

Submission - NSW Health Review of the Mental Health Tribunal in Respect of Forensic Patients: Discussion Paper

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Mental Health Coordinating Council

Building 125, Corner of Church & Glover Streets
Lilyfield NSW 2040

PO Box 668
Rozelle NSW 2039

For any further information please contact:

Corinne Henderson
Principal Advisor | Policy & Legislative Reform
Email: corinne@mhcc.org.au
Tel: (02) 9555 8388 # 101

Jenna Bateman
Chief Executive Officer
Email: jenna@mhcc.org.au
Tel: (02) 9555 8388 # 102

Submission to MHRT_Review@doh.health.nsw.gov.au

Submission: NSW Health Review of the Mental Health Tribunal in Respect of Forensic Patients: Discussion Paper

The Mental Health Coordinating Council (MHCC) is the peak body representing community managed organisations (CMOs/ NGOs) in NSW. Our members deliver a range of psychosocial support programs and services including housing, employment and social inclusion activities, in addition to clinical and peer supported services with a focus on trauma-informed recovery oriented practice. MHCC members also include Primary Health Networks and organisations that provide advocacy, education, training and professional development and information services.

MHCC work in partnership with both State and Commonwealth governments, as well as the public, community and private sectors in order to effect systemic change. We manage and conduct collaborative research and capacity building and development projects on behalf of the sector. MHCC also have a Learning and Development arm (MHCC LD) which is a widely respected registered training organisation delivering nationally accredited mental health training and professional development courses to the mental health and human services sectors.

MHCC is a founding member of Community Mental Health Australia (CMHA) the alliance of eight state and territory community sector mental health peak bodies. Together we represent more than 800 CMOs delivering mental health and related services nationally.

MHCC thanks the Minister for Mental Health, the Hon Tanya Davies for providing us with the opportunity to participate in discussions regarding this review. We look forward to reading the report findings that the Hon Anthony Whealy QC will present to the Minister in December 2017.

In addition to the discussion questions, MHCC make some points in reference to other matters arising the Discussion Paper and consultation with stakeholders. Please note that some footnotes are presented to provide relevant information to those reading the submission, such as MHCC member organisations and other interested stakeholders. These readers may be less well acquainted with mental health and forensic legislation and the role of the Mental Health Review Tribunal (MHRT) in relation to forensic patients.

Many MHCC member organisations work with people living with mental health conditions who have engaged with the public mental health services, and have been subject to involuntary orders and community treatment orders. Some clients may also have also had brushes with the criminal justice and forensic system. This review is therefore of great interest to the sector generally as well as people coming before the Tribunal.

Discussion questions

1.1 Do the current legislative requirements for Tribunal decisions regarding leave and release sufficiently protect the public, including the needs of victims, whilst balancing the rights of forensic patients?

Whilst the community may generally favour a more conservative approach that seeks to curtail or deny rights to forensic patients surrounding leave and release, MHCC agree that the approach in current use balances the rights of all interested parties.

In our view the three types of supervised leave (see footnote)¹ represent an appropriate stepped-care approach to supporting forensic patients transition back into the community. The number of forensic patients granted unsupervised leave (either unsupervised day or overnight leave) during any year over the last 6 years (DP, p.8) is approximately 20 percent. This suggests that a robust process of clinical assessment and risk oversight is adopted.

Likewise, as at 30 June 2017, 149 forensic patients were living in the community on conditional release, representing 35 percent of the forensic patient population. We judge that the support mechanisms in place for all forensic patients with mental illnesses on conditional release, are appropriate since they are subject to supervision by i.e., a “*designated case manager and psychiatrist from the treating mental health service and the patient is required to regularly attend appointments with these specialists.*” . This supervision occurs with the additional support of the Community Forensic Mental Health Service team who also play an important role in providing expert assistance and advice to local mental health services in managing these patients.

1.2 Are there any improvements that could be made to the information provided to the Tribunal and the Tribunal's decision making processes?

The amount of material placed before a Forensic Tribunal Panel can be huge. It might be useful to design a template document as a tool/resource to collate the material that the Tribunal specifies/ requires for hearings into a more manageable format. This of course would require the treating team to take the time to extract the material from the files and present it in a useful and succinct manner. However, it might well be cost effective in the long term in regards to panel preparation and hearing times, and would assist the panel to digest the material more effectively. The template could also be a useful resource for members to use when preparing for and conducting hearings.

1.3 Is the current involvement of victims in the Tribunal decision making process appropriate?

Victims have the right to provide written submissions to the MHRT but not necessarily to give voice to their concerns in a hearing. We understand that it is at the discretion of the Presiding Member as to whether he/she is willing to hear from victims. Victims' oral submissions such as impact statements are a legislative issue for the courts and not within the MHRT's jurisdiction.

The MHRT is responsible for reviewing the material and implementing the law. Nevertheless, in the interests of the health and wellbeing of victims, MHCC are supportive of the proposal that (whilst some of the content of victim submissions may be somewhat extraneous to the Tribunal's decision) that victims are given a time slot to speak to the Tribunal (if they so wish); and for the Tribunal to have the opportunity to reassure them that their submissions have been thoroughly read. However, we agree with the NSW Law Reform Commission (NSWLRC)^{2 3} that the law in relation to victims in proceedings before the Tribunal not be amended, but dealt with on a case by case basis.

¹ 1) Escorted day leave where the forensic patient is escorted at all times by at least one member of staff at the facility; 2) supervised day or overnight leave where the forensic patient is supervised by a responsible adult who has been approved by the treating team and; 3) unsupervised day or overnight leave when appropriate to do provide sufficient safeguards for both the community and human rights of patient.

² NSW Law Reform Commission 2013, *People with cognitive and mental health impairments in the criminal justice system. Criminal responsibility and consequences*, Report 138, s 8.148.

³ *The Mental Health Act 2007 (NSW) s 151(3)-(4) Item .Report 138 - 8.148*, “The MHRT has a discretion to order that a hearing be conducted wholly or partly in private where it is considered desirable to do so, for the welfare of a person who has a matter before the MHRT, or for any other reason. We consider that the problems raised by the MHRT are best dealt with on a case by case basis by the exercise of this discretion to hold hearings in private. Furthermore, the MHRT can and does regulate the circumstances in which victims may make representations as part of a review hearing, and it should continue to manage this as considered appropriate.”

It has been suggested that Victim Support Services (VSS) could be expanded to include supporters trained to assist victims prior to and during hearings. Their role could be to assist victims understand the process, what material might be useful to the panel, and what to expect in terms of outcomes. MHCC support this idea, and would encourage a support service that has an ongoing role in supporting victims to live with and move beyond the trauma of their experiences.

1.4 Are changes required to improve the supervision of forensic patients in the community, in order to protect the public?

There is a great deal of tension about freedom of movement, association and geography in relation to forensic patients on leave or to be released. Bearing in mind a patient's reasonable request to visit for example, relatives or friends that might give rise to fear and distress on the part of victims and the community; a plan should be put in place that meets the needs of all interested parties.

Despite community beliefs, often fuelled by the media, that forensic patients are just 'dumped' back into the community, the process is in fact a very thorough, step-down, supervised, ongoing assessment process that carefully monitors the wellness, risk and reliability of the patient over time. Whilst from time to time clinical judgement may be flawed, the statistics cited in the Discussion Paper⁴ nevertheless demonstrate a process of thorough clinical and risk assessment with public safety as a priority objective. In our view this process is appropriate because it simultaneously gives due consideration to the human rights of a forensic patient.

Sometimes panels may not receive all the information they need to assist decision-making concerning levels of supervision required. The notion of an information template as suggested earlier (p.3) would assist in this regard.

1.5 If so, how could the Tribunal's method for supervising forensic patients in the community be improved to increase community safety?

MHCC suggest consideration of access to peer workers or a mentor program through Community Managed Organisation (CMO/NGO). Such relationships could be established prior to leave and conditional release being granted. The development of rapport with someone 'on the outside' who could be involved with the patient for the long haul, could be a helpful safety net. This might be worth considering as part of a step-down process that starts before any leave is allowed. A peer worker who is not seen as part of the restrictive environment in which the patient resides, who can open doors to other services and supports in the community, and be a sounding board, might prove an invaluable ally for the patient, their family and the treating team. Peer workers are recognised as a growing workforce important to supporting people progress their recovery goals and stay well in the community.

General Comments

- In relation to Question 1.5 above, it has long been suggested that practitioners in community mental health services should be upskilled to work with people exiting the criminal justice/forensic system. As things stand, many correctional and forensic patients are assessed as unsuitable for release because their complex needs cannot be appropriately met in the community. It may be worth considering whether Community Corrections staff, who have a range of qualifications both clinical and psychosocial could have an expanded role in both supervising and capacity building skills for community based practitioners and peer workers.

⁴ NSW Health 2017, *Mental Health Review Tribunal in respect of forensic patients: Discussion Paper*, Available: <http://www.health.nsw.gov.au/patients/mhrt/Documents/mhrt-discussion-paper.pdf>

- Established in 2006 by ADHC, the Community Justice Program (CJP) works with a range of non-government organisations to provide case management, behaviour intervention, psychological therapy, drop-in support and accommodation services to clients. CJP supports people with an intellectual disability across NSW who have a significant ongoing risk of offending or who have committed serious offences and who are beyond the capacity of regular disability services. As with the NSW Government's community forensic disability service, the primary aims of the CJP have been to minimise the risk of reoffending and promote a pro-social and independent lifestyle using evidence based practice for people with an intellectual disability who have exited a correctional facility. MHCC are concerned and interested to understand whether in the emerging NDIS environment (with ADHC no longer in existence) if this service has fully transitioned to FACS or if an even wider service gap is likely to emerge.
- MHCC also comment on the fact that when the Forensic Hospital at Malabar was established, correctional patients were to be treated in a hospital environment rather than the Long Bay hospital. We understand that access to the forensic hospital has not been widely available due to bed shortages since that time. We see this as limiting opportunities for best practice, recovery and rehabilitation that is less cost effective in the long run. This is because services provided in the forensic system are more likely to result in a reduction of recidivism and readmissions than mental health services in corrective environments.
- MHCC note (in Discussion Paper, p.6) that forensic patient numbers (n=425) have increased by 32 percent (n=132) since June 2011. In our view this reflects the lack of early intervention services available to people with complex mental health and coexisting conditions, as well as psychosocial disability in the community. This submission draws the Inquiry's attention to *Review of Mental Health Programmes and Services* (National Mental Health Commission, 2014, *Contributing Lives, Thriving Communities*)⁵ and the *Australian Government's Response*⁶ in which the need to insure effective early intervention across the lifespan by shifting the balance, and transitioning services (and therefore funding) from the hospital to community settings was stressed. The Review "found the greatest inefficiencies in the mental health system come from providing acute and crisis response services when prevention and early intervention services would have reduced the need for complex and costly interventions while supporting people to remain in the community."⁷

It is unsurprising that one consequence of this deficiency in service provision is that some people end up in the criminal justice and/or forensic system. Intervening early, and providing the right interventions at the right time, can save enormous costs both to government and the individual throughout a person's lifetime. The Review⁸ proposed that outlays on hospital funding should reduce over the medium to long term through embedding early intervention in mental health reform, better planning and targeting primary and community care services. "The provision of facilities to treat forensic patients and prisoners with serious mental illnesses is resource intensive," (Commonwealth of Australia, *Costs of facilities, Chapter 13 - Mental health and the criminal justice system*)⁹

⁵ National Mental Health Commission 2014, *Contributing Lives, Thriving Communities - Review of Mental Health Programmes and Services*, Available: <http://www.mentalhealthcommission.gov.au/our-reports/contributing-lives,-thriving-communities-review-of-mental-health-programmes-and-services.aspx>

⁶ Commonwealth Government Australia 2015, *Australian Government Response to Contributing lives, thriving communities - Review of Mental Health Programs and Services*, p.13.

⁷ Ibid, p.44.

⁸ Ibid, p.45.

⁹ Commonwealth of Australia 2006, *A national approach to mental health - from crisis to community: First Report Parliamentary Senate Committee*, Chapter 13, *Mental Health & the Criminal Justice System* 13:89, 1442] Available: http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Former_Committees/mentalhealth/report/c13

According to AIHW in 2016,¹⁰ expenditure on specialised mental health services nationally in 2014-2015 averaged at \$1,029 per patient per day (NT \$1,899). This figure applied to forensic and correctional patients in acute and non-acute hospital environments nationally. When compared to the cost per day in NSW of \$246 (NT \$614) per patient accessing community-based residential care;¹¹ even if an additional cost were applied in the context of providing more intense supervision and additional services to address complex needs, the cost savings are likely to be substantial.

There is now clear evidence from both Australia and overseas suggesting a better and more effective approach to patient care. For example, Like Mind¹² is a service model that provides a place for people to go where they and their families can access both 'clinical' and psychosocial supports, and that reduces the risk of a person requiring care in an acute setting which may lead to greater risk of the use of restrictive practices and interaction with the criminal justice/ and or forensic system.

- MHCC propose that Section 74d¹³ could be reworded to make it clear that the independent report provided is not just informed by a review of case notes and evidence supplied by the previous or the current treating team, but reflects a full face-to-face assessment of the person by a team of clinicians that might well include: psychiatrists, psychologists, occupational therapists, social workers and others with relevant medical and psychosocial rehabilitation expertise.
- Two important documents Report 135 and Report 138 were provided by the NSW Law Reform Commission in 2012 and 2013.¹⁴ MHCC are keen to understand why so many worthy recommendations in those reports have not been implemented. A broad-based review of the *Mental Health (Forensic Provisions) Act 2009* is way overdue despite amendments offered in the *Mental Health (Forensic Provisions) Amendment Act 2013, No 102*, and the review which is the subject of this submission.
- MHCC highlight the necessity to address how the needs of people with personality disorders are dealt with in the forensic system. Ambivalence towards patients diagnosed with personality disorder has been well recognised among psychiatrists for over 40 years (Lewis & Appleby, 1988).¹⁵ There is some debate about whether personality disorders are, or should be, covered under the definition of mental illness. Personality disorders are complex conditions that lead to people presenting with a range of mental health and substance abuse issues including: suicidality, self-harm, as well as physical and psychosocial problems; and for a sub-group, potentially high levels of aggression and violence (UK Department of Health, 2009). People with personality disorders are a client group for whom there can be diagnostic ambiguity and a lack of evidence-based clinical interventions. However recent evidence suggests that for some people, psychological interventions can lead to significant changes in mood states and functioning (Fonagy & Bateman, 2006).¹⁶

¹⁰ Australian Institute of Health & Welfare (AIHW) 2016, *Expenditure on specialised mental health services: state and territory specialised mental health services: Recurrent expenditure 2014 – 2015*, Available: <https://mhsa.aihw.gov.au/resources/expenditure/specialised-mh-services/>

¹¹ Ibid.

¹² Like Mind is a non-hospital environment offering early intervention and holistic care that requires primary health, public and community managed services to work together to provide an integrated model of care. Like Mind website, Available: <http://likemind.org.au/about-us/>

¹³ S.74d – “a report by a forensic psychiatrist or other person of a class prescribed by the regulations who is not currently involved in treating the patient, on the condition of the patient and whether the safety of the patient or any member of the public will be seriously endangered by the patient's release; or”

¹⁴ NSW Law Reform Commission, Report 135: *People with cognitive and mental health impairments in the criminal justice system: Diversion*, August 2012; Report 138: *Criminal Responsibility and Consequences*, June 2013. Available: http://www.lawreform.justice.nsw.gov.au/Pages/lrc/lrc_completed_projects/lrc_peoplewithcognitiveandmentalhealthimpairmentsinthecriminaljusticesystem/lrc_peoplewithcognitiveandmentalhealthimpairmentsinthecriminaljusticesystem.aspx

¹⁵ Lewis G & Appleby L 1988, *Personality disorder: the patients psychiatrists dislike*, Br J Psychiatry, 1988 July 153, 44-9.

¹⁶ Fonagy P & Bateman A 2006, *Mechanism of change in mentalization based treatment of borderline personality*

There is considerable debate as to whether personality disorder is a treatable condition, particularly for Antisocial Personality Disorder which is most prevalent in the criminal justice system, and whether mental health services are equipped to provide adequate services to this client group.¹⁷ As the Mental Health Commission of NSW wrote in its *Issues arising under the Mental Health Act 2007: Discussion Paper: (2012)*¹⁸ "people with personality disorder are often in a state of crisis and can be difficult to manage and engage in treatment or rehabilitation."¹⁹ They can experience significant psychosocial impairment, and for patients with Borderline Personality Disorder, a high mortality rate due to suicide.²⁰ MHCC are keen to see a range of psychological interventions made more available to this group of patients.

- The Minister for Health and the Attorney General have the right to make submissions or appear before the MHRT where it is granting leave or release of a patient. Whilst this is a great improvement on what was the previous power vested in the Minister to hold a person 'at the Governor's pleasure',²¹ MHCC would be concerned to see any changes to Ministerial power that might over-ride clinical assessments and decisions.

Discussion questions

2.1 Are there opportunities to improve the current practices and processes for engaging victims in Tribunal hearings? If so, how can they be improved?

MHCC note that the objectives of the *Mental Health (Forensic Provisions) 1990 Act* in relation to forensic patients do not "recognise harm done to the victim of crime or the interests of victims, but are predominately focused on the safety of members of the public as well as the care, treatment and control of such patients." (DP, p.15).

As mentioned earlier in this submission, MHCC believe that it is entirely appropriate that Registered Victims' concerns are a matter for the courts rather than the MHRT. However, it is equally appropriate that the MHRT take into account Victims' submissions in considering leave and release conditions, may allow and ask for oral evidence, and should convey their knowledge and understanding of the victims' perspectives.

2.2 Are the mechanisms for victims to be heard by the Tribunal appropriate? If not, how could they be improved?

The NSWLRC (DP, p.16) noted that "there were a range of different issues and views including that victims can bring unique perspectives of safety issues that the Tribunal should consider, but that while hearings are open to the public and victims can attend, participation can impact on the privacy of patients or be detrimental to patients. Ultimately, the Commission found that balancing these issues and views should be determined on a case by case basis by the Tribunal."²² MHCC agree that privacy should be maintained and that balancing all parties interests be considered individually.

disorder, Journal of Clinical Psychology, Vol. 62, Issue:4, 2006, pp: 411-430.

¹⁷ Gibbon S Duggan C, Stoffers J, Huband N, Vollm BA, Ferriter M, Lieb K., *Psychological treatments for people with antisocial personality disorder* (Review), JohnWiley & Sons, Ltd, The Cochrane Library, 2010, Issue: 6; UK Department of Health, *Recognising Complexity: Commissioning guidance for personality disorder services*, July 2009.

¹⁸ Mental Health Commission of NSW 2012, *Issues arising under the Mental Health Act 2007: Discussion paper* (September 2012). Available: <http://www.health.nsw.gov.au/mentalhealth/Documents/discussion-paper-01.pdf>

¹⁹ Lieb K, Zanarini MC, Schmahl C, Linehan MM, Bohus, M, Borderline personality disorder, *The Lancet*, 2004, Vol:364, Number: 9432, pp.453-461

²⁰ *Ibid.*

²¹ A legal term referring to the indeterminate length of indeterminate incarceration of forensic patients. Originating in the United Kingdom, it was used throughout the Commonwealth. In Australia where the monarch is represented by a governor-general, governor or administrator, the phrase was modified to be "at the Governor's pleasure." The MHA was amended in 2007 to vest authority only in the MHRT in this context.

²² NSW Law Reform Commission 2013, *People with cognitive and mental health impairments in the criminal justice system. Criminal responsibility and consequences*, Report 138, s 8.145 8.149.

2.3 Is the information available from the Tribunal to victims appropriate? If not, how could this be improved?

When a person is a Registered Victim, they can nominate the kind of information they receive from the Tribunal (DP, p.14). MHCC propose that victims should also be entitled to read a summary of reasons from the Tribunal as to increased patient leave or release in the community and other matters that may affect the victim/s.

2.4 Are support services available to victims appropriate? If not, how could they be improved?

MHCC have great respect for victims' support services under the NSW Department of Justice. The breadth of service, access as well as the skills and expertise of the professionals involved is satisfactory. We do however agree that an expanded service should be available to support victims, prior, during and post hearings.

Where we have heard complaints it mostly relates to there not being a service that adequately meets the complex mental health needs of particular victim groups, who may themselves be experiencing for example: personality disorders, developmental and cognitive disabilities, as well as people requiring specialist trauma therapy in relation to histories of childhood abuse.

We highlight here the Blue Knot Foundation, which should also be provided in the services list. Blue Knot:

- Is a leading national organisation working to improve the lives of Australian adults who are survivors of childhood trauma, including abuse.
- Supports survivors, their families and communities through professional phone counselling, information, resources and educational workshops.
- Delivers professional development training, group supervision and consultancy for workers, organisations and practitioners working with survivors.
- Advocates nationally for trauma-informed policy, practice and systems change.

Blue Knot has worked closely with the Royal Commission into Institutional Responses to Child Sexual Abuse, working with Commission Staff and Legal Representatives throughout the process.

3.1 Does section 162 appropriately balance the interests of participants involved in Tribunal hearings with the need to ensuring transparency of decision making? If not, what legislative or policy amendments could be made?

Whilst MHCC understand that some victims feel very aggrieved that they cannot share their experience by publishing and broadcasting names of any persons involved in the hearings, it is vital that Section 162 of the *Mental Health Act 2007* or the *Mental Health (Forensic Provisions) Act 1990* continues to protect "the privacy and identity of people who come before the Tribunal by prohibiting anyone, except with the Tribunal's consent, from publishing or broadcasting their names. This includes publishing any information, picture or material that identifies them or is likely to lead to their identification." (DP, p.18)²³ This is not only about protecting the forensic patient subject of the hearing whose identity, medical, social and personal history is under review, but about protecting the identity of the professionals giving evidence, as well as the tribunal members on the panel. However, it would be useful if there

²³ This includes (forensic and civil patients), any person who appears as a witness before the Tribunal in any proceedings, or who is mentioned or otherwise involved in any proceedings under either Act. However, the section does not prohibit the publication or broadcast of an official report of the Tribunal proceedings.

was an official explanation as to the reasons and justification for this provision, and at the very least, to acknowledge the issue which concerns many victims.

4.1 Does the make-up of the Tribunal meet the needs of the public, victims and forensic patients? If not, how could it be changed?

MHCC agree that the current mix of Tribunal Members and make-up of panels is fit for purpose. The panels are constituted of three members who can demonstrate a diversity of skills and expertise gained from experience across the mental health and legal services systems.

Qualified in either models of biosocial²⁴ care and treatment and/or psychosocial support and rehabilitation approaches, members come from a wide range of disciplines. The professions represented include: psychiatry, psychology, social work, mental health nursing, occupational therapy as well psychosocial disability and rehabilitation practice, consumer and carer peer workers and advocates with lived experience. Members have extensive knowledge and understanding of contemporary practice approaches and the problems that mental health and forensic patients' experience. They have knowledge and expertise in trauma-informed recovery oriented practice, cultural competence and are well informed about the close relationship between physical and mental health, and the impact on health of the many treatments prescribed. Members are well acquainted with the complexity of coexisting conditions and difficulties such as substance abuse and misuse, gambling, cognitive disability and acquired brain injury etc... Members who sit on forensic hearings are appropriately qualified and experienced in that particular context. Quite a few members have qualifications in two or all three member areas.

MHCC comment that the criteria to appoint members with regards to Legal Practitioner Members (DP, p.22) does not entirely reflect the criteria applied in reality. In fact, Legal Members are selected on both the evidence of their legal expertise as well as their experience in the mental health psychosocial disability space. Many appointees have legal experience highly relevant to the context in which the tribunal operates, in addition to areas that enhance that experience such as family law, human rights, mediation, guardianship, legal aid, homelessness, and the emerging policy reform environment. Therefore, under 'the criteria', we recommend that this be reflected in the description – 'Must be an Australian lawyer with experience in the mental health and psychosocial disability sphere.'

There has been some suggestion that victims should be eligible for appointment on the Tribunal as 'Third' or 'Other' Members. MHCC have concerns about the appropriateness of this idea, unless an applicant's associated experience and ability to contribute can be clearly demonstrated in the context of their wider knowledge of mental illness, coexisting conditions and contemporary care and treatment principles. Their knowledge and skills should be on a par with 'Other' Members with relevant professional expertise and lived experience.

The concepts of procedural fairness and natural justice are central to the 'Principles for care and treatment' in the *Mental Health Act 2007*.²⁵ These principals equally apply to forensic matters. By holding justice and fairness when conducting hearings and making decisions the Tribunal gives effect to those objects and principles. "The Tribunal's independence as a decision maker is paramount and decisions must at all times be arrived at independently and free from improper influence."²⁶ Therefore the Tribunal must be satisfied that all members reviewing the evidence and evaluating the material presented ensure that these principles are upheld and not seek to use their position to advocate for decisions that unfairly limit or deny

²⁴ The biopsychosocial model is a broad view that good patient/consumer outcomes to the intricate, variable interaction of biological factors (genetic, biochemical, etc.), psychological factors (mood, personality, behaviour, etc.), and social factors (cultural, familial, socioeconomic, medical, etc.).

²⁵ *Mental Health Act 2007* (NSW) - SECT 68

²⁶ Mental Health Review Tribunal Website, Values, Available: <http://www.mhrt.nsw.gov.au/the-tribunal/mhrt-values.html>

human rights and the progress of 'recovery' goals for people with mental illness and complex conditions coming before the Tribunal.

4.2 Are the current rules and processes for appointing members of the Tribunal appropriate?

The current rules and processes in relation to the Tribunal recruitment process is fair and transparent. The MHRT has a strong record of ensuring ongoing professional development and peer support across all its member categories.

The Tribunal also collaborates closely with the Mental Health Commission of NSW and other Government Agencies and the community managed mental health sector, and keenly engages with research and sector development projects, discussion and consultation across sector policy reform issues and evidence based practice matters, and relay up-to-date material to its members.

MHCC express their willingness to be engaged in future consultations concerning this review. For further information concerning this submission please contact Corinne Henderson (Please see footnote disclosure,²⁷) Principal Advisor/ Policy & Legislative Reform at corinne@mhcc.org.au

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NSW Law Reform Commission 2013, *Criminal responsibility and consequences*, Report 138, s 8.148.

²⁷ Disclosure: In relation to this submission, Corinne Henderson is a current Member of the MHRT).