



PO Box 668 Rozelle NSW 2039

T 02 9555 8388

F 02 9810 8145

E [info@mhcc.com.au](mailto:info@mhcc.com.au)

W [www.mhcc.org.au](http://www.mhcc.org.au)

ABN 59 279 168 647

15 December 2012

### **Submission to the Discussion Paper: Issues arising under the *NSW Mental Health Act 2007***

The Mental Health Coordinating Council (MHCC) is the peak body representing community managed organisations (CMOs) in NSW. Our members provide a range of psychosocial and clinical services, and support programs, as well as advocacy, education, training and information services with a focus on recovery orientated practice. MHCC's membership consists of 183 organisations whose business or activity is wholly or in part related to the promotion and/or delivery of services for the wellbeing and recovery of people affected by mental health conditions. We work in partnership with both State and Commonwealth Governments to promote recovery and social inclusion for people affected by mental illness, participate extensively in policy and sector development and facilitate linkages between government, community and private sectors in order to affect systemic change. MHCC also manage and conduct research projects and develop collaborative projects on behalf of the sector. MHCC is also a registered training organisation (MHCCLD) delivering nationally accredited mental health and drug and alcohol training and professional development to the workforce.

In September 2012, the Mental Health and Drug and Alcohol Office (MHDAO) released a Discussion Paper: Issues arising under the *NSW Mental Health Act 2007*. The object of this review is "to determine whether the policy objectives of the Act remain valid and whether the terms of the Act remain appropriate for securing those objectives".

Amongst the many issues under discussion are a number of priorities which represent sections in need of comprehensive review including: admission and discharge; the role of primary carers; involuntary and voluntary detention; role, functions and coordination of the different oversight bodies in mental health, such as the Official Visitors and the Mental Health Review Tribunal; and consent to non-mental health treatment.

Back in May 2012, MHCC were asked to furnish the Government with some preliminary thoughts concerning areas that we felt should be discussed. Many of these issues are referred to in the Discussion Paper and have been addressed more fully in this submission.

MHCC welcome the opportunity to respond to the review which was designed in template format. The following items reflect the title, questions and numbers used in the template which start at Number 4. The numbers refer to the section in the Discussion Paper; the item number is the question following that section number.

MHCC have been involved in numerous public and community consultations and circulated requests for feedback from members and the sector via our weekly FYI and stand-alone emails. We also conducted targeted interviews and sought expertise from across service sectors and professional disciplines in order to access the widest possible perspectives and expertise.

This submission seeks to provide MHCC's response to the Discussion Paper as a text document since the template format provided by the Ministry may not be publically accessible and MHCC are keen for members to have access to our paper and receive further responses to inform the next stage of the review process.

For any further information or to provide feedback on this submission please contact Corinne Henderson, Senior Policy Officer at [corinne@mhcc.org.au](mailto:corinne@mhcc.org.au) or T: (02)9555 8388 #101

A handwritten signature in blue ink, appearing to read 'Jenna Bateman', with a large, stylized flourish at the end.

Jenna Bateman  
Chief Executive Officer

## Principles that Underpin Intervention

### 4.1. Is supported decision-making a principle that should be further explored in NSW?

a. Supported decision-making provides an alternative to guardianship or other people taking on decision-making roles. Decision-making should be supported, not substituted. In supported decision-making, consumers are actively helped to identify their values, goals and choices at times when this is particularly difficult.

Supported decision-making is an important part of service and care coordination. A basic premise of this approach is that autonomy does not need to be replaced with substitute decision-making, but can exist alongside it. That is, decision-making should be supported, not substituted. People must be assisted to identify and express their choices even when capacity is in doubt, rather than excluding them from the decision-making process.

Supported decision-making can take many forms. Those assisting a person may communicate the individual's intentions to others or help him/her understand the choices at hand. They may help others to realise that a person with significant disabilities is also a person with a history, interests and aims in life, and is someone capable of exercising his/her legal capacity. While some good models of supported decision-making exist there is no clear policy framework; and guardianship laws and practice still dominate. It is sometimes difficult to designate support networks, particularly when an individual cannot identify a trusted person. In addition, people in institutional settings are often denied support, even when it is available.

b. Supported decision-making is quite loosely defined and articulated in the scant literature. Supported decision-making is referred to in the United Nations Convention on the Rights of Persons with Disabilities 2006 (UNCRPD) in Article 12 (3) on Equal Recognition before the Law, as providing that the: 'states parties shall take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity'. Australia has ratified the UNCRPD and as such is bound to uphold the Articles in the Convention. The inclusion of supported decision-making in an amended *NSW Mental Health Act 2007* (MHA) will go some way towards NSW meeting the international movement towards embedding human rights in both state and national law.

c. MHCC propose that suggested principles concerning 'supported decision-making' discussed further in 4.2.a. be included in Principles of Care and Treatment, which currently sit in s68 of the Act. This section needs to be relocated following the Objects in Chapter 1, and referred to throughout the Act.

### 4. 2. What are the key issues that need to be considered?

a. The principle of providing the 'least restrictive care and treatment' is embedded in the Act. If the principle of 'supported decision-making' were to become a principle it provides an opportunity for more progressive thinking with regards to alternative care options involving substituted decision-making. This could be in relation to involuntary treatment.

At the moment, assessment and review by the MHRT are based on the 'risk of harm to self or others or likelihood of lapsing into an active state of mental illness,' if, for example, a consumer has a history of non-compliance to their treatment plan. What needs to be explored is the degree to which people can be supported in other ways to support themselves to remain safe in the community.

The principle of a person who is mentally ill or mentally disordered being detained on the basis than 'no other care of a less restrictive kind, that is consistent with safe and effective care, is appropriate

and reasonably available to the person' should include alternatives that enable consumers to exercise the most self-determination possible in any circumstance. We propose that embedded in the Principles for care and treatment (s68), the principle of supported decision-making be made explicit as an option for supporting any form of least restrictive care in all contexts, i.e. in hospital or in the community.

Implementing supported decision-making is critical to bringing legislation in line with the national mental health standards for recovery orientated practice that supports self-directed care, which is a cultural shift away from a medical model of managed treatment and coercive care. Substituted decision-making should only be used as a last resort, when it becomes clear that a person does not have the capacity to make personal decisions at that point in time. Until this point, the assumption must be that the person has the capacity to make decisions about their own care.

Importantly, decision-making capacity must be recognised as being decision specific and as such supported decision-making and substituted decision-making can occur simultaneously. The importance of providing people with the information they need to make a decision, and the support to help them process and communicate their choices, is crucial at all times, even once it becomes apparent that the person may lack capacity to make certain decisions at a point in time. Capacity is fluid and must be regarded as such in the legislation, taking into account the episodic nature of mental illness. Review of people with histories of risk of harm to self and others must be approached with caution so as not to discriminate against a person indefinitely. One way to ensure this is to support people maximise their decision-making capacity whenever possible.

We note however that a decrease in substituted decision-making and coercive practices must be complimented by a commitment to increasing availability of community-based care and support to avoid the possibility of neglect. In many ways, both coercion and neglect can be viewed as a failure of the system and a balance must be sought between both.

The provision of 'least restrictive care' alternatives and supported decision-making is dependent on a service system providing access to support services. In order to progress to a rights based model in line with international law and the UN Convention on the Rights of People with Disability (UNCRPD) it is necessary to entrench principles in the legislation that obligate government to provide appropriate resourcing for these services.

MHCC recommend principles informed by the principles outlined in Victorian paper: Office of the Public Advocate, 2009. *Supported decision-making: Background Paper*, 7.2, p.20 and the United Kingdom, Mental Capacity Act 2005, which while similar, includes additional principles 3 and 5 which we recommend be included:

1. The interests of the person with a disability are paramount in supported decision-making arrangements.
2. Every adult has the right to make his or her own decisions and must be assumed to have capacity unless proved otherwise.
3. A person must be given all practicable help before treated as lacking the capacity to make their own decisions.
4. Support and assistance with decision-making should be available to any person with a disability.
5. Any supported decision-making arrangement must have the consent of the person and their supporters.
6. The person with a disability may terminate the arrangement at any time and a supporter may withdraw from the arrangement at any time.
7. Decisions made under supported decision-making arrangements cannot override the will of the person with a disability.

8. If a decision made by an individual is considered unwise, the person should not be assumed as lacking decision-making capacity.
9. Any action or any decision made on behalf of a person who lacks capacity, must be in their best interests.
10. Any action or any decision made on behalf of a person who lacks capacity should ensure the least restrictive of their basic rights and freedoms.
11. Any action or any decision made on behalf of a person must be decision specific.

b. Another issue for consideration is 'dignity of risk'. Dignity of risk is a term used to describe the right of individuals to choose to take some risk whilst engaging in life and is an important concept that mental health service providers should be mindful of. It is essential that consumers are not overprotected, or coerced into treatment.

Following a diagnosis many people feel or are subject to negative attitudes concerning their capacity to function autonomously and be self-directing. In the process of receiving treatment they frequently are deemed to have given up their 'right' to make risky or potentially self-defeating choices without intervention from authorities, clinicians, service providers or family members wishing to protect them.

Every endeavour has an element of risk, and every opportunity for growth carries with it the potential for failure. All people learn through a process of trial and error, often learning as much from their mistakes as from their successes. When people living with a mental illness are denied the dignity of risk, they are being denied the opportunity to learn and recover. Dignity of risk places an emphasis on personal choice and self-determination - two concepts central to 'recovery'.

Anthony (2000) states: *the notion that one has options from which to choose is often more important than the particular option one initially selects.* Likewise Deagon (1996) writes: *Self-determination, or taking responsibility for one's own recovery, is the core component of recovery. Part of that responsibility involves the self-management of wellness and medication, autonomy in one's life choices and the willingness to take informed and planned risks in order to grow.*

What keeps us from encouraging people to make choices? What stops us from allowing people living with a mental illness the dignity of risk? One of the biggest barriers is fear of the unknown, and the legal ramifications of failure. Mental health service providers are concerned that if a consumer takes a risk and fails that it implies they are failing in their duty of care. We need to encourage workers to see the positives in risk and allow consumers to take control for their choices and actions. Failure can be used as a learning opportunity and supporting people through failure can assist them to develop resilience.

Hope is central to recovery. Every choice involves both the possibility of failure or success. Paternalism and taking away people's choices by not allowing them to take risks or try new things, crushes hope. This can be seen in many people who have been institutionalised or hospitalised for a great length of time. It can lead to learned helplessness, which is often more debilitating and disabling than any illness in itself (Petersen, Maier & Seligman, 1995). By supporting dignity of risk and encouraging people to make choices and take chances, service providers help to combat learned helplessness and bolster self-esteem, self-respect, empowerment, hope and support recovery.<sup>i</sup>

c. Supporting Recovery is a concept that must be imbedded in the Principles that 'Underpin Intervention' (s105) and be reflected throughout the Act. The National Standards for Mental Health Services (2010) was revised to include the Principles of Recovery Orientated Practice. The standards must be contained in the legislation along with Principles.

Principles of recovery-oriented mental health practice

From the perspective of the individual with mental illness, recovery means gaining and retaining hope, understanding of ones abilities and disabilities, engagement in an active life, personal autonomy, social identity, meaning and purpose in life, and a positive sense of self. It is important to remember that recovery is not synonymous with cure. Recovery refers to both internal conditions experienced by persons who describe themselves as being in recovery—hope, healing, empowerment and connection—and external conditions that facilitate recovery—implementation of human rights, a positive culture of healing, and recovery-oriented services, (Jacobson & Greenley, 2001, p. 482). The purpose of principles of recovery-oriented mental health practice is to ensure that mental health services are being delivered in a way that supports the recovery of mental health consumers.

The following should be included as an addendum to the Principles for care and treatment in the Act:

#### 1. Uniqueness of the individual

Recovery oriented mental health practice:

- recognises that recovery is not necessarily about cure but is about having opportunities for choices and living a meaningful, satisfying and purposeful life, and being a valued member of the community
- accepts that recovery outcomes are personal and unique for each individual and go beyond an exclusive health focus to include an emphasis on social inclusion and quality of life
- empowers individuals so they recognise that they are at the centre of the care they receive.

#### 2. Real choices

Recovery oriented mental health practice:

- supports and empowers individuals to make their own choices about how they want to lead their lives and acknowledges choices need to be meaningful and creatively explored
- supports individuals to build on their strengths and take as much responsibility for their lives as they can at any given time
- ensures that there is a balance between duty of care and support for individuals to take positive risks and make the most of new opportunities.

#### 3. Attitudes and rights

Recovery oriented mental health practice:

- involves listening to, learning from and acting upon communications from the individual and their carers about what is important to each individual
- promotes and protects individual's legal, citizenship and human rights
- supports individuals to maintain and develop social, recreational, occupational and vocational activities which are meaningful to the individual
- instils hope in an individual's future and ability to live a meaningful life.

#### 4. Dignity and respect

Recovery oriented mental health practice:

- consists of being courteous, respectful and honest in all interactions
- involves sensitivity and respect for each individual, particularly for their values, beliefs and culture
- challenges discrimination and stigma wherever it exists within our own services or the broader community

#### 5. Partnership and communication

Recovery oriented mental health practice:

- acknowledges each individual is an expert on their own life and that recovery involves working in partnership with individuals and their carers to provide support in a way that makes sense to them
- values the importance of sharing relevant information and the need to communicate clearly to enable effective engagement
- involves working in positive and realistic ways with individuals and their carers to help them realise their own hopes, goals and aspirations.

## 6. Evaluating recovery

Recovery oriented mental health practice:

- ensures and enables continuous evaluation of recovery based practice at several levels
- enables individuals and their carers to track their own progress
- ensures that services demonstrate that they use the individual's experiences of care to inform quality improvement activities
- require that the mental health system reports on key outcomes that indicate recovery including (but not limited to) housing, employment, education and social and family relationships as well as health and well-being measures

Reference: Recovery Principles have been adapted from the Hertfordshire Partnership NHS Foundation Trust Recovery Principles in the UK.

## Delivery of care – Standards

It is necessary that that the principles are supported by the mental health standards that 'incorporate recovery principles into service delivery, culture and practice providing consumers with access and referral to a range of programs that will support sustainable recovery'.

The following should also be included as an addendum to the Principles for care and treatment in the MHA: Standard 10

### 10.1 Supporting recovery

#### Criteria

- 10.1.1 The MHS actively supports and promotes recovery oriented values and principles in its policies and practices.
- 10.1.2 The MHS treats consumers and carers with respect and dignity.
- 10.1.3 The MHS recognises the lived experience of consumers and carers and supports their personal resourcefulness, individuality, strengths and abilities.
- 10.1.4 The MHS encourages and supports the self-determination and autonomy of consumers and carers.
- 10.1.5 The MHS promotes the social inclusion of consumers and advocates for their rights of citizenship and freedom from discrimination.
- 10.1.6 The MHS provides education that supports consumer and carer participation in goal setting, treatment, care and recovery planning, including the development of advance directives.
- 10.1.7 The MHS supports and promotes opportunities to enhance consumers' positive social connections with family, children, friends and their valued community.
- 10.1.8 The MHS demonstrates systems and processes for consumer and carer participation in the development, delivery and evaluation of the services.
- 10.1.9 The MHS has a comprehensive knowledge of community services and resources and collaborates with consumers and carers to assist them to identify and access relevant services.
- 10.1.10 The MHS provides access for consumers and their carer(s) to a range of carer-inclusive approaches to service delivery and support.

The MHA should refer to and reflect these standards for service delivery where appropriate throughout the Act.<sup>ii</sup>

## **Treatments for conditions other than mental illness**

### 5.3. Are the provisions in the Mental Health Act relating to the provision of non-mental health treatment appropriate?

The provisions in the Act dealing with 'other medical treatments' (s98-s104) should be amended to reflect an emphasis on supported decision-making (as discussed in 4.1. and 4.2.) and the use of advance directives where possible, with substitute decision-making only used as a last resort. There needs also to be reference to other possible substitute decision-makers such as a primary or nominated carer or a person with whom the individual has a close, continuing relationship and who may have better knowledge than the authorised medical officer and treatment team of the wishes of the consumer who may not have capacity to consent at a particular point in time.

### 5.4. Should the provisions relating to non-mental health treatment be better aligned with the Guardianship Act?

When a person is incapable of consenting to their own medical and dental treatment, the *Guardianship Act 1987* provides the legal basis for another person close to them to give this consent (Chapter 12, Disability and Guardianship). This is usually carried out without a guardianship order, and the Act sets out who can make decisions without such an order (the person responsible). The hierarchy for deciding who is a 'person responsible' is firstly someone already appointed as a guardian. Next in line is a spouse or de facto partner, as long as there is a 'close, continuing relationship'. Since the 1999 changes this category includes lesbian and gay partners who live with the person. De facto partners do not need to have lived together for any particular length of time, as long as the relationship is ongoing and close. Third is a person who 'has care' of the person, and fourth is a 'close friend or relative'. The MHA should include a provision that specifies that every attempt be made by the authorised medical officer to contact a nominated or primary carer or 'person responsible' if one is known to services, and that consent in emergency situations by the medical officer or Director-General is consent of last resort.

The Guardianship Act is based on the philosophy that, as far as possible, people should be able to make their own decisions. Even if the person lacks the formal legal capacity to manage their affairs, the Act requires that their views be taken into careful account by any substitute decision-maker. The provisions in the MHA and reference to review by the Mental Health Review Tribunal (MHRT) concerning medical treatment needs to better support decision-making of the individual concerned and not operate on the basis that refusal to consent is indicative of a lack of capacity. The same respect for choice should be applied as is applied generally in the community and only in emergencies should a 'best interest' decision prevail.

## **Definition of Mental Illness**

### 6.5. How should mental illness be defined in the Act?

a. In 2006, Karras et al. wrote that: *Definitions of mental illness are notoriously difficult to draft. If they are framed too narrowly they deny services to people. If they are too broad they may result in unnecessary intervention.*<sup>iii</sup>

Under the *NSW Mental Health Act 2007* (s.4) 'mental illness' is defined as a condition characterised by the presence of symptoms which seriously impairs, either temporarily or permanently, the mental functioning of a person. A 'mentally ill person' is someone who suffers a mental illness

where, owing to that illness, there are reasonable grounds for believing that care, treatment or control of the person is necessary, for their own or others' protection. This determination must take into account the person's continuing condition, including the effects of any likely deterioration in their condition (Karras et al. 2006).<sup>iv</sup>

In MHCC's view the question is not how mental illness should be defined because defining it is beyond definition, but that the application of the MHA pertains to those individuals whose capacity for decision making is impaired and that this may put them at risk of harm to self and other.

b. Concerning the test or definition for mental illness, frequently people are caught in the system. Since there is no objective standard required to be met before an order can be made or renewed by the Tribunal. The MHRT have no basis on which to make a decision than the: "reasonable person standard which makes no allowance for the mentally ill" (Breunig v. American Family Insurance Co., 173 N.W.2d 619 (Wis. 1970)). Such a refusal goes back to the standard set in *Vaughan v Menlove* (1837) 132 ER 490 (CP) a seminal English tort law case that first introduced the concept of the reasonable person in law, where Menlove's attorney argued for the subjective standard. In the 170 years since, the law has kept to the legal judgment of having only the single, objective standard. Such judicial adherence sends a message that the mentally ill would do better to refrain from taking risk-creating actions, unless they exercise a heightened degree of self-restraint and precaution, if they intend to avoid liability. Generally, the courts have justified that by not accepting mental illness as a bar to recovery, a liable third party, in the form of a care-giver, will be more likely to protect the public because of the potential for liability. The courts have also stated that the reasoning behind the harsh treatment is because, unlike children or the physically disabled, members of the public are unable to identify a person with a mental illness. Therefore for a person on a CTO the only realistic way of avoiding repeated renewals is to convince the health care agency or MHRT that the person will continue to take their medication. With a history of 'non-compliance' even when the past is far from recent together with 'lack of insight' stated as part of the assessment of risk of harm, makes it extremely difficult for a consumer to get out from under a CTO.

#### 6.6. Are personality disorders currently adequately addressed in the Act?

While personality disorders are considered part of the mental disorders spectrum at a clinical level and are included in classificatory systems such as ICD-10 and DSM-IV, according to the World Health Organisation (WHO) there have been concerns about the validity and reliability of diagnosis of many subtypes of personality disorders and questions have been raised regarding the amenability of personality disorders to treatment. However, the WHO has acknowledged that there is growing evidence that many personality disorders are in fact amenable to treatment. There is now strong concern particularly with regards to the diagnosis of Borderline Personality Disorder (BPD) which many clinicians reframe as Complex PTSD characteristically present in people with histories of childhood sexual abuse.<sup>v</sup>

The evidence is clear that there are a number of interventions that assist people with BPD including Dialectical Behaviour Therapy and several models of psychotherapy. Governments have been slow to acknowledge the need for policy development and equity of access to services for people with complex trauma needs, primarily because they are long-term and costly interventions. Whilst MHCC strongly advocate availability and access to appropriate services, such therapeutic interventions can only be effective when engaged in voluntarily. Therefore unless individuals present with symptoms that can be defined under the Act as a mental illness or mental disorder we would not advocate inclusion of people with personality disorders. MHCC concur with the view that personality disorders, like many psychiatric diagnoses may well be social constructs that can lead to abusive and coercive interventions.

The WHO make the point that if a particular condition is not responsive to treatment or if no treatments are available, it is difficult to justify involuntary admission to a mental health facility. However, consideration must be given to people with conditions previously deemed untreatable such as Personality Disorders. We recommend that for people who come under the MHA presenting with co-existing personality disorders and mental illness (as defined under the Act) the Government must ensure that appropriate services are available across the service system. This would serve to address the concern that people with personality disorders are being inappropriately denied mental health services.

#### 6.7. Is Dementia currently adequately addressed in the Act?

It is necessary that the MHA specifically refer to supported decision-making processes utilised under the Guardianship Act for people with dementia. The NSW Mental Health Act Guide Book has highlighted how dementia can cause difficulties regarding application of the *NSW Mental Health Act 2007*. Whilst the illnesses that cause dementia do not fall within the Act's definition of 'mental illness', a person with dementia (similar to people with other conditions such as acquired brain injury) may experience symptoms, such as auditory hallucinations, delusions or a serious disorder of mood, that are recognised by the Act. Therefore, MHCC support the care of people with the symptoms described under the Act whether resulting from dementia and/ or mental illness, with the emphasis on supported decision-making extremely important for this group of particularly vulnerable people, who the system often medicates and manages rather than cares for appropriately under the practice principles of recovery or enabling. It is critical that mental health and age care work closely together so that an individual does not fall between service gaps and that people are appropriately cared for in mental health facilities using principles of recovery and enablement.

It is particularly problematic when consumers are in age care facilities where their behaviours may present 'challenges' for care givers and other residents. They are frequently found to be over sedated and have little access to alternative therapeutic interventions. It is hoped that a person coming under the MHA may be somewhat protected from negligent and abusive treatment by the review processes of the MHRT. The Specialist Mental Health Services for Older People (SMHOPS) has been a welcome initiative in oversighting and delivering a more appropriate model of care to older people which is flexible, recovery orientated and individualised.

It is critical that Doctors and other people treating people with early stage dementia encourage individuals to provide Advanced Directives so that as the dementia progresses they can take into account the wishes about how the individual would choose to be treated when they lack capacity.

#### 6.8. Should any conditions be explicitly excluded from the definition of mental illness?

There are a number of conditions that should be explicitly excluded from the definition of mental illness, including, Intellectual Disability, Autism and any other developmental disabilities as well as Cognitive Disability, unless co-existing with an identified mental illness or mental disorder.

Developmental disability is a term used to describe lifelong disabilities attributable to mental or physical impairments, manifested prior to age 22. It is not synonymous with 'developmental delay' which is often a consequence of a temporary illness or trauma during childhood. **People with developmental disabilities** experience mental health issues and mental illness in greater numbers than the general population and where people with developmental disabilities experience coexisting mental illness and come under the Act they must be offered support so as to maximise their ability to make decisions about their care and treatment.

Intellectual disability is a developmental disorder. People with intellectual disability have significantly more difficulty than others in learning new things, understanding concepts, solving problems, concentrating and remembering. Consequently, they require extra support to learn and achieve their full potential. Intellectual disability is often present from a person's early years. It is not a mental illness. However people with intellectual disability experience the same types of mental health problems as those without coexisting disability.

Autism is a disorder of neural development characterized by impaired social interaction and communication, and by restricted and repetitive behaviour. The diagnostic criteria require that symptoms become apparent before a child is three years old. It is one of three recognized disorders in the autism spectrum (ASDs), the other two being Asperger syndrome, which lacks delays in cognitive development and language, and pervasive developmental disorder, not otherwise specified (commonly abbreviated as PDD-NOS), which is diagnosed when the full set of criteria for autism or Asperger syndrome are not met. Similarly people with Asperger's spectrum disorders experience the same types of mental health problems as those without coexisting disability and require supported decision-making assistance so as to maximise their ability to make decisions about their care and treatment. Where capacity is proven absent, a person must be provided with a substitute decision-maker under the Guardianship Act.

Acquired Brain Injury is a type of cognitive disability, a term that is extremely broad, and not always well-defined. In loose terms, a person with a cognitive disability has greater difficulty with one or more types of mental tasks than the average person. Most cognitive disabilities have some sort of basis in the biology or physiology of the individual. The connection between a person's biology and mental processes is most obvious in the case of traumatic brain injury and genetic disorders, but even the more subtle cognitive disabilities often have a basis in the structure or chemistry of the brain.

#### 6.9. Are there any other comments you wish to make concerning the definition of mental illness?

Whilst MHCC agree that the current definition of mental illness in the MHA does not pathologise an individual with a diagnosis, the use of the term 'irrational' is superfluous in the context of severe disorder or thought form. The term 'irrational' is also context specific and may be open to various interpretations.

### **Mental Health Review Tribunal (MHRT) Hearings**

#### 7.1. 10. Do you believe that the MHRT should be able to make community treatment orders (CTOs) and/or defer the discharge of a detained person for up to 14 days at an appeal hearing against a refusal to discharge the person? Why/ why not?

- a. As the Act stands there are a number of alternatives available under s44 (Appeals against discharge refusals). These are to: discharge an involuntary patient; reject the appeal and further review and detain a person under s37; adjourn the matter; reclassify a person as a voluntary patient; and determine that no further right of appeal may be exercised. There are many situations that arise where a CTO would be a preferred alternative, and MHCC support the proposal that the MHRT be able to make CTOs, at present not possible under s44 (4). This is because we believe it provides an opportunity for a 'less restrictive alternative' to involuntary status and will lead to people not being detained longer than necessary, because of a history of risk of harm and concerns regarding duty of care. However, in order to prevent unnecessarily long CTOs, there should be an opportunity for short orders stated in the Act, particularly as a consideration for people with first episode admissions.

- b. MHCC deem it reasonable that the powers of the MHRT are aligned for appeal and review of involuntary status. However, the 14 days should require consent from an individual who agrees on the basis that accommodation or other arrangements are to be made and that they are willing to be detained as a voluntary patient.
- c. Currently, under s37 (involuntary detention) the Act provides that the MHRT must conduct a mental health inquiry 'as soon as practicable' after admission as an involuntary patient. Until June 2010, this was interpreted to mean 'within 7 days' but following the amendments to the MHA that required that Magistrates' Inquiries be held by the MHRT saw reviews scheduled for 3-4 weeks after admission, which led to an increase in appeals against discharge (s44). MHCC welcomed the subsequent recognition by the Government that such wait times were unacceptable and the provision of funding to bring hearings forward to two weeks after admission. MHCC suggest that it may be helpful for the MHA to state the timeframe for review to ensure that patients are clear about when they can expect to receive an independent review of detention decisions, if they have not been discharged already. We note that law reform proposals in Tasmania (*Mental Health Bill 2011 (TAS)*) guarantee hearings within 4 days of admission for formal review of detention and patient rights protection. We would advocate that the MHA state that reviews must be held no longer than 5 working days following admission (i.e. 7 days including a weekend).

7.2. 12. Do you believe that the Act should be amended to allow the MHRT, when undertaking a mental health inquiry, or a review of an involuntary patient, to make a CTO and delay the person's discharge until appropriate accommodation and other arrangements are in place? Why/ why not?

See recommendations- 7.1.10a & 7.1.10.b

7.2. 13. If you do believe such an amendment is appropriate, do you think that any restrictions should be placed on such orders? (E.g. should there be a maximum period that a person can be detained pending discharge or further review by the MHRT if they have not been discharged by the end of that period? Should the person be able to still seek discharge and appeal if it is refused, as other persons detained involuntarily can do?)

On the basis of the recommendations stated in 7.2.10 and 7.2.12 a person should only be detained voluntarily and therefore at the end of the review period should be free to discharge themselves even if suitable arrangements have not been made. Alternatively they could remain as a voluntary patient. If the facility wishes to detain a person longer, they would need to institute a hearing to determine whether a person should be held based on 'the continuing condition of the person, including any likely deterioration in the person's condition and the likely effects of any such deterioration' if they were to be discharged (s14).

7.3. 15. Do you believe that the Act should be amended so that voluntary patients must be reviewed at least once every 12 months of continuous residence voluntarily or involuntarily in MHFs? Why/ why not?

Yes, MHCC recommend an amendment to the MHA requiring review of voluntary patients every 3 months. This is to ensure service accountability and to avoid an individual receiving unnecessarily restrictive care and treatment. We refer to the recent Ombudsman's report, *Denial of rights: the need to improve accommodation and support for people with psychiatric disability: A Special Report to Parliament under s.31 of the Ombudsman Act 1974 (Nov 2012)*, in which they refer to the many instances when people are languishing in hospital when well enough to be discharged because the review is still to be conducted.

7.4. 17. Do you believe that the Act should be amended to allow for initial involuntary treatment of persons in the community? Why/ why not.

No, it is completely inappropriate in any circumstances for involuntary treatment to be made possible without the MHRT hearing an application for a CTO (s 52(3)). We propose that this is a safeguard which prevents pressure being placed upon clinicians to treat by interested persons (including service providers), and protects consumers from coercive practices. We propose that most emergencies will result in a patient self-presenting or being brought to services. Such a proposal is particularly problematic for people unable to advocate for themselves and will likely lead to increased discrimination against vulnerable members of the community.

Without a more robust and cohesive community mental health service system, this option is unrealistic. Whilst the principle has some merit in the current service environment far more work needs to be done to enhance access and care coordination in order to keep people out of hospital and cared for in the community.

7.4.18. What restrictions, if any, do you believe should be placed on initial involuntary treatment in the community, and why?

See 7.4.17 – We do not believe it is appropriate under any circumstances for involuntary treatment to be possible without a hearing. It is necessary to ensure the person concerned be involved in decisions concerning involuntary status.

8.20. Where the police officer has requested that the person be returned to their custody following a mental health assessment, how long should mental health facilities be able/required to detain a person to enable officers to attend and take custody of that person?

Our understanding is that from a police force perspective current arrangements are working well in metro NSW where police are communicating effectively with hospital staff. However, in rural and remote areas where distance is a challenge a longer period of detention would assist police. The recommended maximum period of time recommended is 4 hours. However, this extended time should not become the norm and regulations must clearly ensure people are not detained longer than has been common practice to date.

8.21. Are there any other comments you wish to make concerning this issue?

MHCC have been told that health facilities are most generally proactive in calling police early in the process of assessing a client. They generally let police know in advance when the person will need to be collected so as to maximise the time available for police to prepare and coordinate pick-up within the hour that the hospital is able to hold them (s32 (4)). However well this works in practice, it is not in 'the spirit of the Act' and needs to be formalised in the legislation. The time frame of about 4 hours would then more appropriately represent the timeframe necessary for clinicians to assess and process consumers to be transported. Rarely are police more than 4 hours away even in remote areas.

## **Detention of Voluntary inpatients**

9.22. Does the NSW Mental Health Act need to include a provision that allows a nurse employed by the mental health facility to hold a voluntary patient wanting to discharge themselves against medical advice? Why/ why not?

MHCC agree that there are some circumstances where it is necessary for nurses to have the authority to detain a person they have assessed as being mentally ill or disordered. However, this role should only be designated to a Registered Mental Health Nurse with a minimum of 5 years experience. This is particularly necessary in rural and remote areas where often a psychiatrist is unavailable, and where an authorised person is required to both detain and discharge a person from a designated mental health facility (DMHF). MHCC emphasise the need for recognition of the competencies and expertise that exist amongst practitioners of disciplines other than psychiatry. In fact, very often members of a treating team particularly mental health nurses have more regular interactions with a consumer, and know better the baseline presentation of an individual and have knowledge of what has helped recovery in the past.

9.23. In what circumstances, if any, would it be reasonable to hold a voluntary patient who wanted to discharge themselves before an authorised medical officer could undertake a review?

It is only reasonable to hold a voluntary patient if they are a risk to self and others and are, under the definition in the MHA a mentally disordered person (e.g. psychotic and at risk of suicide or serious self-harm). In our view, being mentally ill or having a continuing condition is not sufficient reason to hold a person against their will. Bearing in mind consideration concerning a person's capacity to make decisions discussed earlier (4.1 & 4.2) in such circumstances consumers should have access to processes that support decision-making and appropriate care coordination ensuring that they will be not discharging themselves into an environment that puts them at risk.

9.24 If allowed, what would be an appropriate time period of the mental health nursing staff to hold a voluntary patient pending a review by the authorised medical officer?

If a person is assessed as a risk to self and others and is mentally disordered as defined under the MHA, and is demonstrating impaired judgement, nurses have a duty of care to detain them until such time as an authorised medical officer can conduct a review. However, every attempt should be made to organise a review within 4 hours and should an authorised medical officer be unavailable, alternative means such as video-links and SKYPE should be utilised to conduct an assessment.

9.25 If mental health nursing staff were to have such authority:

- a) What skills and experience would be required?
- b) Should a specific staff position (or positions) in the facility be nominated?

a. MHCC understand that earlier amendments to the MHA made in 2010 enable other mental health professionals i.e. suitably qualified mental health nurses and suitably qualified psychologists to be appointed authorised persons under the Act. Under Definitions (4) in the Act, 'authorised medical officer' of a mental health facility means: (a) the medical superintendent of the mental health facility, or (b) a medical officer, nominated by the medical superintendent for the purposes of this Act, attached to the mental health facility concerned. Under (b) such a nomination already includes an appropriately qualified registered mental health nurse.

We understand that this practice is currently operational in some remote areas, e.g. Lightning Ridge. The training required is currently available provided for example at the NSW Institute of Psychiatry. Such training should be made more widely available to experienced mental health nurses and clinical psychologists working in areas with poor access to authorised medical officers, willing to take on those roles.

b. Yes, specific positions should be nominated in the facility, so that there is always someone available to make an assessment 24/7, and that no ambiguity arises as to whose role has the appropriate authority.

9.26 Are there any other comments you wish to make concerning this issue?

The other side to coercion is neglect. A consumer also has the right to be protected and nurses will naturally be inclined to fulfil their duty of care in an emergency. However, attention should always be paid to the consumer choice, and whilst a person may not be assessed as a mentally ill or mentally disordered person and at risk of harm to self and others they or their family/carer may genuinely feel they are at risk and have a right to be protected. More often than not, there is great pressure on beds, and whilst the issue of coercion and involuntary detention are well publicised human rights issues, a less discussed matter is those people unable to access services because they fail to meet the criteria. (MHCC have discussed this further under the title OTHER, item 4. where we have discussed appeals regarding non-access to services).

**Initial Assessment for Involuntary Detention**

10.27. Where medical and psychiatric resources are limited, are there other mechanisms for enhancing the quality and access to Form 1 assessments?

In circumstances where there is limited access to psychiatric resources (such as in rural/remote locations) use should be made of audio visual access to psychiatrists in other locations. MHCC recommend the establishment of a network of senior clinicians in the public system (with access to AV) able to provide external advice. Where possible and where not distressing for the consumer, an external clinician should 'meet' the consumer via audio visual. However, as already suggested (9.22) there are some circumstances where it is necessary for nurses to have the authority to provide an assessment as to whether a person is mentally ill or disordered. However, this role should only be designated to a Registered Mental Health Nurse with a minimum of 5 years experience. Likewise, if a senior clinical psychologist of more than 5 years experience is available, their skills and expertise should be recognised and assessment must be made collaboratively with experienced mental health nursing staff. Where only telephone advice is possible, this should only be used as a last resort and policy concerning any kind of external assessment advice should be recorded and appropriately noted in a form designed for this specific purpose.

10.28. Should accredited persons have a role in completion of the Form1 and under what conditions?

This question is unclear since Form 1 is completed by the authorised medical officer after examination of the person under s27.

11.30. Do you believe that the Act should be amended to allow for Form1 assessments by video link at certain prescribed health facilities in rural and remote areas in NSW? Why/ why not?

MHCC have mostly addressed this question in 10.27. However, what not previously discussed are circumstances when a person is brought to or self-presents at a non-gazetted facility and no suitably qualified staff with mental health expertise are available. In such instances a local GP with mental health experience should be available to assess the person concerned with an external psychiatrist via video-link. This is far from ideal, so if the person to be assessed has had prior contact with services in the community and those contacts are known, e.g. carers, community services such as HASI providers, drug and alcohol services etc., these mental health workers should be contacted to provide relevant information.

11.31. Are there any other potential methods of addressing this issue which you believe may provide same or similar benefits to that of the proposal?

This question has been answered in 11.30.

11.32. What practical issues do you think need to be addressed in implementing such a proposal and how do you think they should be addressed?

MHCC understand that video-link may not be available in some remote areas, and that transporting a person may be impracticable and undesirable. However, every hospital has internet access and use can be made of SKYPE audio-visual technology so that a Form 1 assessment can be completed. Using the telephone as an option is really unsatisfactory.

11.33. Are there any comments you wish to make concerning transport of persons for assessment?

The National safety priorities in mental health: a national plan for reducing harm, 2005. Australian Council for Safety and Quality in Health Care sets out good principles for safe transport of people experiencing mental disorders. As the document makes clear 'mental health consumers have the right to safe transport that minimises interference with their rights, dignity and self-respect and that avoids traumatising family members, particularly children.' Of particular concern to MHCC is the use of restraint, including sedation, during transportation and the experience of significant stigma that adds to psychological distress and creates a negative perception of care. When consumers are transported long distances in order to be assessed, by police rather than the ambulance service, this can be particularly distressing and every effort must be made to avoid adverse events. People should not be transported long distances without a suitably trained member of staff, strictly adhering to clear policies and protocols to ensure that the least restrictive, and safe transport of people experiencing a mental illness is used. Despite being less than desirable, assessments as recommended in 10.27 and 11.30 – 11.33 are preferable to transportation of people long distances.

### **Review of treatment, planning and medication**

12.34. Should the Act be amended to include provision for treatment review and if so, what limits should be placed around this?

It is explicitly stated in s68 Principles for care and treatment that:

- (e) People with a mental illness or mental disorder should be provided with appropriate information about treatment, treatment alternatives and the effects of treatment, and that:
- (h) Every effort that is reasonably practicable should be made to involve persons with a mental illness or mental disorder in the development of treatment plans and plans for ongoing care.

However, in practice, consumers are often minimally involved in developing treatment plans, evident by the fact that goals identified in involuntary treatment plans, rarely include stated aspirations identified by the consumer. Often, consumers express their experience of not being listened to; their concerns regarding medication side effects, negative physical health outcomes and mode of delivery minimised; and poor information sharing about alternatives that could be offered. Whilst, we recognise that this is an area that presents many dilemmas for service providers and is a contentious one in terms of the research, and different models of practice across disciplines, the MHA needs to make the Principles clearer by embedding recovery principles in the legislation, leading to improved implementation into practice and establishing greater obligations on service providers to maximise consumer self-determination.

People under the MHA should have access to a treatment review when requested during their appointments with their treating psychiatrist and such requests should be seen with a focus on the therapeutic relationship between consumer and clinician. The consumer should be afforded adequate opportunity to discuss their concerns, make their goals clear and be provided with information and support regarding potential alternative options.

12.35. Should patients on a CTO also be able to apply for treatment review?

a. Whilst people on a CTO are obligated to keep appointments with their treating psychiatrist (usually every 1-3 months) consumers frequently report that these arrangements do not provide adequate opportunity for them to have their medication reviewed. Even when a review is undertaken, consumers would prefer an independent review from outside the service team because their perception is that fixed views and loyalties exist between those in a treatment team/ facility. MHCC recommend that every consumer be entitled to one independent treatment review after 3 months in a mental health facility, and 3 months when on a CTO.

b. MHCC's recommendation is that the Act provide for an expanded questioning and accountability monitoring role to be undertaken by the MHRT. Likewise, we propose that consumers are better informed about the role of Official Visitors (OVs) and supported to have greater access to an OV under s129 (referring matters raising any significant public mental health issues or patient safety or care or treatment issues to the Principal Official Visitor or any other appropriate person or body). This would require an enhanced role for OVs and increased access, especially to people transitioning out of hospital back into the community quickly. There is some evidence that this oversight role expanded to consumers in the community would be beneficial. This would require government commitment to greatly expanded services, and this might be undertaken in a number of ways including the engagement of non-government services to collaborate more closely with OVs and treating teams supporting consumers to access treatment reviews.

12.36. Should the treatment review be undertaken by the MHRT or another party? What would be the role of the Medical Superintendent?

In our view the treatment review should be presented to the MHRT as a review /variation and the medical superintendent be responsible for providing the person requesting the review with an alternative clinician that the consumer is satisfied is independent. The MHRT should not have to conduct an actual hearing unless there is a change to the treatment plan. If a treatment review has occurred there is no reason for the MHRT do anything but sign acknowledgement in the file that such a review was conducted, unless the consumer is dissatisfied with the outcome and requests a review.

13.38. Should the legislation include any specifications regarding treatment of children with ECT? If yes, please provide.

It is widely accepted that ECT is an undesirable treatment for any person under the age of 18, because of the possible risks to a developing brain. However, circumstances do arise where for example a child may have unremitting psychosis that has not responded to any medication. In such circumstances we propose that certain safeguards should be in place to make sure that every care has been taken in assessing the need for this treatment. We propose that 2 independent specialist child psychiatrists should be consulted as well as a psychiatrist with expertise in neuroscience and research in the field of ECT (e.g. Loo, C, Mitchell, P, Sachdev, P, McDarmont, B, Parker, G, & Gandevia, S, 1999. 'A double-blind controlled investigation of transcranial magnetic stimulation for the treatment of resistant major depression,' American Journal of Psychiatry, 1999; 156: 946-948). We recommend that a majority decision would need to prevail in order to proceed.

13.39. Are there any other comments you wish to make concerning ECT?

a. In NSW ECT may be administered to voluntary clients with their informed consent, or when capacity is in doubt only with the authority of the MHRT determining whether a person is capable of consenting and has consented. However, for involuntary clients, the tribunal can approve ECT if 'the patient is incapable of giving informed consent or is capable of giving informed consent to the electro convulsive therapy but has refused, or has neither consented nor refused, to have the treatment administered,'(s96, 3b,i). Thus as Carney et al, write "capacity does not provide rights to decide whether to undergo treatment." This presents a 'catch 22' situation, where a person demonstrates that they understand what ECT is, and refuse to give consent. This is likely to be assessed as evidence of their lack of capacity. In our view, this dilemma could be addressed if the legislation was drafted to make clear that only in circumstances in which it can be determined that capacity is not present is when a person expressing refusal to consent has (for example as a consequence of severe depression) impaired judgement resulting in nihilism, and that they do not propose willingness to engage in any alternative treatment if available.<sup>vi</sup>

b. MHCC recommends that data should be publically reported on the numbers of ECT treatment provided in both public and private settings. The reports should reflect more than overall numbers but provide information for example on age range and numbers of people on maintenance ECT.

### **Psychosurgery**

14. 40. Should the legislation be amended to permit the use of psychosurgery, including deep brain stimulation? If YES, what sort of restriction or limitations should be imposed? Please provide details.

During the review of the MHA1990 in 2006, and draft exposure bill in 2007, MHCC noted the conclusion reached by the Psychosurgery Review Working Group - that psychosurgery can be effective for, "a very small and specific group of patients suffering from some chronic, disabling and treatment resistant psychiatric illnesses." We acknowledge the submissions from several psychiatrists reiterating this view. This group of consumers should not be disadvantaged by the prohibition of a form of treatment to which they wish to consent and that may give them relief from the severe, long-term distress caused by their mental illness.

14.41. Are there any other comments you wish to make concerning psychosurgery or deep brain stimulation?

Any consideration of psychosurgery would have to come with the proviso that rigorous measures are put in place to ensure that consumers are fully informed of their rights, options and possible consequences of the procedure and that consent is genuinely informed consent. We stress the point that psychosurgery should be banned as an involuntary procedure in any circumstances.

### **Declaration of Financial Interest**

15. 42. Should medical practitioners who propose or administer ECT be required to disclose any financial or commercial relationship with the facility in which it is proposed to administer the treatment (other than being an employee)?

Medical practitioners should be obliged to disclose any financial or commercial relationship with a facility in which it is proposed they administer the treatment, even if in this instance they are an employee. For example, some medical practitioners may be part-time employees, but be contracted as a private practitioner to undertake other roles or referrals.

15.43. Should the requirement for disclosure of financial relationships be limited to the administration of ECT, or should it be broader, for example medication, surgical procedures, or admission to and treatment within private facilities?

Disclosure should include any financial relationship across provision of all services including admission to private facilities.

### **Consumer engagement in the development of treatment plans**

16.44. Should treatment plans developed with consumer input be formally recognised in the Act, and if so, how?

MHCC strongly recommend that consumer input into treatment plans is formally recognised in the MHA to ensure that the treating team take the person's goals for recovery into account. This ensures that recovery principles are embedded in the legislation including the principle of 'nothing about us without us', highlighting the importance of respecting 'lived experience'. The current format of the treatment plan template has a section requiring the Goals and Objectives of the treatment plan. Whilst generalised comments on behalf of the treating team are always present, usually identifying their goals for the individual. Almost never is any reference made to consumer identified goals. We propose that a section be specifically added to the template requiring the individual's input into the treatment plan.

Newton-Howes and Mullen (2011) write "it does not seem to serve patients' best interests to diminish their freedom to make decisions". There is clear evidence that involving consumers in developing their treatment plan has positive outcomes. At the very least, involving consumers increases engagement in their own care promotes autonomy. As outlined in the Victorian Government's 'Treatment Plans under the Mental Health Act: Chief Psychiatrist's Guideline' document, this process of involvement fosters open and ongoing communication between the health service and the consumer in which information is shared, and self-directed care is encouraged (p. 2).<sup>vii</sup>

In circumstances where a person lacks capacity and is unable to contribute to the development of a treatment plan at a point in time, they should be provided with the supports and information to be involved at each step of the process as previously outlined in MHCC's recommendations in responses to questions 4.1 and 4.2 concerning supported decision-making and OTHER points 1 & 2.

As previously noted, supported decision-making and the recognition that capacity is decision specific. As such, a person may be able to make decisions about some elements of care even when involuntary, and this point is emphasised (Brayley, 2010). What also requires recognition under the MHA is the role of carers or significant others in treatment planning, where appropriate and where the consumer consents.<sup>viii</sup>

16.45. In what circumstances should such treatment plans be allowed to be overridden?

In order to ensure that people experiencing mental illness are treated equally before the law, it is imperative that decisions about treatment plans be based on whether the person has the capacity to make decisions for themselves, rather than whether the outcome is considered most beneficent in the eyes of the practitioner (O'Brien, 2010). For example, if a person is aware of their situation, has a good understanding of the options available to them and is capable of making a decision to be on one type of medication over another, or none at all, then despite belief that it is not the 'right decision' this treatment plan should not be overridden.

It is only in the circumstance that a person is deemed not to have capacity, and is unable or unwilling to be supported to make decisions, that a treatment plan should be overridden without agreement from the consumer. It goes without saying that any changes must be according to their best interests. As the legislation already makes clear the presence of a mental illness does not necessarily mean a loss of capacity (Ryan, 2011).<sup>ix</sup>

### **Non-admission and discharge of persons brought involuntarily to a declared mental health facility**

17.46. Do you think that concerns about non-admission and discharge are an issue that requires legislative and/or policy reform? Please provide reasons.

MHCC propose that people who lack decision-making capacity should be able to access treatment that is in their best interests, without having to show that they are at risk of some kind of "serious harm" additional to the harm involved in just having a treatable illness.

17.47. What do you think are the most appropriate means of addressing the issue? Why do you believe these are the most appropriate means?

MHCC recommend that people refused admission to mental health facilities should have a right to appeal a non-admission decision, and that their primary carers should be able to appeal on their behalf, bearing in mind supported decision-making and considerations regarding capacity taken into account as discussed earlier in (4.1).

17.48. If a mechanism for appealing decisions about non-admission and discharge was introduced, which independent body (or type of person/professional) should be responsible for hearing these appeals?

MHCC believe that the MHRT are the appropriate body to conduct these hearings and that these hearings could be single member hearings unless a three person hearing is requested by the person appealing the decision. There needs to be the facility to conduct a response within 24 hours in such circumstances.

17.49. Are there any other comments you wish to make concerning this issue?

The person appealing the decision should also be able to request a face to face hearing.

### **The Rights of Primary Carers**

18.50. What type of information relevant to follow-up care should be provided to the primary carer? Should the Act specify the types of information to be provided?

The only information a carer should be provided with is that which directly relates to the psychiatric care and treatment of the person under the MHA, and only with the permission of the person concerned or guardian if appointed. Likewise, with a consumer's permission, a nominated or primary carer should be informed concerning discharge planning and follow up care in the community which may affect decisions made around care of the 'least restrictive kind'. For example a person may be discharged on the basis that their carer has agreed that they can reside at their premises, and this may have affected the decision to discharge if the person were otherwise to become homeless.

A policy framework must be developed to provide guidance to clinicians concerning information sharing with carers. Such policy should be referred to in the legislation.

18.51. In what circumstances, if any, should the Act permit or require disclosure of information to persons affected by a patient's discharge (e.g. absconding or leave)?

Disclosure of information regarding a person's discharge, leave or absconding should only be directed to primary or nominated carers, and in circumstances where a consumer is unwell and has absconded and has an AVO in place, wherever possible a person protected by the AVO if known should be informed. This of course does not apply to those services and professionals involved in care coordination and transition of services.

18.52. In what circumstances, if any, should primary carer rights be extended to other family members? What type of information should they be eligible to receive?

a. Only in circumstances where a primary carer is not contactable (e.g. overseas) and the consumer has been subject to a serious health emergency that puts their life at risk, or they have absconded, should other members of the family be contacted. Ideally when a consumer has capacity, treating teams should be advised as to alternative contact people are in emergency circumstances. Equally a consumer may want to identify particular people who they do not want to be contacted.

b. We highlight at this point the issue of primary carers who are children or young adults. In many situations whilst a child may not be known as the primary or nominated carer, particularly in single parent families, this may well be the reality. A young person may be undertaking a range of responsibilities including looking after siblings, and treating teams must pay real attention to family dynamics and interests so as to minimise some catastrophic outcomes when a parent becomes hospitalised.

Children have reported that in such circumstances they have been parked with ex-partners with whom there is little or fractious relationships, or separated from siblings in out of home care and unable to visit the parent that they have been caring for. Mostly, however the complaints centre around unwillingness to inform and talk to a young person about care and treatment and investigate what contributions they can make to discussions and what supports can be provided to ensure better outcomes for both the consumer and their children.

MHCC recommend that a legal requirement of admission includes a question to identify children and other family members closely involved in caring for the consumer so that they can be contacted, supported and provided with appropriate information (see also 18.50).

18.53. In what circumstances should the Act permit or require disclosure of information to estranged carers and families without patient consent?

In the event of no primary carer /nominated carer existing, disclosure to estranged families without a patient's consent should only occur in the event of their death occurring.

18.54. Are there any other comments you wish to make concerning the rights and recognition of primary carers?

a. MHCC recommend establishment of an electronic national nominated carer register to be accessible to all gazetted hospitals, public and community mental health services. The registration of a primary/nominated carer should be initiated only by a consumer as an advance directive entered into the system by a medical practitioner, when they have capacity or by their guardian. The register should state who they wish to be involved in their care and treatment and informed concerning discharge etc. Equally the consumer can identify those people they wish not to be contacted in any circumstances. We understand that consumers can opt to provide this information via ehealth since

July 2012. At the moment it is often unclear as to whether a carer has been nominated or is assumed to have a relationship or interest in the consumer.

b. The amendments to the *NSW Mental Health Act 1990* present in the 2007 Act (Chapter 4, part 1, Division 2s 73-s79) are felt to be a reasonable balance between the recognition of the importance of carers by providing them access to some information to help them provide care, whilst at the same time enabling the consumer the right to control who is able to access this information. From consultations with carers MHCC have been given to understand that carers are pleased to have been given special rights to be informed of some legal proceedings that are held under the Act and to be given other specific patient information, and that this has been a move that has led to a cultural shift in the willingness of those treating a person under the Act to meaningfully engage with carers throughout the recovery journey. Carers are characteristically encouraged to be involved, including at appointments developing treatment plans (with the consumer's consent) and at inquiries and hearings.

### **Role of Official Visitors**

19. 55. Should the role of the Official Visitors be expanded or more clearly defined? Please provide details.

MHCC recommend that the role of the OV is substantially expanded. As it stands OVs are not as visible in the system as they should be. Often people request to see an OV, but the consumer is discharged prior to the OV visit. Consumers also need to be better informed about the role of the OV and offered greater opportunity to meet with an OV.

19. 56. Should Official Visitors have the right to monitor the care and treatment of consumers who are detained under the Act but admitted to wards other than a mental health facility?

Yes. Our understanding is that greater clarity is necessary concerning the position of consumers in medical and surgical wards that are not part of a 'declared facility'. We propose that OVs should be notified of such circumstances and have the right to monitor the care of these people, especially when the person was admitted directly to the facility and mental health services may be unaware of the admission. Usually when a medical admission is referred from a mental health facility there is greater scope for care coordination, so it is important that consumers have access to holistic care and treatment across the service systems.

19. 57. What is the scope and best reporting pathways for Official Visitors? How can this be standardised?

MHCC's understanding is that there are standardised visiting and meeting forms that work well. Any concerns raised during visits are expanded on and followed up at the next visit, and any ongoing problems are raised with the Principal OV who reports to the Minister. The problem as we understand it is the lack of time to undertake the broad spectrum of tasks undertaken by the OVs and times allocated to report writing which we are told is inadequate.

19. 58. Are there any other comments you wish to make concerning the role and responsibilities of Official Visitors?

a. We recommend that fees paid be commensurate with the work undertaken by Tribunal Members. This would provide greater access to people with appropriate qualifications and experience who are unable to undertake the work at the nominal fees on offer.

MHCC value the contribution of community OV's with 'lived experience', some are trained professionals and some are not. However, we are aware of the limited resources available to provide community OV's with sufficient training. Whilst the OV puts on its own excellent training opportunities, access to external training is limited. MHCC are one of the organisations that characteristically offer some sponsored places at forums and conferences, but the Ministry, particularly in the light of the paltry fees should at least fund some external Professional Development and practice supervision per annum, per OV.

b. We understand that documentation could be improved around reporting to the OV with regards to the 'seclusion' register, and that more training is necessary in the facilities to adequately inform the OV concerning these matters.

### **Role of the Mental Health Review Tribunal (MHRT)**

#### 20.59. Should the Act be amended to further strengthen or clarify the role of the Mental Health Review Tribunal?

The use of the word strengthen in this question could be misleading and in itself requires further discussion. To strengthen could be understood as suggesting the MHRT to have increased powers as a quasi-judicial body over the health system in which people are 'treated, cared for and controlled'. Alternatively it could be interpreted as: that under a more contemporary piece of legislation the MHRT could maximise the human rights of those individuals under the MHA. Therefore, we discuss as follows:

According to Winick (2003:24) "the medical model granted too much deference to physicians to make the essentially legal determination of when fundamental liberty can be taken away. It produced sometimes unnecessary deprivations of liberty for unnecessarily long periods of time". Like the medical model, "the legal model has also been subject to criticism on the basis that it has transferred power to lawyers and judges, who often have little understanding of a client's needs; and that, by emphasising legal needs, it can neglect the client's therapeutic needs" (Carney et al, 2011). MHCC propose that the purpose of the legislation is to promote the principles of therapeutic jurisprudence, which seeks to find ways in which the legal model can be applied to balance legal and therapeutic criteria, in order to enhance the therapeutic outcomes for people subject to the civil commitment process (Winick, 2003:24, 25). The MHRT can only work within the legislation that it has, and its decisions can only be as efficacious as the law enables.<sup>x</sup>

Vivienne Topp, solicitor presenting at the LIV conference in 2002 said that therapeutic jurisprudence has at its centre a view of the law as a therapeutic agent. It focuses on the law's impact on emotional life and on the psychological well-being of the individual. What this means for individuals is that the processes of, and outcomes from, the law are considered in terms of how they impact on the whole person. This perspective sits well with the principles of recovery.

Traditionally the role of the MHRT was based on two principles: police power and *parens patriae* power. The police power safeguards the community from harm, based on the finding of mental illness and risk of harm to self and others. *Parens patriae* power involves the state acting for a person in their 'best interests' when that person is deemed to lack capacity to make appropriate decision for themselves (Carney et al, 2011). We share the growing legal concern with the application of human rights principles and the therapeutic consequences of such decision making.

How the MHRT can resolve the fundamental tensions between consumers' care and treatment, their rights and their treatment needs and future risks and balance those between the interests of the community, is a hard call. Through statements of principals and goals, mental health legislation gives shape to the direction of public mental health services, and it will only be through embedding

recovery principals in the MHA that the MHRT can be empowered to determine whether proposed involuntary and voluntary care and treatment or discharge meets the necessary criteria for all concerned. The over-riding aim should always be a return to autonomy, maximising self-determination and independent living.<sup>xi</sup>

#### 20.60. How can it be strengthened to further facilitate the objectives of the Act?

a. MHCC reiterate earlier recommendations concerning various ways in which the MHA and the role of the MHRT can be strengthened to facilitate the objectives of the Act - primarily by embedding Recovery Principles, principals of supported decision-making and the use of advance directives as central components to meeting the requirements of the UNCRPD to which Australia is a signatory.

However, additional mechanisms could be initiated that would enhance the work of the MHRT and set some benchmarks for good practice. We propose that feedback in terms of reports on the efficacy of treatment plans and the ability to implement CTOs could be made requirements at review that could be interrogated more thoroughly. This would lead to greater accountability concerning engagement with community services and social inclusion, access to therapeutic alternatives and recovery pathways. Such initiatives would greatly improve the therapeutic role of tribunal hearings, which ideally should become a process in which consumer and carer perspectives are heard and validated and seen as a positive monitoring process towards recovery and self-determination, and a place in which consumers feel their concerns get a fair hearing.

b. The MI Principles (UNCRPD 46/119: The protection of persons with a mental illness and improvement of mental health care) outlines states' obligations in relation to the independent oversight of mental health decision-making, and procedural rights to be afforded to people subject to them. At each review the MHRT must consider whether the criteria and rationale are still satisfied, and if not discharge a patient. Considerations of the MHRT should better balance the dignity of risk and potential paternalism presented by treating teams.

#### 20.61. Should there be a formal relationship between the Official Visitor Program and the Mental Health Review Tribunal?

The role of the OV needs to be clarified. The mission statement reads that "The Official Visitors Program aims to safeguard standards of treatment and care and the rights and dignity of people being treated under the *NSW Mental Health Act 2007* while maintaining an independent community perspective". However, the OVs are not strictly independent of the health system since they have a MOU with the MHRT and have an agreement whereby a system is in place for raising issues identified by the Tribunal or OV Program in relation to the other body, and the MHRT Registrar is a member of the OV Advisory Committee. So we would suggest that there is no need for a formal relationship as the two bodies are already collaborating effectively.

#### 20.62. Are there any other comments you wish to make concerning the Mental Health Review Tribunal?

MHCC wish to highlight the importance of drafting the legislation to better focus on the role of service/ care coordination as an area for improvement in treatment planning particularly for discharge and review for people on CTOs. This necessitates discussion on role delineation and workforce development across professional disciplines working in public, private and the community sectors working with people under the MHA. Whilst this aspect of care is characteristically thought of as an area for policy standards and guidelines rather than legislation, there is no reason why the MHRT could not play a more significant role in monitoring care coordination through case manager report mechanisms.

Frequently, public mental health services have a poor understanding of the range of community managed support services available in a particular location. Engagement with services and social inclusion is not just dependent on the willingness of a consumer to engage, but on competencies of case workers, many of who are trained in disciplines that provide scant knowledge of the NGO mental health community managed sector. A quality management system for feedback should be a requirement of the treatment plan/report back if a CTO review occurs. If the MHRT question in a review the person's engagement with other services, an obligation on the part of the health agency could be introduced into the legislation that requires the case manager to report back on that aspect of care in detail next review.

## **OTHER**

Are there any other comments that you wish to make in relation to the NSW Mental Health Act 2007?

1. Advance directives have legal force in NSW (Common Law). They are most effective if they are made in consultation with treating health-care professionals (i.e., GP, case manager and/or psychiatrist). MHCC propose that consumers be encouraged to write advance directives that set out what they want to happen if they become incapable of making decisions for themselves. This should include information about who they do or do not want to care for them, or what treatment they want or do not want. Advance directives should be referred to in clearly in the Principles for care and treatment (s68) following on from point (i) inserting after (*people with a mental illness or mental disorder should be informed of their legal rights and other entitlements under this Act and all reasonable efforts should be made to ensure the information is given in the language, mode of communication or terms that they are most likely to understand*), this should include information concerning their right to make an advance directive when they have capacity.
2. Advance directives continued. Under Schedule 3 Statement of rights (Section 74 (3)) Statement of rights - Your rights - additional information should be provide concerning the law with regards to Advance Directives in NSW. We note that a variety of advance directives have been considered by the courts in NSW that have ruled they should be upheld and enforced in certain circumstances. However, whilst there is no limit what can be put in an advance directive, unlike other Australian states, NSW does not have any written laws about advance directives. We refer to the work of the Australian Ministers' Advisory Council, in 2011, A National Framework for Advance Care Directives particularly in reference to the code for ethical practice and best practice standards (pp.14 -17).<sup>xii</sup>
3. Criteria for involuntary treatment. The MHA currently permits coercive treatment of persons living with mental illness if it is considered by two doctors to be necessary to prevent serious harm to the person or to others (s14). Although harm-based criteria have historically existed in mental health laws all over the world, more enlightened approaches to mental illness (as reflected in human rights obligations under the UN Convention on the Rights of Persons with Disabilities, Article 12) have cast doubt on the appropriateness of this approach to involuntary treatment. In particular, there has been a shift towards a view that mentally ill people who retain legal capacity to make medical decisions should be able to refuse medical treatment if they do not wish it, regardless of perceived risk of harm without that treatment. This would give persons with mental illness the same rights as all patients in general medicine - and is reflected in legislation in Scotland (Mental Health (Care and Treatment) (Scotland) Act 2003 (UK)), and in proposed new mental health legislation in Tasmania and Victoria. MHCC have concerns that this approach may lead to neglect of a person who may refuses to engage with services.

MHCC propose that criteria based on harm alone or capacity alone would not represent best practice. What are necessary are more nuanced considerations that need to be made explicit in the Act. We suggest that currently decisions made by the MHRT clearly evoke capacity as part of review/ inquiry considerations. For example if a person has a history of risk of harm to self and others, and their continuing condition (s14 ) including any likely deterioration in the person's condition and the likely effects of any such deterioration, are taken into account including the possibility of lapsing into an acute phase of illness, are considered from the point of view of a person's current capacity to acknowledge their need to engage with services and willingness to do so without coercion (i.e. a CTO) as the least restrictive care (s53,68 etc.) and the length of time that a person has consistently shown capacity. (See also: Other Item 6 below).

4. Right to care. The International Covenant on Economic, Social and Cultural Rights (ICESCR: 2000) recognises “the right of everyone to the enjoyment of the highest attainable standard of physical and mental health”. Article 12(2) outlines the steps that states should take to initiate full realisation of those rights including those steps to ensure access to the services and support necessary for all who become ill, (Carney et al, 2011).<sup>xiii</sup> The covenant states that “the right includes the right to services that are accessible, acceptable, appropriate, and of good quality.” It is only by entrenching such goals (including cultural appropriateness) in legislation that states will get serious about the requirements necessary to meet the objects of the parliament, and become more accountable to provide the services in the community to meet those needs.
5. Legal representation. The absence of legal representation at most hearings other than involuntary detention, particularly for people with co-existing cognitive disability and mental illness raises questions as whether representation should not be more widely available as it is in other jurisdictions (e.g. the UK). It is very difficult for a consumer to adequately represent themselves in terms of their status under the MHA or address the relevant aspects of their treatment plans before the MHRT. This also requires that people whose capacity is in question should be appropriately supported and given adequate time prior to a hearing particularly when instructing the solicitor representing them. This should include access to information concerning the hearing process and likely outcomes.
6. Wide use of CTOs. The WHO reported in 2003, that in the face of growing demand worldwide, CTOs remain one of the most contentious issues in psychiatry, their efficacy remaining unclear (Light et al., 2012).<sup>xiv</sup> An international review of empirical data on CTOs concluded that “it was impossible to state whether they were beneficial or harmful, that there was inconsistent evidence about the effects of CTOs on clinical and quality-of-life outcomes, and that stakeholder perceptions were mixed”(Churchill et al., 2007).<sup>xv</sup> A Cochrane review in 2009 concluded that CTOs might not be an effective alternative to standard care, and that even if they are effective, whether any benefit is due to the compulsory nature or simply the intensity of the treatment they facilitate (O'Brien et al., 2009, cites in Light et al., 2012).<sup>xvi</sup>

Most specialised mental health services in Australia are provided in community settings, one in six is involuntary. The number of CTOs made in NSW has been increasing in NSW (NSW Mental Health Review Tribunal Annual Report 2011/2012) reports growth of 25% over 3 years: 2009-10/ 3956 - 2010-11/4694 - 2011-12/4984

Research has also shown that rates of CTOs appear to be higher in Australia than in other countries as follows (Lawton-Smith, 2005):

Canada (Ontario and Saskatchewan)	2 per in 100,000
US (New York)	2 per 100,000
AUS (Qld, Vic), NZ, US (Columbia)	40-60 per 100,000

There is also significant variation in the rate of CTOs across different Australian jurisdictions (Light et al., 2011).<sup>xvii</sup> This suggests that CTO use is not necessarily always tied to clinical or other

benefit for the individual. The research clearly indicates that use of CTOs is not evidence based. While some studies have shown that there may be some benefits for people who have a diagnosis of schizophrenia, most research concludes that at best the evidence is equivocal (Churchill et al., 2007; Rolfe et al., 2008; Kisely et al., 2011).<sup>xviii</sup>

A significant justification for the use of CTOs is what is termed 'non-compliance' with medication. However, it must be understood that people often refuse to take their medication for other reasons including side-effects. Further, while there are alleged benefits of coercing people to comply with their treatment plan, this coercion is a reason for people wanting to disconnect with the mental health system and in fact contradicts the foreseen benefits through increasing feelings of stigma and alienation (Rolfe et al., 2008).<sup>xix</sup> It has been found that consumers may be less likely to engage in treatment once a CTO has been lifted than if they had not been coerced into treatment (Moncrieff & Smyth, 1999).<sup>xx</sup> Where 'clinicians' are more likely to view CTOs more favourably, consumer views are mixed and more often negative than not (O'Brien et al., 2009; Rolfe et al., 2008).<sup>xxi</sup>

A CTO being in place is often the reason for a poor therapeutic relationship with a case manager and treating team, and often escalates the situation if a CTO is coming up for review. Section 53 (7b) refers to the importance of the therapeutic relationship in that; "in determining the duration of a community treatment order, the Tribunal must take into account the estimated time required: (b) to establish, or re-establish, a therapeutic relationship between the person and the person's psychiatric case manager". We suggest consideration of the detrimental impact of the CTO itself particularly when the CTO is extremely hard to implement and serves only as a breaching mechanism. Alternative strategies need to be legislated.

In our view the extraordinary number of CTOs in place as well as people unnecessarily detained in mental health facilities involuntarily in NSW is demonstration of a failure of the system to provide appropriate prevention, early intervention and recovery support services in the community. Whilst, the legislation itself cannot legislate for services to exist, the legislation is interpreted to make allowances for the failure of the system to provide care and treatment of the 'least restrictive kind'. We recommend that the legislation be sufficiently rigorous as to obligate the government to provide the necessary supports to provide the least restrictive care in real terms. We draw attention to the Ombudsman's report

*Denial of Rights: the need to improve accommodation as support for people with psychiatric disability*, which was tabled in the NSW Parliament on 29 November 2012.

The report follows the Ombudsman's inquiry into the access of people in mental health facilities to accommodation and support services under the Disability Services Act 1993, conducted in 2011-12. The report points to "the need for significant work to be done to uphold the right of people with psychiatric disability to live in the community, to receive treatment in the least restrictive environment possible, and to have fair access to disability support".<sup>xxii xxiii</sup>

7. Australia's Human Rights obligations. Australia has ratified a number of international treaties including the UNCRPD, e.g., the International Covenant on Civil and Political Rights (ICCPR) and the International Covenant on Social and Cultural Rights (ICESCR). Australia is responsible for complying with these instruments, but they will only become part of Australian law once implemented through domestic legislation. Obligations arising under these conventions are not justiciable within domestic courts, although the Commonwealth, State and Territory governments have committed to implementing human rights principles in National Mental Health Strategy. In 1992, Australian governments agreed to develop legislation that was consistent with the principles relating to people with mental illness, and the Attorney General's department concluded that each jurisdiction's mental health legislation either complied or was being amended with these principles. However, several commentators have noted that changes

in the intervening years have not significantly resulted in the protection of human rights in a mental health context (Carney et al., 2003, cited in Carney, T, Tait, D., Perry, J., Vernon, A., Beaupert, F. 2011, 'Australian Mental Health Tribunals: Space for Fairness, Freedom, Protection and Treatment.' Themis Press: pp. 37-39).<sup>xxiv</sup>

MHCC propose that this review of the NSW MHA presents an opportunity for the NSW Government to redraft the legislation to mirror the objectives of various international conventions that the Commonwealth ratified so that the law more effectively protects the rights of consumers and carers, and promotes the highest attainable standard of mental health care. Such a piece of legislation can only strengthen the potential for the Administrative objectives and functions of the NSW public health system as stated in the MHA (s105) to meet the needs of those the Act seeks to protect (Carney et al., 2012).<sup>xxv</sup>

8. Access to treating psychiatrist. MHCC stress the importance of greater access to treating psychiatrists presenting at MHRT hearings. Senior psychiatrists characteristically only assess involuntary patients to certify on admission and discharge, and most usually see people on a CTO once every 3 or 6 months during short consultations. Consumer expectation is that they will have time to talk and build a relationship with their treating psychiatrist which often is impossible in the time available. This is not helpful in terms of building therapeutic relationships, and whilst we understand it is a matter of resources, we would recommend that if a person remains involuntarily in a facility for more than 1 year, or remains on a CTO for more than 2 years that the senior psychiatrist is present at the following hearing/inquiry.
9. MHRT hearing presenters. Hearings frequently take place with case managers who have poor knowledge of a consumer because of staff turn-over or absences due to leave or illness. Whilst understanding that this can and does happen, MHCC would recommend that leave and change overs could be better planned for and that the legislation require best practice in hearing presentations as part of consumer rights to procedural fairness.
10. Seclusion and Restraint. The National Mental Health Seclusion and Restraint Project was a collaborative initiative between the Australian Government and State and Territory Governments. In line with the 'National Safety Priorities in Mental Health: a National Plan for Reducing Harm' the project aimed to reduce and, where possible, eliminate the use of seclusion and restraint in public mental health services. MHCC propose that the key principles for seclusion and reduction practice be clearly reflected in the legislation as principles, outlined in the National Plan for Reducing Harm.<sup>xxvi</sup>
11. Hearing time allocation. There is evidence that in other jurisdictions more time is available to undertake hearings. MHCC stress the importance of the potential for a hearing to play a therapeutic role in the care and treatment of a consumer. Whilst the legislation as it stands makes very clear the limitations of the MHRT to interfere in medical decisions, to most consumers this is at the centre of their concerns, and it is important for them to have the opportunity to express their concerns to an independent body (MHRT) who can at least record those concerns and follow it up if another review takes place. Too often time constraints leave consumers feeling unheard and powerless, and that their hearing is a foregone conclusion. We appreciate the financial constraints that lead to short time frames. Nevertheless, the government must address the issue and support best practice, i.e. that more funds need to be allocated to improve the quality of the hearing experience for consumers, where necessary.

12. Administrative improvements. Two administrative improvements could enable the MHRT to better undertake their role and further facilitate the objects of the Act:

- In the first instance the materials provided at reviews generally include progress notes. These notes are hand written, and it is fair to say that often notes and signatures are very hard to decipher. In these times where computer technology is available to everyone working in the system, there is no reason why notes cannot be typed into a template. This would certainly assist the tribunal members in getting through the material presented.
- It is noted that treatment plans frequently list the medication either by brand or generic names. This is very confusing for the consumer, who knows the medication by the brand name on the prescription and then is confused by the generic name on the treatment plan. We propose that the legislation stipulate that both names must be on the treatment plan. This will also assist non-clinical panel members trying to understand the detail regarding the medications prescribed.

13. Interim estate management orders. NSW is the only jurisdiction in Australia that empowers the MHRT to make interim 'estate management' orders for up to six months, appointing the NSW Trustee as substitute decision-maker, but only for 'detained involuntary patients' (Protected Estates Act 1983(NSW) ss16, 17, 19, 20). Some critics argue that this would be better served by utilising adult guardianship laws, as for other citizens, and that this inappropriately requires that competence is canvassed in all cases (contrary to the UNCRPD: NSW Parliament (2010:101). Our view is that whilst not ideal, that ultimately consumers are better served by access to interim orders determined by the MHRT, than the Guardianship Tribunal in this instance. We believe that this is less stigmatising because it is understood as a temporary order to meet a short-term need.

14. Functionality of the legislation. MHCC have a number of issues that we suggest would improve the usability of the Act.

- Chapter 4 s68. Principles of care and treatment. As suggested earlier this submission, Principles expressing the central purpose of the Act and intention of the parliament, should appear as the frontispiece to the Act (not in the middle as s68).
- A complete glossary of terms and definitions to be available in one place in the Act, in addition to where relevant to particular chapters.
- Whilst the request for release if refused or not determined within 3 working days can be appealed to the Tribunal (s44) nowhere identifies complaints mechanisms that a person may want to access concerning their care and treatment. We recommend that this might be useful information to add to Part 1 – Rights of patients or detained persons and primary carers after s69 (or direct people to useful websites in an addendum).
- Likewise it would be useful if the Act more clearly indicated how a person might challenge decisions concerning their capacity to consent, i.e. to ECT.
- It would be useful to medical and admin staff to identify that if the criteria of these two sections (s51 & s52) in the MHA are shown not to be met in the documentation presented to the MHRT, that the Tribunal does not have jurisdiction to proceed with the hearing.
- Further to comments from the NSW Law Reform Commission in *Consultation Paper 5 - People with cognitive and mental health impairments in the criminal justice system*, outlining the various definitions covering cognitive and mental health impairments relevant to the mental health and criminal justice context. We recommend that there would be great benefit in clarifying or standardising the terminology and raise for consideration the issue of whether the relevant legislation should contain an overarching definition covering cognitive and mental health impairments. As it stands the MHA and the Mental Health (Forensic

Provisions) Act 1990 (NSW) refer variously to “mental illness”, “mentally ill person”, “mentally disordered person”, “mental condition” and “developmental disability”.

- We draw attention to the language of the legislation which could be improved to reflect recovery principles. The NSW Act refers to providing for the ‘care, treatment and control’ of mentally ill and disordered persons. Whilst not a perfect solution, the Victorian legislation uses the language of ‘care, treatment and protection’ which is preferable.

---

<sup>i</sup> Parsons, C., 2008. Neami presentation TheMHS Conference 2008.; Perske, R, 1973, *Hope for the families - New directions for parents of persons with retardation or other disabilities*. Nashville. Abingdon Press, p. 51. Anthony, W. 2000, ‘A Recovery oriented service system: Setting some system level standards.’ *Psychiatric Rehabilitation Journal*, 24(2), 159-168. Deegan, P, 1996, ‘Recovery as a journey of the heart.’ *Psychiatric Rehabilitation Journal*, 11, 11-19. Petersen, C., Maier, S.F., Seligman, M.E.P. 1995, *Learned Helplessness: A Theory for the Age of Personal Control*. New York: Oxford University Press, p. 241-242. Advocates Inc. & Deegan, P, 2001, ‘The intentional care approach to supporting client choice,’ *Intentional Care*.

<sup>ii</sup> Karras, M, McCarron, E, Gray, A. & Ardasinski, S, 2006, *On the edge of justice: the legal needs of people with a mental illness in NSW*. Law and Justice Foundation of NSW: Sydney.

<sup>iv</sup> Ibid.

<sup>v</sup> Barnard, C.P. & Hirsch, C. 1985, ‘Borderline personality and child sexual abuse.’ *Psychological Reports*, 1985, 57, 715-718.; Herman, J. L, Perry, J.C & Van de Kolk, 1989, ‘Childhood Trauma in Borderline Personality Disorder.’ *American Journal of Psychiatry*, 146, 490 – 495.; Lindberg, F. H. & Distad, L. J. 1985, ‘Posttraumatic stress disorders in women who experienced childhood incest.’ *Child Abuse and Neglect*, 9, 329-334.

<sup>vi</sup> Carney, T, Tait, D., Perry, J., Vernon, A., Beaupert, F. 2011, *Australian Mental Health Tribunals: Space for Fairness, Freedom, Protection and Treatment*. Themis Press: pp. 151 – 152.

<sup>vii</sup> Newtown-Howes, G., & Mullen, R., 2011, ‘Coercion in Psychiatric care: Systematic review of correlates and themes’, *Psychiatric Services*, 62(5), pp. 465-470.

<sup>viii</sup> Brayley, J., 2010, ‘Your right to know: consumer and carer participation in involuntary mental health care’, *MIFSA News*.

<sup>ix</sup> O’Brien, A. J. 2010, ‘Capacity, consent and mental health legislation: Time for a new standard?’ *Contemporary Nurse*, 34(2), pp. 237-247.; Newtown-Howes, G., & Mullen, R., 2011, ‘Coercion in Psychiatric care: Systematic review of correlates and themes’, *Psychiatric Services*, 62(5), pp. 465-470.; Ryan, C.J. 2011, ‘One flew over the cuckoo’s nest: Comparing legislated coercive treatment for mental illness with that for other illness’, *Bioethical Inquiry*, 8, pp. 87-93.; Swanson, J. W. et al. 2008, ‘Psychiatric advance directives and reduction of coercive crisis interventions’, *Journal of Mental Health*, 17(3), pp. 255-267.; Swanson, J. W., Swartz, M. S., Ferron, J., Elbogen, E. B., & Van Dorn, R. A., 2008, ‘Psychiatric advance directives and reduction of coercive crisis interventions’, *Journal of Mental Health*, 17(3), pp. 255-267.

<sup>x</sup> Carney, T, Tait, D., Perry, J., Vernon, A., Beaupert, F. 2011, *Australian Mental Health Tribunals: Space for Fairness, Freedom, Protection and Treatment*. Themis Press: pp. 151 – 152; Winick, B. J, 2003, ‘Therapeutic Jurisprudence and problem solving courts,’ *Fordham Urban Law Journal*, 30, 1055-1103.

<sup>xi</sup> Winick, B. J, 2003, ‘Therapeutic Jurisprudence and problem solving courts,’ *Fordham Urban Law Journal*, 30, 1055-1103.; Cain, M., Karras, M., Beed T. & Carney, T, 2011, *The NSW Mental Health Review Tribunal: An analysis of clients, matters and determination*, NSW Law & Justice Foundation.

<sup>xii</sup> Australian Ministers’ Advisory Council, 2011, National Framework for Advance Care Directives particularly in reference to the code for ethical practice and best practice standards (pp.14 -17). Available: [http://www.ahmac.gov.au/cms\\_documents/AdvanceCareDirectives2011.pdf](http://www.ahmac.gov.au/cms_documents/AdvanceCareDirectives2011.pdf)

- 
- <sup>xiii</sup> Carney, T, Tait, D., Perry, J., Vernon, A., Beupert, F. 2011, *Australian Mental Health Tribunals: Space for Fairness, Freedom, Protection and Treatment*, Themis Press: pp. 151 – 152.; Winick, B. J, 2003, 'Therapeutic Jurisprudence and problem solving courts,' *Fordham Urban Law Journal*, 30, 1055-1103.
- <sup>xiv</sup> Light, E., Kerridge, I., Ryan, C., & Robertson, M., 2012, 'Out of sight, out of mind: making involuntary community treatment visible in the mental health system', *Ethics and Law: MJA 196 (6) 21 May 2012*.
- <sup>xv</sup> Churchill, R., Owen, G., & Singh, S., 2007, 'International Experiences of Using Community Treatment Orders,' Department of Health.
- <sup>xvi</sup> O'Brien A. J. et al. 2009, 'Compulsory community mental health treatment: Literature review', *International Journal of Nursing Studies*, 46(9).
- <sup>xvii</sup> Light, E., Kerridge, I., Ryan, C., Robertson, M., 2012, 'Community treatment orders in Australia: rates and patterns of use', *Australia Psychiatry*, 0(0), pp. 1-5.; Churchill, R., Owen, G., & Singh, S., 2007, 'International Experiences of Using Community Treatment Orders', Department of Health.; Rolfe, T. et al. 2008, 'Are consumers on community treatment orders informed of their legal and human rights? A West Australian study.' *International Journal of Mental Health Nursing*, 17, pp. 36-43; Kisely, S. L., Campbell et al., 2011, 'Compulsory community and involuntary outpatient treatment for people with severe mental disorders,' *Cochrane Database of Systematic Reviews*.
- <sup>xviii</sup> Churchill, R., Owen, G., & Singh, S., 2007, 'International Experiences of Using Community Treatment Orders', Department of Health and Institute of Psychiatry, Kings College London.; Rolfe, T. et al. 2008, 'Are consumers on community treatment orders informed of their legal and human rights? A West Australian study.' *International Journal of Mental Health Nursing*, 17, pp. 36-43.; Kisely, S. L., Campbell et al., 2011. 'Compulsory community and involuntary outpatient treatment for people with severe mental disorders,' *Cochrane Database of Systematic Reviews*.
- <sup>xix</sup> Rolfe, T. et al. 2008, 'Are consumers on community treatment orders informed of their legal and human rights? A West Australian study.' *International Journal of Mental Health Nursing*, 17, pp. 36-43.
- <sup>xx</sup> Moncreiff, J. & Smyth, M., 1999, *Psychiatric Bulletin*, November 1999, 23, 644-646.
- <sup>xxi</sup> O'Brien A. J. et al. 2009, 'Compulsory community mental health treatment: Literature review', *International Journal of Nursing Studies*, 46(9); Rolfe et al., 2008, 'Are consumers on community treatment orders informed of their legal and human rights? A West Australian study,' *International Journal of Mental Health Nursing*, 17, pp. 36-43.
- <sup>xxii</sup> NSW Ombudsman's report, 2012, Denial of Rights: the need to improve accommodation as support for people with psychiatric disability. Available: <http://www.ombo.nsw.gov.au/news-and-publications/publications/reports/community-and-disability-services/denial-of-rights-the-need-to-improve-accommodation-and-support-for-people-with-psychiatric-disability>
- <sup>xxiii</sup> Mental Health Review Tribunal Annual Report 2011/2012. Available: <http://www.mhrt.nsw.gov.au/mhrt/pdf/Annualreportfinal2012.pdf>  
Churchill, R., Owen, G., Singh, S., & Hotopf, M., 2012, 'International experience of using community treatment orders', *Department of Health and Institute of Psychiatry, Kings College, London*.; Light, E., Kerridge, I., Ryan, C., & Robertson, M., 2012, 'Out of sight, out of mind: making involuntary community treatment visible in the mental health system', *Ethics and Law: MJA 196 (6) 21 May 2012*.; Centre for Values, Ethics and the Law in Medicine 2012, A thematic review of research about community treatment orders, unpublished. Lawton-Smith S. A. A Question of Numbers: The potential impact of community-based treatment orders in England and Wales. London: King's Fund 2005.; Churchill, R. et al. 2007, International experiences of using community treatment orders. London: Department of Health and Institute of Psychiatry, Kings College London. Dawson, J. 2005, Community treatment orders: international comparisons. Dunedin, Otago University Press. Kisely, S. L., Campbell et al., 2011. 'Compulsory community and involuntary outpatient treatment for people with severe mental disorders,' *Cochrane Database of Systematic Reviews*. O'Brien A. J. et al. 2009, 'Compulsory community mental health treatment: Literature review', *International Journal of Nursing Studies*, 46(9). ; Rolfe, T. et al.

---

2008, 'Are consumers on community treatment orders informed of their legal and human rights? A West Australian study,' *International Journal of Mental Health Nursing*, 17, pp. 36-43. Light, E. M. 2012, 'Out of sight, out of mind: Making involuntary community treatment visible in the mental health system', *Medical Journal Australia*, 196, pp. 591-593.; Light, E. et al. 2012, 'Community treatment orders in Australia: rates and patterns of use', *Australia Psychiatry*, 0(0), pp. 1-5. NSW Ombudsman, 2012, 'Denial of Rights: the need to improve accommodation as support for people with psychiatric disability'. Available: <http://www.ombo.nsw.gov.au/news-and-publications/publications/reports/community-and-disability-services/denial-of-rights-the-need-to-improve-accommodation-and-support-for-people-with-psychiatric-disability>

<sup>xxiv</sup> Carney, T, Tait, D., Perry, J., Vernon, A., Beaupert, F. 2011, *Australian Mental Health Tribunals: Space for Fairness, Freedom, Protection and Treatment*. Themis Press: pp. 37-39).

<sup>xxv</sup> Ibid.

<sup>xxvi</sup> Reference: National Mental Health Working Group, 2005, 'National safety priorities in mental health: a national plan for reducing harm, Health Priorities and Suicide Prevention Branch', Department of Health and Ageing, Commonwealth of Australia, Canberra. Available: <http://www.health.gov.au/internet/main/publishing.nsf/content/mental-pubs-n-safety>