), which had been convened in 1954 as the move from institutional to community-based care was starting to take hold. In this new climate, cumbersome 'quasi-criminal' (Percy Report: para. 348) legal processes to prevent inappropriate admission no longer made sense and a looser, lighter touch legal approach was seen as being more in line with the changing times (Fennell, 1996: 328-29; Rapaport and Manthorpe, 2009: 255-58). Reflecting this, the Percy Report (and the MHA 1959 which followed) reduced the role of 'hard' law in the admission process, opting instead for greater medical autonomy coupled with various non-judicial oversight mechanisms, including second opinion safeguards and mental health reviews. John Hamilton, the Medical Director of Broadmoor Hospital, described the resulting Act as being 'regarded at home and abroad as a most enlightened piece of progressive legislation, heralding a new era in the care of the mentally disordered' (1983: 1721).

Two decades on, the MHA 1959 had begun to look quite different in a changed landscape. Psychiatric practices were changing as the 'pharmacological revolution' took hold and multi-disciplinary teams were becoming established. Trust in the medical profession had reduced and the values of patient autonomy and patient rights were gaining traction, initially in the United States (Rothman, 1991) and then in the United Kingdom (Wilson, 2014). Meanwhile high-profile scandals were drawing public attention to the levels of neglect and abuse that were occurring in British psychiatric hospitals (Hamilton, 1983: 1722). From this impetus, there emerged the 'new legalism' of the Mental Health Act 1983 (MHA 1983), which included a statutory standard for admission and a right to a tribunal review (Shapland and Williams, 1983; Szmukler and Gostin, 2021).

The impetus for the next phase of legislative reform came from a very different place. This time, 'the risk posed to the public by those with mental illness, and the failings of the mental healthcare system to adequately manage those risks, was the major driver of the perceived need for reform' (Wessely, 2018: 7). The Mental Health Act 2007 (MHA 2007) presaged a move to a more risk-focused approach to mental health law, characterised by John Fanning (2020) as the 'new medicalism'. This included broadening the definition of mental disorder as well as introducing provision for compulsory community treatment. Perhaps unsurprisingly, given its focus on risk, the period following the MHA 2007 came into force saw a significant increase in the use of compulsory powers with the rate of involuntary hospitalisations shooting up from 51.7 per 100,000 in 1988/89 to 114.1 per 100,000 in 2015/16 (Wessely, 2018: 49). A further law reform project, chaired by psychiatrist Sir Simon Wessely, was announced in October 2017. The impetus for reform this time is summarised by the Chair as follows:

> There is a clear case for change: the rate of detention is rising; the patient's voice is lost within processes that are out of date and can be uncaring; there is unacceptable overrepresentation of people from black and minority ethnic groups amongst people detained; and people with learning disabilities and or autism are at a particular disadvantage. We are also concerned that we are out-of-step with our human rights obligations (Wessely, 2018: 45).

One further domestic impetus which does not emerge from the preceding discussion is that which underpinned the review of the MHA 2001 in Ireland. The MHA 2001 includes a requirement that, no later than 5 years after the establishment day, the Minister for Health carry out a review of the legislation and make a report in this regard to the Oireachtas (2001: s. 75). This kind of automatic review clause has the advantage of keeping mental health law on the political agenda; however, it also runs the risk that a review, and any reform proposals it formulates, will be formulaic rather substantive.

Even from this brief account, it emerges that the decision to reform is highly responsive to broader social and political pressures. It also emerges that law reform is generally treated as something separate from – and largely subsequent to – underlying changes in policy and practice. Practices and policies evolve and law reform is then introduced to address these. Thus, although there have been some moves to broaden the vision (see for example, the identification of 'system-wide enablers' in the most recent review of the MHA 1983, (Wessely, 2018: 209-219)), the interactions between law and the broader mental health system, including factors such as economics/funding, staffing, and broader culture, receives limited attention in law reform processes. As discussed below, the systems approach adopted by the Royal Commission provides an important counterpoint to this. Before this, a closer look at processes in operation shows both the significance of process and, drawing again on the English example, the variety of processes employed.

Law Reform Processes in Operation

Mental health law reform processes are significant for both normative and instrumental reasons. From a normative perspective, the legitimacy of reform proposals is dependent on the rigour, care and inclusiveness of the process employed to develop these. An overtly political or an evidentially or analytically sloppy process will not (and should not) withstand normative scrutiny. Viewed instrumentally, a law reform process which has not gained at least some degree of stakeholder confidence will struggle to deliver meaningful change. The significance of process and in particular the importance of comprehensive integration of the service user/consumer contribution at all tiers of the law reform process is reinforced by Art. 4(3) of the CRPD. This requires all states parties to 'closely consult with and actively involve persons with disabilities … through their representative organisations' in developing and implementing legislation and policies to give effect to the CRPD. As Paul Harpur and Michael Stein argue, this requirement may constitute a 'tipping point' in ensuring participation by persons with disabilities in relevant processes.

A focus on process pays attention to a variety of factors. These include the role and independence of the review body; the terms of reference for the review, including how expansive or tightly constrained these are; the membership and expertise of the review body and the locus of decision-making authority. Also relevant is the quality of the evidence relied upon to ground findings and to support recommendations made, including the range and reliability of evidence used; the scope and scale of consultation; and the integration of the outcome of consultation into the review. Bearing this in mind, it is informative to take a closer look at the variety of law reform processes which have been employed in just one (admittedly active) jurisdiction: UK/England.

Process in Practice

The Percy Report shows a Royal Commission in action. As described by Mintrom et al, Royal Commissions are 'governmental entities established by the head of state to investigate and report on specific matters of public concern' (2021: 80). Although Royal Commissions have fallen out of favour in the UK in recent times (Barlow, 2013), traditionally, they had a level of standing compared with other processes arising from 'their perceived independence, neutrality, and transparency' (Mintrom, 2021: 81). The Percy Commission sat for 3 years and consulted extensively, including at least some consultation with people with first-hand experience of mental illness and their family members or carers (Rapaport and Manthorpe, 2009: 254). The members of the Commission had wide experience in mental health related issues and a commitment to what we would now call social justice (Rapaport and Manthorpe, 2009: 253). The Percy Commission produced a 324-page, evidence-based, Report and almost all of its recommendations was given effect in the MHA 1959 (Rapaport and Manthorpe, 2009: 262). While some elements of the process, especially the level of involvement of service users/consumers, would not stand up to modern scrutiny, for its time, this might reasonably be described as a successful law reform project.

The legislation which following, the MHA 1983, emerged from quite a different process. In light of societal changes, in 1972 the Royal College of Psychiatrists established a Working Party to review the MHA 1959. However, unlike previous reform processes, this time there was a strong and organised alternative voice to that of the establishment. The National Association for Mental Health (MIND) and its legal officer Larry Gostin, provided a powerful policy analysis, drawing heavily on principles, including the adoption of the least restrictive alternative and the application of due process values, which had been emerging in the United States (Gostin, 1975). MIND proved itself to be an effective lobbying force (Hilton, 2007: 220-22) and following the enactment of the MHA 1983, MIND

estimated that two-thirds of its new provisions had been advocated for by MIND (Hilton, 2007: 225-26).

The next phase in the reform cycle offers an insight into the politics of law reform. Following the emergence of public concerns about a perceived threat posed by people with mental illnesses, an expert review group comprising of 12 members and chaired by the legal academic Professor Genevra Richardson, was convened in July 1998. The group was tasked with undertaking a 'root and branch review' of the MHA 1983, and specifically with providing recommendations regarding the introduction of measures for compulsory community treatment (Report of the Expert Committee, 1999: 140). However, as Jill Peay, a member of the expert group, explains '[t]he Richardson Committee was set up with a fairly clear brief. It was not our task to formulate policy, rather to reflect the legislative framework to reflect government policy' (Peay, 2000: 6). The Richardson Committee grounded its legal analysis in a set of underlying principles which it used to direct its approach to law reform. The principles identified were patient autonomy, consensual care, non-discrimination, reciprocity, respect for diversity, equality, respect for carers, effective communication and provision of information, and evidence-based practice, (Peay, 2000: 9). These principles, and in particular, the identification of reciprocity, (the State's obligation to provide quality care if requiring individuals to be subject to compulsion) were remarkably prescient (and indeed we will see many of them reflected in the Royal Commission report). These principles are carefully integrating into a workable set of recommendations which were unanimously agreed by all members of the expert group. The Richardson Report was presented to government in July 1999. However, it was not published until November 1999 when it appeared alongside a Green Paper setting out the British government's view on mental health reform (DoH, 1999). The Green Paper was a very different kind of document, described by one member of the Richardson Committee as having taken 'part of the skeleton of Richardson, but abandoning its ethical heart' (Peay, 2000: 8) and by another of having abandoned its 'principled musculature' (Peay, 2000: 8). The MHA 2007 reflected the Green Paper rather than the Richardson Report and, as described above, the period since its enactment has seen a substantial increase in the use of compulsory powers.

The most recent law reform project, the Wessely Review, was formally commissioned by the Prime Minister and afforded a much broader remit than that of the Richardson Review. The Review's Terms of Reference (2017) identified specific concerns (including rising rates of detention; disproportionate levels of detention of black and minority ethnicities; and a range of stakeholder concerns) and required the review to work with stakeholders to make recommendations to government. The Terms of Reference explicitly recognised that some of the solutions were likely to lie in practice rather than in legislation and stated that the Review 'should consider practice-based solutions where possible'. The Review was chaired by a psychiatrist and the three Vice Chairs were a retired High Court judge (Sir Mark Hedley); a Rabbi and member of the House of Lords (Baroness Julia Neuberger) and a service user and Serious Mental Illness Living Consultant (Steven Gilbert) (Wessely, 2018: 34). Gilbert chaired a 13-member Service User and Carer Group which comprised people who had either been detained under the MHA 1983 or had cared for someone detained and this Group provided a separate evaluation of the Report (Wessely, 2018: 35-38). This deeper engagement service users/consumers and the more extensive terms of reference are positive features and indication that service user/consumer involvement is now becoming an established and essential part of law reform processes. The Wessely Review reported in December 2018, setting out 150 recommendations (Wessely, 2018: 297-314), aimed at enhancing human rights protections and affording a central role to the service user/consumer in all aspects of mental health decision-making (Laing, 2022: 163-65). A Government White Paper which accepted the vast majority of the Wessely Review's recommendations was published in January 2021 (Laing, 2021: 165) and a draft Mental Health Bill was published in June 2022. We can, therefore, describe this as a politically successful review. However, as Judy Laing argues, ultimately the success or failure of the measure introduced

will depend on resources and the provision of 'system-wide supports and enablers' (2021: 175). Yet, this is something which, because of the way in which this law reform project (and indeed all the other projects discussed above) was established, the Review was unable to address in other than a minimal way. As will be seen below, the Royal Commission approach offers a fresh perspective on this key aspect of law reform.

The Royal Commission at Work

The Royal Commission was established by the Victorian government in February 2019 with the aim (in the words of the Victorian premier) of fixing a 'broken system' (RC Interim Report, 2019: 11). The extensive review of the Victorian mental health system presented in the Royal Commission's Interim Report suggests that this was not an overstatement. The Royal Commission estimated that over 1.1 million Victorians experienced a mental illness each year and that a further 1.5 million were at risk of experiencing such an illness (Interim Report, 2019: 27-8). For a range of reasons, the Victorian mental health system was unable to cope with this. Problems identified by the Royal Commission included the inability to access mental health services; difficulties in navigating the system; barriers to services; and services which were uninclusive and exclusionary.

The political choice of a Royal Commission is indicative of the scale of the problem. Royal Commissions are expensive and time-consuming, although they do have a degree of prestige and an 'air of independence and impartiality which translate well to the general public' (Mintrom, 2021: 82). One criticism of Royal Commissions has been their vulnerability to the political process; as Mintrom et al describe, '[o]nce the final report has been submitted, governments can choose to simply ignore recommendations or respond only to those that suit their political goals' (2021: 81). Notably, however, the Victorian government of the day committed in advance to implementing all of the Royal Commission's recommendations (Executive Summary, 2021: 31) (although of course, political commitments are never failsafe).

Royal commissioners are independent of government and are typically 'drawn from the ranks of highly respected members of society' (Mintrom et al, 2021: 82). Like all policy influencers, the work of commissioners 'call[s] for skills in strategic thinking, gathering evidence, making arguments, working in teams, conflict management, negotiating, networking, and engaging multiple audiences' (Mintrom et al, 2021: 83). This Royal Commission comprised four members from different professional backgrounds: the Chair, Penny Armytage is a former senior public servant with extensive review/public inquiry experience ; Dr Alex Cockram is a psychiatrist and leader in mental health care; Professor Allan Fels AO is an economist and former chair of the Competition and Consumer Commission and a carer for a family member with schizophrenia; and Professor Bernadette McSherry is a legal academic with extensive engagement in public service. While representatives from law and psychiatry are almost always part of mental health law reform projects, the inclusion of public sector and economics expertise at this top-level brought a broader set of skills and experience and indicated from the outset that this project was aimed at a much higher level of integration that the usual. In addition to the four Commissioners, there was an eight-member Expert Advisory Committee which comprised members with lived, professional and sector experience of the Victorian mental health system (Interim Report, 2019: 11).

The Royal Commission delivered an Interim Report in November 2019 with nine recommendations for immediate action. The Royal Commission's final five-volume report was published in February 2021. This set out 65 recommendations across the mental health system which were intended to deliver 'transformational reform' (Executive Summary, 2021: 18 et seq). As described by the Royal Commission itself, the aim was that reforms would 'rebalance the system so that more services will

be delivered in community settings, and extend beyond a health response to a more holistic approach to good mental health and wellbeing' (Executive Summary, 2021: 20). All aspects of the rich analysis in the Royal Commission's Report merit close engagement. However, given the focus of this chapter, the primary concern is with the law reform elements and in particular with the processes employed by the Royal Commission in developing these.

Legislative Reform Proposals

A core element of the Royal Commission's recommendations is that a new Mental Health and Wellbeing Act should be introduced to replace the Mental Health Act 2014 (Vic) (MHA 2014). The MHA 2014 had been introduced in the wake of Australia's ratification of the CRPD and following a five-year consultation process. It introduced a range of measures aimed to minimise the use and duration of compulsion and to introduce greater respect for human rights, supported decision-making and recovery-oriented practice (RC Report Vol. 4: 17). The Royal Commission concluded that, despite its recency, the MHA 2014 needed to be replaced. It set out several reasons for this view. First, it identified the narrow scope of the MHA 2014 which, like mental health legislation in most other jurisdictions, was narrowly focussed on compulsory admission and treatment and had 'little relevance for people who are not subject to, nor at risk of being subject to, compulsory treatment orders' (RC Report Vol. 4: 22). Secondly, 'despite the extensive consultation processes, the best efforts of many, and the careful and considered drafting of the legislation', the aspirations behind the MHA 2014 to embed supported decision-making and recovery-orientated practice had not been realised (RC Report Vol. 4: 23). This was primarily because supported decision-making and recovery-oriented practice had not been embedded into treatment, support and care (RC Report Vol. 4: 26). Thirdly, there were contradictions between the MHA 2014 and the applicable human rights frameworks, as set out in the Victorian Charter of Human Rights and Responsibilities and in the CRPD (RC Report Vol. 4: 29-30). Finally, the Commission identified the lack of clear accountability structures under the MHA 2014 (RC Report Vol. 4: 32).

The proposed Mental Health and Wellbeing Act aims to shift the legislative focus away from compulsion towards the delivery of treatment and the enhancement of wellbeing, with the underpinning goal being delivery on the right to the highest attainable standard of mental health and wellbeing (RC Report Vol. 4: 35-6). The proposed Act presents a new vision of mental health law as an enabler of mental health and wellbeing, rather than as a mechanism for compulsion. This is not to say that the proposed Act would absolutely prohibit the use of compulsory admission or treatment. It retains the possibility of compulsory treatment as a last resort; however, as outlined in detail in an 89-page chapter, the Commission proposes a range of measures to ensure that compulsory treatment is only used as a last resort (RC Report Vol. 4: 359-447). While a statement of this kind of goal has now become a feature of most mental health law reform processes, the systems approach adopted by the Commission (and discussed further below) exhibits a level of practical grounding which substantially exceeds such proposals elsewhere.

The proposed Act engages a variety of legal tools to give effect to its vision of mental health law as an enabler of mental health and wellbeing in practice (RC Report Vol. 4: 39-40). First, it uses objectives and principles to guide interpretation of the Act. These are aimed not just at guiding courts but also providing a basis for engagement for people living with mental illness and their families, carers and supporters; as well as for service delivery and the resolution of complaints (RC Report Vol. 4: 40-1). The primary objective of the Act is the delivery of the highest attainable standard of mental health. This has three clearly stated elements: promoting conditions in which people can enjoy good mental health and wellbeing; reducing inequities in access to and delivery of mental health and wellbeing services; and providing a diverse range of comprehensive, safe, high

quality mental health services. The guiding principles are: the full and effective participation in society by people with mental illness; the protection and promotion of human rights; supporting people with mental illness to make decisions for themselves; recognition and promotion of the value of families, carers and supporters; the promotion of recovery-based practices; and, the provision of appropriate compulsory assessment and treatment only as a last resort (RC Report Vol. 4: 37).

The use of interpretative objectives and guiding principles is a relatively common feature of mental health laws in many jurisdictions. However, the Royal Commission's proposed Act is distinguished by two factors. The first of these is its robust focus on delivering the highest attainable standard of mental health and the inclusion of an explicit requirement that the Department of Health and mental health and wellbeing services make decisions in line with the Act's objectives (RC Report Vol. 4: 37). Secondly, the proposed Act emphasises structures and systems. It provides the legislative basis for a set of new bodies and roles (a Mental Health and Wellbeing Commission; a Chief Officer for Mental Health and Wellbeing; and Regional Mental Health and Wellbeing Boards) and an expanded role for complaint processes (RC Report, Vol. 4: 39). As part of this, the Act provides for greater accountability and reporting arrangements for service providers, which in turn is linked back to the objectives and principles of the Act. The Act also provides for the establishment of multiagency panels to co-ordinate the range of services which people with mental illness may require (RC Report, Vol. 4: 39). Finally, it introduces an array of concrete measures to ensure that compulsion actually is a measure of last resort. These include provision of non-legal advocacy for consumer placed or at risk of being placed on compulsory treatment orders; greater adoption of supported decision-making practices; simplified provisions on compulsion; and strong monitoring arrangements for restrictive practices.

Some elements of the proposed Act reflect reforms/reform proposals in other jurisdictions. Efforts to reduce the use of compulsion are now relatively commonplace, as are attempts to introduce forms of supported decision-making into mental health law. The question of access also now features on many law reform agendas, whether through references to the highest attainable standard of health as an underlying principle for mental health legislation (the Richardson Report, 1999) or, in the Indian Mental Healthcare Act 2017, by the introduction of a right to access mental health care (Duffy and Kelly, 2017; Pathare and Kapoor, 2022). However, the Royal Commission's proposals extend beyond this, seeking to set out a new and more expansive telos for mental health law which looks beyond the three goals which Lady Hale identified and which are set out above to instead incorporate the enhancement of mental health in all its forms and seeks to put in place the elements required to deliver on this.

Underpinning Evidence

As identified above, both the legitimacy and the success of law reform proposals depend on the quality of the evidence that underpin them. The Royal Commission's proposals are underpinned by a substantial body of evidence and by an explicit intention to place the service user/consumer at the heart of the reform process. The Royal Commission links this to its systems approach (discussed below), drawing on expertise which indicates that this has been the key to the most successful healthcare reforms in recent times (RC Report, Vol 1: 66). As described in the Interim Report, the Royal Commission conducted its inquiry through consultations, submissions, hearings, its own research and analysis and contributions by leading experts (Interim Report: 14).

The consultative process was extensive; there were 61 sessions in 21 locations attended by more than 1,650 people, with consultees invited to reflect on what was working well; not well; and how things might be improved (Interim Report: 14). There were 3,267 submissions, including 52

submissions in which the person making the submission was supported by the Commission (Interim Report: 18). There were also public hearings which were focussed on issues of particular concern (including stigma, prevention and early intervention; access to and navigation of the mental health system; families and carers; rural and regional; Aboriginal and Torres Strait Islander people; LGBTQI+ and culturally and linguistically communities; community resilience; suicide prevention; prioritisation and governance of mental health services) and a series of targeted engagements (Interim Report: 18). The Royal Commission also engaged with a wide range of research, including research which it had specifically commissioned and specialist advisory panels (Interim Report: 22).

The range and quality of evidence employed by the Royal Commission is undoubtedly impressive, reflecting a deep and multi-faceted inquiry as well as indicating broad and inclusive consultation. Beyond this, a distinguishing feature of the Royal Commission Report when compared with equivalent reports is the space and weight which it accords to personal stories and case studies. As the Report describes 'these stories provide the individual's personal recollection of their interactions and experiences with Victoria's mental health system' (RC Report Vol. 1: xvii). Thus, while the Royal Commission chose the stories it included, the stories themselves are unmediated. It is clear from the Royal Commission's own observations that these stories had a powerful impact on its deliberations (RC Report Vol. 1: 3-4).

The inclusion of stories like these is a powerful device (Massaro, 1989) which links the Royal Commission's work back to the real-world experiences of people impacted by mental health law. This adds a legitimacy and depth to the Royal Commission's proposals, engendering empathy in the reader and humanising the people for whom negotiation of the mental health system has been an unavoidable part of the lives. There are also instrumental benefits to the inclusion of unmediated personal narratives of this kind. Mintrom et al's analysis of some of the most successful Australian Royal Commissions identifies the role of narrative framing in making recommendations hard to ignore (2021: 92). Thus, across the most successful Royal Commissions, 'a lesson we draw is the importance of taking time to listen to people and empathise with the stories they tell and the views they express'. The effect is to bind people together in their commitment to change in ways that go beyond material interest and engage also with emotion (2021: 92).

A Systems Approach

Probably the most distinctive element of the Royal Commission's work is its adoption of a systems approach. This reflects the broader inquiry with which it was tasked, specifically to report on 'how Victoria's mental health system can most effectively prevent mental illness, and deliver treatment, care and support so that all those in the Victorian community can experience their best mental health, now and into the future' (Interim Report: 11). A systems approach to reform is grounded in the well-established view that society should be regarded as a social system, comprising a range of sub-systems. Derived initially from the biological sciences, this view was adopted in a social context by the American sociologist Talcott Parsons (1951) and developed by, amongst others, the German sociologist Niklas Luhmann (1991). While systems theory (and especially Luhmannian systems theory) can be highly abstract (King and Thornhill, 2003), the Royal Commission's systems approach draws substantially on the much more practically grounded work of the Australian health systems expert, Professor Jeffrey Braithwaite. Quoting from Braithwaite and colleagues (2013: 57-8), the Commission outlines the core elements of how systems operate as follows:

> Complex systems are a group of visible and invisible interconnected parts that function together to achieve a goal. They are often characterised by:
>
> - interdependent relationships with other systems

• deep, interdependent relationships between system parts, including parts that operate as a 'system within a system'
• dynamic behaviour, including an ability to self-organise, adapt, learn and develop new features over time in response to change, the outcomes of which are often unpredictable (Report Vol. 1: 55).

As the Royal Commission recognised, complex systems are unpredictable. Thus, '[c]hanges in one part of a complex system have the potential to create large changes in other parts of the system that can be seemingly unrelated in time, proximity or proportion to the initial change' (Report Vol. 1: 56). This means that some system changes can have unintended consequences (Report Vol. 1: 58). It also means that system change cannot simply be achieved by directing the system to produce an outcome; instead, change is achieved by 'shifting the underlying conditions that hold the most influence over how the system, and those people within the system, operate' (Report Vol. 1: 58). This then means that reform can require changes to parts of the system that 'appear distant, unrelated or even counterintuitive to achieving the desired outcome' (Report Vol. 1: 58). In light of this, the Royal Commission employed a four-stage systems change framework (Davidson and Morgan, 2018) in developing its proposals. The first stage defines the purpose of the system and of the planned change; the second seeks to gain clarity and a better understanding of the problems and conditions that affect the system; the third stage finds leverage through identifying the parts within the system where interventions will have the greatest impact; the final stage involves acting strategically through taking steps to create and sustain positive change (Report Vol. 1: 62).

Although the Royal Commission's systems approach extended well beyond law reform, the systems change framework can be seen throughout the law reform choices made. The need for a clear vision and purpose is expressed through the objectives and principles of the proposed Mental Health and Wellbeing Act and the various ways these are reinforced (Report Vol. 1: 75). In seeking to understand the system, the Royal Commission identified the complexity of mental health and its causes; the scale and diversity of system parts and how they interrelate; and the divergent perspectives on mental health among key stakeholders ('those who regulate, fund, govern, use, need, work in or benefit from') in the system (Report Vol. 1: 61). It also identified the different kinds of conditions of the system. These incorporate readily visible parts, such as government policies, organisational practices and the allocation of resources; observable parts, such as relationships and connections or power dynamics; and, hidden parts, such as underlying beliefs and values (Report Vol. 1: 77). Through this analysis, the Royal Commission identified 'systems levers' through which change could be effected. It describes a systems lever as a place 'where a seemingly small or discreet shift in one part of the system produces big changes across the system' (Report Vol. 1: 77).

A key systems lever identified was the statutory establishment of the Victorian Collaborative Centre for Mental Health and Wellbeing. This had been identified as a key action in the Interim Report (Report Vol. 1: 77), which noted that this model is already well established in respect of cancer and cardiac diseases (Interim Report: 394). The aim of the Collaborative Centre is 'to provide adult clinical and non-clinical services, emphasise the participation and inclusion of people with lived experience, and conduct interdisciplinary research' (Interim Report: 392). The idea of bringing together service delivery (within the local community) and interdisciplinary research is that this 'enables people with lived experience to participate in the design, development and production of research programmes and reinforces the translation of research and evidence into high quality care' (Interim Report: 392).

The establishment of the Collaborative Centre also plays a strategic role in sustaining the law (and broader system) reform project into the future. Thus, as the Royal Commission describes, while the

Collaborative Centre is just one institution, it 'holds a mandate to influence mental health treatment, care and support across Victoria, with a view to changing some of the "deeper" characteristics of the system' (Report Vol. 1: 77). In the first phase of implementation of the Royal Commission Report, the Victorian Collaborative Centre for Mental Health and Wellbeing Act 2021 received Royal Assent in November 2021 and the steps to establish the Collaborative Centre are underway at the time of writing. Crucially, the Act requires that at least two members of the Board of the Centre are persons who have had experience of mental illness or psychological distress and at least two members are persons who have supported such persons and that one of the two directors of the Centre must be a person with experience of mental illness or psychological distress. McSherry (2023) argues that this statutory specification creates the potential 'for not only effective service delivery but also ground-breaking interdisciplinary research'.

Conclusion

It is difficult to envisage a time when law reform ceases to be part of the mental health landscape. For this reason, there is a need for a systemic understanding of law reform processes. This chapter has looked more closely at reform process and has argued that the quality of the processes employed is inherently linked both to the legitimacy of the law reforms proposed and to their chances of success. The innovative law reforms proposed by the Royal Commission reflect the process used in their development, and the emphasis placed on the involvement at every level of the service users/consumers that the system is established to service. It will be instructive (and important) to see how the effectively the Royal Commission's proposals work in practice. If the Victorian government remains true to its promise to implement all of the Royal Commission's recommendations, this should relatively quickly start to become apparent

The work of the Royal Commission offers lessons for law reform processes in other jurisdictions. The most far-reaching of these is the vision of a system-wide review in which law reform is only one component, informed by the methodologies of the system change framework used by the Royal Commission. Clearly this kind of review requires extensive and highly sophisticated engagement as well as considerable resources and realistically, is likely to be a once in a generation endeavour. Nonetheless, if the Victorian experiment can be shown to have worked, it will provide a valuable template for law and policy makers in other jurisdictions. There are also other, possibly more easily realisable, lessons from the Royal Commission's work which can be integrated into more traditional law reform processes. First, the Royal Commission shows that deep involvement of service users/consumers at every stage of the process is essential and that this needs to become established practice in all reform processes. The Royal Commission Report also shows both normative and instrumental benefits in integrating unmediated service user/consumer voices into the final report. Secondly, there are lessons to be learned from the strategic elements of the Royal Commission's approach. The accurate identification of system levers will undoubtedly be more challenging where the reform analysis is primarily focussed on the legal system. Nonetheless, a law reform methodology which recognises the importance of findings levers and thinking strategically is still likely to have more chance of effecting meaningful change than one which does not take account of strategic elements. Finally, and possibly most significantly, the Royal Commission shows ways to think about law reform which expand and reinterpret the telos of mental health law and the kind of legal interventions which might be considered in the mental health sphere. For these reasons, the Royal Commission (and Professor McSherry) have done the broader world of mental health law reform some considerable service.

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