A Mental Health Act for the 21st Century

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Peter Dodd, Solicitor Health Policy and Advocacy

Michelle Cohen, Senior Solicitor

Level 7, 173-175 Phillip Street, Sydney NSW 2000 • DX 643 Sydney
Phone: 61 2 8898 6500 • Fax: 61 2 8898 6555 • www.piac.asn.au

Introduction

The Public Interest Advocacy Centre

The Public Interest Advocacy Centre (PIAC) is an independent, non-profit law and policy organisation that works for a fair, just and democratic society, empowering citizens, consumers and communities by taking strategic action on public interest issues.

PIAC identifies public interest issues and, where possible and appropriate, works co-operatively with other organisations to advocate for individuals and groups affected. PIAC seeks to:

- expose and redress unjust or unsafe practices, deficient laws or policies;
- promote accountable, transparent and responsive government;
- encourage, influence and inform public debate on issues affecting legal and democratic rights; and
- promote the development of law that reflects the public interest;
- develop and assist community organisations with a public interest focus to pursue the interests of the communities they represent;
- develop models to respond to unmet legal need; and
- maintain an effective and sustainable organisation.

Established in July 1982 as an initiative of the (then) Law Foundation of New South Wales, with support from the NSW Legal Aid Commission, PIAC was the first, and remains the only broadly based public interest legal centre in Australia. Financial support for PIAC comes primarily from the NSW Public Purpose Fund and the Commonwealth and State Community Legal Services Program. PIAC also receives funding from the Trade and Investment, Regional Infrastructure and Services NSW for its work on energy and water, and from Allens for its Indigenous Justice Program. PIAC also generates income from project and case grants, seminars, consultancy fees, donations and recovery of costs in legal actions.

PIAC's work in mental health

PIAC has a long history of involvement in the area of mental health. This work includes both legal casework and advocacy on behalf of clients, and also policy development. PIAC's policy development in this area, as in the other areas in which PIAC contributes, relies heavily on PIAC's experience – especially in representing and working with clients.

In 1988 and 1990, PIAC made submissions to and participated in the Royal Commission into the Former Chelmsford Private Hospital and Mental Health Services in New South Wales. In 1988, PIAC made a submission on the definition of 'mental illness' in the then *Mental Health Act* to the Complaints Unit of the Department of Health. In 2006, PIAC made a submission to the Review of the *Mental Health Act 1990* and commented on the exposure draft of the Mental Health Bill 2006 (NSW), which became the current *Mental Health Act 2007* (NSW) (MHA).

More recently PIAC has made several submissions and participated in public consultations regarding the NSW Law Reform Commission Inquiry into people with cognitive and mental impairments in the criminal justice system.

PIAC's submission to the current review

PIAC welcomes the opportunity to participate in the NSW Government's statutory review of the MHA. This submission represents PIAC's response to the NSW Government's September 2012 *Discussion Paper: Issues arising under the NSW Mental Health Act 2007* (Discussion Paper).

PIAC's submission is structured to draw especially on the areas in which PIAC has direct and indirect experience. In Parts 1-5, the submission addresses in detail a number of issues that are raised by the Discussion Paper. In Part 6, PIAC responds to a number of the specific questions posed by the Discussion Paper, bearing in mind that some of the material answering these questions is set out in the earlier parts of this submission.

We also note that PIAC was invited to participate on the Expert Reference Group for the current review. PIAC's chief executive officer, Edward Santow, represents PIAC on that body.

PIAC acknowledges the research assistance for this submission by College of Law placement, Helena Canaris.

1. Legislation for the 21st Century – Why the NSW Mental Health Act needs restructuring

On 17 July 2008, Australia ratified the International Convention on the Rights of Persons with Disabilities (CRPD) and it entered into force for Australia on 16 August 2008. These are significant milestones for people with mental illness in Australia. Australia's ratification of the CRPD signals an intention on the part of the Australian polity to give force to the rights set out in the Convention. For present purposes, it means that the human rights considerations to which the CRPD refers must be of central importance when the NSW Government, and ultimately the NSW Parliament, considers law reform in mental health legislation.

Despite existing safeguards in the MHA and Australia's ratification of the CRPD, concerns about the widespread use of coercive treatment and detention in closed hospital environments persist in NSW and Australia wide. Two recent reports highlight this reality 'on the ground'.

The first report by the National Mental Health Commission recommends a reduction in the use of involuntary practices and the need to work to eliminate seclusion and restraint.[1] The report concludes that Australia-wide:

> The experience of specific treatment practices without a patient's consent (or undertaken involuntarily) are of concern. Rates of involuntary admissions have remained stubbornly around 30 per cent of all mental health hospitalisations.[2]

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1 National Mental Health Commission, *A Contributing Life: the 2012 National Report Card on Mental Health and Suicide Prevention* (2012) <http://www.mentalhealthcommission.gov.au/our-report-card.aspx> at 7 December 2012.

2 Ibid, 11.

The Report confirms the right of patients to have treatment provided in the 'least restrictive' manner,[3] which is affirmed and mandated in various places in the MHA. For example, while it is not expressly mentioned in the general objects clause in s 3 of the MHA, s 68(a) evinces Parliament's intention that the principle of 'least restriction' be applied in respect of people with a mental illness.

Another recent report by the NSW Ombudsman highlights how lack of resources, restrictions in eligibility for supported accommodation found in legislation and practice, and the practices of those providing mental health care, result in the principle of least restriction not being always applied in NSW.[4]

The Ombudsman reviewed the files of 95 people in 11 mental health facilities across NSW, who had been identified as being unable to live in the community due to a lack of appropriate and available accommodation and support options. While being critical of disability accommodation policy, which discriminates against people with mental illness, and highlighting resource issues, the Ombudsman found that

> the types of reports provided by mental health staff to the MHRT [Mental Health Review Tribunal] and the quality of the information provided in the reports, varied across facilities.[5]

The Ombudsman also found that Mental Health Review Tribunal (MHRT) hearings

> did not consistently prompt mental health staff to conduct a current assessment of the person to inform the treating team's opinion about the individual's readiness for discharge. We identified reports that were largely unchanged over a number of years, including repeated references to the same behaviour incidents.[6]

Both the law and the practice in mental health in NSW should reflect Australia's commitment to the CRPD and other international human rights principles, such as the principle of least restriction.[7] The MHA should be both amended and restructured to ensure that existing human rights safeguards in the MHA and those embodied in the CRPD are reflected, not just in words but also in practice throughout NSW.

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3 Ibid, 45.

4 NSW Ombudsman, *Denial of Rights: the need to improve accommodation and support for people with psychiatric disability* (2012) <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> at 7 December 2012

5 Ibid, 41.

6 Ibid, 27.

7 United Nations, *Principles for the protection of persons with mental illness and the improvement of mental health care,* GA Res 46/119 (1991).

2. The Mental Health Act and human rights

2.1 Treating mental illness under international human rights law

The legislative review process of the MHA should take place with close reference to the human rights that are required to be afforded to people with mental illness and, in particular, to the framework of the CRPD.

Australia is a party to the following international conventions that form the body of international law that protects the rights of persons with a mental illness:

- CRPD (entered into force in May 2008);
- the Convention Against Torture and other Cruel, Inhuman and Degrading Treatment or Punishment (CAT) (entered into force in June 1987);
- the International Covenant on Civil and Political Rights (ICCPR) (entered into force in March 1976);
- the International Convention on Economic, Social and Cultural Rights (ICESCR) (entered into force in January 1976);
- the Convention on the Rights of the Child (CRC) (entered into force in September 1990); and
- the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) (entered into force in September 1981).

The human rights that are protected by these international instruments, and which are especially relevant to the protection of the human rights of persons with mental illness, include:

- the right to liberty and security of the person;
- the right to privacy and reputation;
- the right to freedom of movement; and
- the protection from cruel, inhuman or degrading treatment.

The way that treatment is administered and decisions are made, and the manner in which the mental health system is resourced, can also affect:

- the right to recognition and equality before the law; and
- the right to a fair hearing.

Mental health legislation in NSW should require mental health practitioners to make their decisions and act in accordance with the human rights afforded to persons with a mental illness under international law. Relevant principles that evolve out of human rights law, and which should be incorporated into a revised version of the MHA, include respect for inherent dignity, individual autonomy, equality and non-discrimination, full and effective participation and inclusion in society, respect for difference of persons with disabilities, equality of opportunity, accessibility, and respect for the evolving capacities of children.

2.2 The Convention on the Rights of Persons with Disabilities

The CRPD is one of the most recent pieces of international law, and was ratified by Australia in July 2008. The CRPD is of particular relevance to mental health legislation in Australia, and provides a critical legal framework within which to assess the rights that are afforded to people with mental illness.

Article 1 of the CRPD makes clear that persons with mental illness are within scope of the Convention, stating that the Convention applies to those persons who have

> a long-term physical, mental, intellectual or sensory impartment which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.

The CRPD clarifies the obligations of State Parties to promote and ensure the rights of persons with disabilities, and superseded a previous paternalistic model of regulation of persons with mental illness. This previous model of mental health regulation is reflected within the substituted decision-making structure of the MHA.

The CRPD adopts a modern approach to the protection of the rights of persons with a mental illness, in a capacity-based, supported-decision-making framework. The CRPD provides a high level of detail as to the steps that State Parties are required to take to uphold the rights of persons with mental illness.

Importantly, the CRPD confirms that involuntary treatment of persons with a mental illness impacts upon fundamental human rights, including the right to liberty, the right to integrity and the right to be free from degrading and humiliating treatment. As such, it is critical that the domestic legislation of State Parties provide that safeguards and supports must be put into place to ensure the least possible interference with this rights where persons do not have capacity to consent to treatment. These safeguards include the ability to make advanced directives, second opinions, and regular review of decisions and in general, the allocation of sufficient resources to support individuals with limited capacity to make decisions.

Discrimination against persons with mental illness

Discrimination against persons with mental illness is prohibited in domestic Australian law under both the *Disability Discrimination Act 1992* (Cth) and the *Anti-Discrimination Act 1977* (NSW). The principals of non-discrimination against persons with mental illness are also protected under international law, in particular in the ICCPR (Article 14 and 26), the ICESCR (Article 3) and the CRPD (Article 5).

Article 5(3) of the CRPD specifically requires State Parties to take all reasonable steps to accommodate persons with a disability on an equal basis in order to promote equality and eliminate discrimination against persons with a disability, and article 5(4) of the CRPD affirms that special measures, 'which are necessary to accelerate or achieve *de facto* equality of persons with disabilities', should not be considered discrimination.

Some aspects of the current MHA have the effect of entrenching stigmas and discrimination against people with mental illness. For example, where the MHA provides that persons with mental illness can receive medical treatment without their consent, even where they have capacity to make decisions about their treatment, would appear to discriminate against people with mental illness. Similarly, risk of harm criteria for involuntary treatment or admission means that persons with mental illness or impairments may be placed in preventative detention, when other groups of people who may be at high risk of self-harm to themselves or others (without mental illness) are not.

Stigmas regarding persons with mental illness are habitually based on perceptions that persons with mental illness are violent, dangerous, and unable to make decisions for themselves. These stigmas mean that persons with mental illness will more frequently experience discrimination when seeking employment, accommodation and access to social services, because of their mental illness.[8]

It is critical that mental health legislation in NSW be amended as far as practical to address systemic discrimination in NSW against persons with mental illness. A new legislative framework should provide sufficient support and safeguards for people with a mental illness who, at critical times, are not able, or find it difficult, to advocate for themselves.

2.3 Access to mental health services

Increasing access to mental health services is critical to ensuring equality and to protecting the human rights of persons with mental illness. A large number of people in NSW wish to access particular kinds of mental health services, but are not able to do so. This issue is raised in relation to hospital services at page 46 of the Discussion Paper and in relation to services such as supported accommodation for people with a mental illness in the recent NSW Ombudsman's report referred to above.[9]

Access to mental health services may impact on human rights because inadequate services may mean that involuntary treatment is used even when it is not an option of last resort. There is a risk that, because of a lack of services, involuntary treatment may occur at a higher rate than necessary. If all persons with mental illness had access to appropriate support and assistance to manage their illness and make decisions about their treatment, this could reduce the incidence of involuntary treatment.

2.4 Culturally appropriate mental health services

Mental health services should respect the cultural rights of persons with a mental illness. The following rights are specifically engaged in the CRPD in respect of Indigenous people and people

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8 Mental Health Council of Australia, *Consumer and Carer experiences of stigma from mental health and other health professionals* (2011) <http://www.mhca.org.au/index.php/component/rsfiles/download?path=Publications/Consumer%20and%20Carer%20Experiences%20of%20Stigma%20from%20Mental%20Health%20and%20Other%20Health%20Professionals.pdf at>at 19 December 2012.

9 NSW Ombudsman, above n 4.

from culturally and linguistically diverse (CALD) communities who receive involuntary treatment for mental illness:

- Article 21 - freedom of expression and opinion and access to information;
- Article 30 - participation in cultural life, recreation, leisure and sport; and
- Article 30(4) - explicitly protects the right of people with disabilities to recognition.

As such, the MHA should ensure that a supported decision-making model takes into account the cultural background and preferences of people with mental illness. PIAC suggests below that the MHA be restructured with clear statements mandating supported decision making in the treatment of all persons with a mental illness and ensuring that there are attempts at involving the person in decision making about their care before a person is made an involuntary patient. If the MHA is not restructured in this way, the principles of supported decision-making, in particular taking into account cultural considerations, should be included in s 68 of the MHA (principles for care and treatment).

2.5 Treatment of children under the MHA

The CRPD and the CRC contain a framework for treating persons under 18 years of age for mental illness.

Article 3(h) of the CRPD states that one of the general principles of the CRPD is to ensure respect for the evolving capacities of children with disabilities and respect for the right of children with disabilities to preserve their identities.

Article 7(2) of the CRPD requires that in all actions concerning children with disabilities, the best interests of the child should be the primary consideration. The 'best interests' principle is also the core principle that is contained in the CRC.

Article 7(3) of the CRPD states that children have the right to express their views freely on all matters affecting them, their views being given due weight in accordance with their age and maturity, on an equal basis with other children, and to be provided with disability and age-appropriate assistance to realise that right.

Accordingly, any decision concerning children under the MHA should require the decision maker to consider what is in the best interests of the child. In addition, children should not automatically be considered to be unable to contribute to decisions regarding their treatment. Medical practitioners should consider whether minors have an ability to consent to medical treatment, based on an assessment of their capacity, and the principles of supported decision making. In effect, adopting these principles means that children have a right to be actively involved in decisions regarding their medical treatment.

2.6 Involuntary treatment

The following sections of the CRPD protect the rights of persons with mental illness with respect to involuntary treatment:

- Article 3(a) - the right to inherent dignity and individual autonomy, including the freedom to make one's own choices;
- Article 12 – the right to equal recognition of persons with a disability before the law;
- Article 17 – the right to integrity of persons with a disability;
- Article 19 - the right for persons with disability to live independently and be included in the community;
- Article 21 - the right to freedom of expression and opinion and access to information;
- Article 22 - the right to privacy;
- Article 23 - the right to family;
- Article 25 - the right to health;
- Article 29 - the right to political and public life; and
- Article 30 – the right participation in cultural life, recreation, leisure and sport.

Article 12(4) of the CRPD discusses how decisions regarding restrictive treatment of persons with mental illness should be made. It states that:

> State Parties shall ensure that all measures that relate to the exercise of legal capacity provide for appropriate and effective safeguards to prevent abuse in accordance with international human rights law. Such safeguards shall ensure that measures relating to the exercise of legal capacity respect the rights, will and preferences of the person, are free of conflict of interest and undue influence, are proportional and tailored to the person's circumstances, apply for the shortest time possible and are subject to regular review by a competent, independent and impartial authority or judicial body. The safeguards shall be proportional to the degree to which such measures affect the person's rights and interests.

In particular, Article 12(4) of the CRPD affirms that safeguards on restrictive and involuntary treatment should be included within mental health legislation. This includes ensuring that there are reliable and accessible mechanisms in place to allow for second opinions with respect to medical decisions, and protections in place to uphold the right for persons to apply for independent review with respect to decisions that affect them.

The current ss 13-15 of the MHA seek to uphold the rights of persons with mental illness by requiring that involuntary treatment of a mentally ill or disordered person only be administered where an authorised medical officer is of the opinion that no other care of a less restrictive kind is appropriate or reasonably available to the person in the circumstances.

However, these provisions fall short of what is required under international law: that involuntary treatment itself should only be administered as an option of last resort, and that mental health laws should not make provisions for the involuntary treatment of people that have the capacity to consent to or to refuse treatment. These principles are reflected throughout the CRPD and specifically in the UN *Principles for the protection of persons with mental illness and the improvement of mental health care*.[10]

[10] United Nations, *Principles for the protection of persons with mental illness and the improvement of mental health care,* GA Res 46/119 (1991).

PIAC submits that the decision-making capacity of persons with a mental illness should be assessed consistently with Article 12 of the CRPD.. The CRPD requires capacity to be assessed as proportionate and particular to the need of the individual concerned, at the relevant period of time. This approach takes into account that the mental health of a person will often fluctuate over periods of time.

The approach adopted by the CRPD is also supported by the World Health Organisation, which has indicated that it has a formal view that even though the presence of a mental illness may affect capacity, a person with a mental illness may still have the capacity to carry out some decision-making functions.[11]

2.7 The principle of supported decision making

Supported decision making is a principle that should be incorporated into mental health legislation in NSW.

Article 12 of the CRPD says that persons who require help with exercising their legal capacity must be given the support they require, in the form of supported decision making. Supported decision making can take a number of forms. On one end of the spectrum, it can involve making sure that people have the appropriate means to make decisions (such as access to technology and relevant communication formats, providing additional time, and discussion of options) and, on the other, it can involve family or nominated support persons making some decisions, based on the known preference of the person with a disability.

In essence, a supported decision-making model means that all decisions made concerning the medical treatment of persons with mental illness under the MHA will be made in a way that maximises the ability of the person to participate in decisions that affect them, where they have the capacity to do so.

By way of example, the Exposure Draft of the Victorian Mental Health Bill 2010 adopted some of the key principles of a supported decision-making model.[12] These were that:

- Persons with a mental illness have the same rights and responsibilities as other members of the community and should be empowered to exercise those rights and responsibilities.
- A person with a mental illness is presumed to have the capacity to make decisions about matters relating to their mental illness if the person appears to be capable of doing specified things.
- A person with a mental illness must as far as is reasonably possible in the circumstances be supported to enable the person to make his or her own decisions.
- Treatment services should be provided for the benefit of the person and only for therapeutic or diagnostic purposes and never be administered as a punishment or for the convenience of others.

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11 World Health Organisation, *Quality Rights Toolkit* (2012) <http://www.who.int/mental_health/publications/QualityRights_toolkit/en/index.html> at 7 December 2012.

12 Victorian Government, Exposure Draft Mental Health Bill (2010) <http://www.health.vic.gov.au/mentalhealth/archive/MHActreview/index.htm> at 7 December 2012.

3. Advance care directives

The option of advance care directives should be incorporated into NSW mental health laws. An advance care directive is a written statement setting out a person's wishes and directives for their future health care. In the mental health area, an advance care directive allows a person with legal capacity to express views about the prospect of future medical treatment in the knowledge that, at that future time, the person might not have the capacity to express their views. In this way, advance care directives enhance the ability of a person with a mental illness to ensure that any future medical treatment best accords with their wishes, and it also provides some protection against receiving medical treatment that they would not consent to if they had capacity.

Advance care directives should be taken into account when determining whether administration of involuntary treatment on a patient, where the patient does not have capacity to provide consent, is reasonable and is the least restrictive possible.

Although not having legislative force, advance care directives are becoming more common in NSW. The NSW Supreme Court has upheld a patient's right to determine their future health care through an advance care directive[13] However, currently in NSW advance care directives remain informal mechanisms that are not supported by legislation. A wider use of advance directives and legislative provisions to regulate advance directives would clearly be consistent with the principles embodied in the CRPD.

Accordingly, the ability for persons with mental illness to make advance care directives with regard to mental health treatment, which are required to be upheld in certain circumstances, should be incorporated into the mental health legislation in NSW (see response to Questions 44 and 45 below)

4. Community Treatment Orders

4.1 Introduction

PIAC acknowledges that Community Treatment Orders (CTOs) were introduced relying on the principle of least restriction and that the alternative to a CTO for some consumers would be periods of involuntary detention in a psychiatric hospital. However, the number of CTOs in NSW has greatly escalated since they were introduced and the original concept of CTOs being designed for a relatively small number of consumers in a particular situation has been superseded by CTOs being the most common form of coercive treatment for mental illness. These unintended consequences have been exacerbated by the fact that the NSW Mental Health Advocacy Service does not have the capacity to provide legal representation for the vast majority of consumers in CTO hearings before the MHRT.

PIAC therefore submits that the MHA be amended to return CTOs to their original purpose as alternatives to compulsory hospitalisation for the relatively small number of consumers who do

[13] *Hunter and New England Area Health Service v A* [2009] NSWSC 761.

not have capacity to make decisions about their mental health treatment. This is consistent with the CRPD, in particular Article 12, which guarantees the right of people with disability to equal recognition before the law.

4.2 Background

The principle of least restriction

CTOs were first introduced relying on the principle of least restriction. The *Principles for the protection of persons with mental illness and the improvement of mental health care* (adopted by General Assembly resolution 46/119 of 17 December 1991) state:

> Every patient shall have the right to be treated in the least restrictive environment and with the least restrictive or intrusive treatment appropriate to the patient's health needs and the need to protect the physical safety of others.[14]

Section 12(b) of the MHA reflects that principle.

CTOs were introduced as an alternative to compulsory detention under the MHA. PIAC recognises that with appropriate safeguards, CTOs can provide an alternative to continued compulsory treatment in hospital.

Dawson[15] makes the point that apart from CTOs, there are other methods to 'leverage' consumers into psychiatric treatment:

> In North America, for instance, greater reliance may be placed on the criminal law: that is, on the arrest of mentally disordered persons (often for minor crimes) and their subsequent diversion to mental health care through the vehicle of specialised mental health courts, established for this purpose, within the criminal justice system.[16]

PIAC strongly believes that NSW should avoid going down this path. CTOs therefore certainly have their place as an alternative to hospitalisation and can be part of diversion from the criminal justice system. However, PIAC prefers the model of supported decision making as mandated by the CRPD, rather than a model of compulsory care and treatment. CTOs should be, as they were originally envisaged, options of last resort, when attempts to involve a consumer in their mental health treatment plan has failed, and there is clear evidence that they lack the capacity to make decisions about their health care.

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14 United Nations, *Principles for the protection of persons with mental illness and the improvement of mental health care,* GA Res 46/119 (1991).

15 John Dawson, 'Community Treatment Orders and Human Rights' in Bernadette McSherry (ed), *International Trends in Mental Health Laws* (2008) 148, 149.

16 Ibid.

The current test for CTOs

In *Harry v Mental Health Review Tribunal*[17] (Harry's case), the NSW Court of Appeal held that a finding that a person was a 'mentally ill person' under the MHA was not a condition precedent to placing that person under a CTO.

Therefore, the current legal position is that for a person to be placed under a CTO in NSW, the only tests relevant are those found in s 53(3) of the MHA (unless the person is before the MHRT under an 'Inquiry' pursuant to sections 27 and 43 of the MHA):

> The Tribunal may make a community treatment order for an affected person if the Tribunal determines that:
>
> (a) no other care of a less restrictive kind, that is consistent with safe and effective care, is appropriate and reasonably available to the person and that the affected person would benefit from the order as the least restrictive alternative consistent with safe and effective care, and
>
> (b) a declared mental health facility has an appropriate treatment plan for the affected person and is capable of implementing it, and
>
> (c) if the affected person has been previously diagnosed as suffering from a mental illness, the affected person has a previous history of refusing to accept appropriate treatment.

According to s 53(5), a person has a 'previous history of refusing to accept appropriate treatment' if the following are satisfied:

> (a) the affected person has previously refused to accept appropriate treatment,
>
> (b) when appropriate treatment has been refused, there has been a relapse into an active phase of mental illness,
>
> (c) the relapse has been followed by mental or physical deterioration justifying involuntary admission to a mental health facility (whether or not there has been such an admission),
>
> (d) care and treatment following involuntary admission resulted, or could have resulted, in an amelioration of, or recovery from, the debilitating symptoms of a mental illness or the short-term prevention of deterioration in the mental or physical condition of the affected person.

Section 53(2) of the MHA says that the MHRT should also consider, when making a CTO:

> a) a treatment plan for the affected person proposed by the declared mental health facility that is to implement the proposed order,

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[17] *Harry v Mental Health Review Tribunal* (1993) 33 NSWLR 315.

(b) if the affected person is subject to an existing community treatment order, a report by the psychiatric case manager of the person as to the efficacy of that order,

(c) a report as to the efficacy of any previous community treatment order for the affected person,

(d) any other information placed before the Tribunal.

If a person is before the Tribunal under an 'inquiry' pursuant to sections 27 and 43 of the MHA, the Tribunal may not make a CTO unless the Tribunal is of the opinion that the person is a mentally ill person as defined by the MHA (s 53(4)). This reflects the particular nature of the review under this section, where an assessed person has been only in hospital for a relatively short period, and presumably not ready for community release.

PIAC considers that s 53(4) should be removed from the MHA and that the MHRT should have powers in this situation to order CTOs. This is preferable to giving power to clinicians to be able to make CTOs in certain circumstances without the MHRT's involvement (see response below to Questions 22 to 26 of the Discussion Paper).

4.3 The overuse of CTOs

The Court of Appeal in Harry's case did not envisage that CTOs would be used extensively in NSW. Kirby P commented:

> I accept that, as a practical matter, the occasions on which the Tribunal would see a person who did not satisfy the definition of a 'mentally ill person' would be rare. This is because the Act imposes on the medical superintendent, who did not consider such a person to be mentally ill, the duty to discharge that person. Accordingly, such a person would not ordinarily be brought before the Tribunal. In such a case, no community treatment order would therefore be made.[18]

Clarke JA commented that 'according to the second respondent' (Dr Cullen) in the case, CTOs were designed to remedy the limited 'options available to clinicians who were required to deal with a small but significant number of patients who fell into the category of what is colloquially known as 'revolving door' patients.'[19]

> These are patients with a mental illness who are able to be treated successfully in hospital but who, once they are no longer mentally ill and were released, would often refuse to take medication with the consequence that their condition might deteriorate to such a degree that involuntary admission was again necessary.[20]

PIAC submits that the current situation regarding CTOs is very different to the situation envisaged by their Honours in Harry's case, both because of changes in the legislation in subsequent

[18] Ibid 329.

[19] Ibid 337.

[20] Ibid 337.

iterations of NSW mental health legislation and, perhaps more significantly, changes in policy and practice.

The most recent published Annual Report of the MHRT (2011-12) advised that there were 4,697 hearings by the MHRT regarding s 51 of the MHA (ie, CTOs), including adjournments. Consumers/patients were legally represented in only 1143 of these hearings (24%).[21]

The total number of CTOs made in NSW actually reached a peak in NSW in 2007 when 6,263 were made either by the MHRT or visiting Magistrates who then conducted the initial inquiries under s 27 of the MHA.[22]

Since the 1980s, CTOs have been introduced throughout the western world, but rates of use vary considerably. Citing a 2003 survey, Donnelly asserts that Victoria has the highest rate of CTO usage in the world (55 people per 100,000), followed by NSW (37.4 per 100,000).[23]

This seems to suggest that CTOs are now used routinely to enforce administration of medication, rather than as a last resort method of avoiding the need to hospitalise people with mental illness.

4.4 Critiques of CTOs - consumers and others

Light et al characterise CTOs as 'one of the most contested issues in psychiatry' and cite several studies that question their efficacy.[24] These authors also cite other criticisms of CTOs:

> Criticisms of CTOs include their potential to undermine non-coercive efforts to engage patients, and the inappropriateness of any attempts to increase coercion to compensate for under resourced services.[25]

The Discussion Paper acknowledges (at pp38-9) consumer dissatisfaction with CTOs as well as other compulsory orders, often manifested by complaints relating to levels of medication and a lack of consideration of their serious side effects. PIAC supports the introduction of mechanisms in the MHA that allow consumers to request reviews of their medication levels under CTOs, as well as mandated regular reviews of medication and treatment plans (see below).

PIAC is aware, through consultations with consumers and persons seeking advice and representation, that there are other consumer concerns regarding CTOs. Because of some side-effects of psychotropic medications, many people on CTOs believe they cannot function effectively in the community. Regular requirements to accept medication and visits from

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21 NSW Mental Health Review Tribunal, *Annual Report 2011-12*, 22.

22 Ibid 31.

23 Mary Donnelly, 'Community-based care and compulsion: What role for human rights?' (2008) 15 *Journal of Law and Medicine* 782, 782.

24 Edwina Light, Ian Kerridge, Christopher Ryan and Michael Robertson, 'Out of sight, out of mind: making involuntary community treatment visible in the mental health system' (2012) *Medical Journal of Australia* 198(9) 591, 591-2.

25 Ibid 592.

community mental health workers may have an adverse effect on employment prospects or the ability to study or undergo training. Although CTOs may be seen as a least restrictive alternative to hospitalisation, they certainly restrict the liberty of consumers subject to them. Many people resent what they perceive as strangers entering their home to check on their CTO compliance. Despite the safeguards in s 57(3), which prohibits use of force to administer medication and s 57(5) which prohibits entry into premises without consent, the constant threat of re-hospitalisation contained in s 58 means that consumers subject to CTOs often feel powerless in negotiations about medication and the timing and location of visits by the community mental health team.

Clisby and Starr, informed by consumer experiences in the Northern Territory, refer to examples of where the concept of least restrictive alternative might be used as a justification 'for what might arguably be fairly restrictive practices'.[26] They cite the example of a person on a CTO where

> there are severe side effects to the medication. The side effects may be impotence, or tiredness, or tremor or restlessness to name just a few. Sometimes, the case manager may not understand the impact the side effects are having on the consumer's life… Yet the consumer may consider the treatment to be highly restrictive because the medication affects the ability to live a normal life.[27]

4.5 CTOs and the CRPD

The CRPD requires 'supported decision making' rather than 'substituted decision making'. This is found specifically in paragraphs 2 and 3 of Article 12, which are concerned with the issue of capacity. They require governments to ensure that people with disability receive the support they need to exercise their legal capacity on an equal basis with others, in all aspects of their lives.

Article 12(4) of the CRPD states:

> State parties shall ensure that all measures relating to the exercise of legal capacity respect the rights, will and preferences of the person, are free of conflict of interest and undue influence, are proportional and tailored to the person's circumstances, apply for the shortest time possible and are subject to regular review by a competent, independent and impartial authority or judicial body. The safeguards shall be proportional to the degree to which such measures affect the person's rights and interests.

CTOs represent a form of what has been previously described as 'substituted decision' making. Although the CRPD clearly prefers supported decision making, it is clear that CTO legislation is caught by the term 'measures relating to the exercise of legal capacity' under the CRPD. The safeguards referred to in Article 12(4) should therefore be applied to CTOs.

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26 Judy Clisby and Marlyn Starr, *The Least Restrictive Alternative – is it Too Restrictive?* <http://www.cvp.nt.gov.au/documents/Publications/letterspresentations/TheLeastRestrictiveAlternativePresentationtext.pdf> at 7 December 2012.

27 Ibid 6.

The principle at common law is that an adult must be presumed to have legal capacity. McHugh J in *Re Marion*[28] restated this, where he found that:

> The common law accepts that a person has rights of control and self-determination in respect of his or her own body which other persons must respect. Those rights can be altered with the consent of the person concerned. Thus, the legal requirement of consent to bodily interference protects the autonomy and dignity of the individual and limits the power of others to interfere with that person's body.[29]

Mahoney JA in Harry's case refers to what he sees as an exception to the principle that a person should not be forced to receive medical treatment without consent:

> People who need treatment may not have the capacity or judgement to give consent to the treatment she needs [sic].[30]

4.6 Recommendations for law and policy reform

The MHA should reflect the CRPD in recognising that there should be a presumption that persons with potential cognitive disabilities have legal capacity and that any form of substitute decision making, which includes CTOs, should be limited to measures of last resort and must be applied only for the shortest time possible.

The MHA should therefore clearly state that the presumption of capacity applies to all of its provisions, including those relating to CTOs.

A presumption in favour of capacity would reflect the earlier objects of CTOs and be consistent with the CRPD, in particular Article 12. In practical terms, this would mean that to successfully apply for a CTO, a hospital or community mental health service would have to establish that the consumer did not have the capacity to make decisions about their own treatment, as well as satisfy ss 53(3) and 53(5).

PIAC also recommends that CTOs should initially be limited to a period of six months. After two CTOs have been granted, and before a third CTO is considered, an independent review of the CTO should be mandated, where an independent psychiatrist provides a report on the efficacy of the treatment plan and reviews the current level of medication. The MHRT should have a discretionary power to request such a review at any time, including if and when a patient requests a review of a CTO. The MHRT should have the power to amend the CTO in accordance with any findings in such a review. Only after such a review should the MHA allow CTOs of more than 12 months' duration.

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28 *Re Marion* (2002) 175 CLR 218.

29 Ibid 309-310.

30 *Harry v Mental Health Review Tribunal*, above n 17, 333.

5. Involuntary admissions

5.1 Introduction

PIAC starts from the premise that coercive treatment should always be used only as a last resort. Further, coercive treatment and care in a closed environment should only be the last resort as against coercive treatment in the community.

Consistent with the CRPD, there should be a presumption of capacity in adult persons, and if a person has capacity to make decisions about their health care, involuntary treatment in any context, hospital or community care, has no justification. Otherwise it is discriminatory.

Coercive care in the closed environment of a locked psychiatric ward is only justified on risk of harm grounds, and only then if there are no other less restrictive alternatives available.

Therefore, the MHA test for involuntary admission should first require lack of capacity to be established, then a risk of harm to self or others, and then a reasonable satisfaction that there are no other less restrictive alternatives to coercive care and detention available.

PIAC believes that these principles are currently embodied in the MHA but could be made much more explicit and less ambiguous in the language used in the legislation. As stated above, the commitment to the non-discriminatory principles in the CRPD should be made explicit in the legislation, both through a clear obligation to supported decision making in all mental health care and a capacity test for all forms of involuntary treatment.

The structure of the MHA should change and its object provision should be broadened to reflect the principles of supported decision making and patient autonomy. For involuntary hospitalisation, capacity and risk of harm tests should apply. A definition of 'mental illness' that applies to a narrow range of disorders requiring coercive care, and possible detention, should remain in the MHA.

5.2 The structure and purpose of the MHA

The current MHA and all its previous iterations in NSW have been primarily concerned with the 'care, treatment and control' and detention of involuntary patients. There have always been some references to voluntary patients, but this has been, and these references remain in the current MHA, primarily about the relationship between voluntary and involuntary patients and the process of making a voluntary patient involuntary.

In the wake of the CRPD, and its emphasis on supported decision making as against coercive treatment and care, there is a strong argument to broaden the focus of the MHA. There is concern that current and previous NSW mental health legislation, because of its focus on coercive treatment and risk of harm, has failed to focus on patient autonomy and principles of supported decision making.

PIAC has stated above the principles deriving from the CRPD that involuntary treatment itself should only be administered as an option of last resort, and that mental health laws should not

make provisions for involuntary treatment of people that have the capacity to consent to or to refuse treatment.

To implement these principles, two changes are needed to the current MHA. First, there needs to be a new test for involuntary treatment and detention that reflects the principles stated above. Secondly, the structure and the primary objects provision of the Act need to be amended, by making a commitment to supported decision making and the use of involuntary detention as an option of last resort.

The tests for involuntary detention and treatment and the consequent involvement of the MHRT in the continued detention of involuntary patients, should be a separate part of the legislation, with the overall structure of the legislation providing that involuntary detention and treatment are last resorts that can only be considered when:

- attempts at involving a person in decision making about their care have failed;
- the person lacks capacity to make their own decisions about their care and treatment;
- hospitalisation in a closed environment and coercive care are justified on risk of harm criteria; and
- there are no alternative options to detention and coercive care of a less restrictive kind.

5.3 Capacity as against risk of harm

There has been a recent debate in NSW in relation to whether the test for involuntary detention should revolve around capacity, in conformity with the CRPD, or risk of harm.[31]

PIAC sees this as a false dichotomy in that there are clearly reasons not to treat compulsorily someone who has the capacity to make their own decisions about their care and treatment (which applies to both CTOs and involuntary treatment orders in hospital) but there is also a human rights principle that dictates that someone should not be detained and compulsorily treated without a clear public interest purpose. This principle has been reflected previously both in the common law,[32] and in previous and current mental health legislation – ie, that a person's liberty should not be removed unless the outcome of their non-detention and not receiving treatment is that there will be significant or serious harm to the person or harm to other persons.

Risk of harm tests provide an extra safeguard against applications for involuntary treatment in a closed environment where there is no reason for detention and treatment in hospital other than it being justified as 'in the patient's best interest'. Put another way, although forced treatment in hospital may be justified for some physical conditions if a person lacks capacity (eg, if a person needs an urgent operation), there is no justification for forced hospitalisation for mental illness as against treatment in the community, unless there are risk of harm factors that require close observation and/or keeping the patient safely separate from the community.

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31 Sascha Callaghan and Christopher Ryan, 'Rising to the human rights challenge in compulsory treatment – new approaches to mental health law in Australia' (2012) 46 *Australia and New Zealand Journal of Psychiatry* 611.

32 *In Re Hawke,*(1923) 40 WN (NSW) 58, 59 per Harvey J.

There is justification in detaining a person if they are a risk of harm to others for several reasons. First, keeping the person in a closed environment prevents immediate harm to others that might otherwise occur if the person were at liberty. Detention accompanied by coercive treatment is only further justified on the basis that the treatment will have a positive effect on the mental illness, which in turn will ameliorate further harming behaviour.

Protecting a person from self-harm is justified in that, if a person has a serious mentally illness and lacks capacity to make decisions about their care because of that illness, and they harm themselves, the consequences are likely to be partially or wholly irreversible. Therefore it is justifiable for the MHA to contain protective measures that prevent significant and irrevocable harm occurring to a person where there is evidence that they are likely to directly self-harm or carry out self-harming acts.

Callaghan and Ryan also raise the issue of the need to distinguish between harm caused by the continuation or deterioration of a person's condition and additional harm that is the basis of risk of harm tests.[33] PIAC believes that if the former became part of the test, the test would become both circular and highly paternalistic – ie, the person has a mental illness and such illnesses always require treatment, so they are therefore at risk of harm if they do not receive treatment. PIAC submits that the MHA should make clear that 'risk of harm' refers to additional harm, arising from non-treatment, with the harm accruing to the person or other persons.

PIAC submits, in addition, that the principle of least restriction should remain part of any test for involuntary treatment and detention, as well as other forms of involuntary treatment, such as CTOs.

There is no conflict or inconsistency between these basic principles, and no reason why mental health legislation should not reflect all three principles – ie, by incorporating a capacity test, a risk of harm test and a principle of least restriction test. PIAC notes that all three principles are part of the tests for involuntary detention in the Victorian exposure draft Mental Health Bill.[34]

PIAC submits that there should be an additional test for the consideration of the MHRT, at the point where an 'assessable person' is presented to the MHRT for review. Those presenting the assessed person should present evidence that satisfies the MHRT that there were significant attempts at involving the assessable person in decision making about their care and treatment and that these attempts have failed. This will ensure that the MHA reflects the principles of supported decision making embodied in the CRPD.

5.4 The definition of mental illness under the MHA

The definition of mental illness in s 4 of the MHA is essentially the first limb of the test for involuntary detention of a patient (although given the decision in Harry's case, not necessarily the test for involuntary treatment under a CTO).

Section 4 of the MHA defines 'mental illness' for the purposes of the Act as:

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33 Callaghan and Ryan above n 31, 615.

34 Above n 12.

a condition that seriously impairs, either temporarily or permanently, the mental functioning of a person and is characterised by the presence in the person of any one or more of the following symptoms:

(a) delusions,
(b) hallucinations,
(c) serious disorder of thought form,
(d) a severe disturbance of mood,
(e) sustained or repeated irrational behaviour indicating the presence of any one or more of the symptoms referred to in paragraphs (a)-(d).

The purpose of this definition is to establish that for the purposes of the MHA (ie, involuntary treatment and detention) only certain conditions that 'seriously impair … the mental functioning of a person' are covered by the definition. The public purpose behind this definition is linked to the primary object of the MHA, which is to provide for the 'care, treatment and control of persons who are mentally ill or mentally disordered' (s 3).

Although it might be contested by some clinicians, psychotic illnesses are generally considered those that best respond to intervention by psychotropic medication and consequent treatment in a hospital setting, while other conditions such as 'personality disorders' are best treated in the community. Although the so-called 'talking therapies' are also recognised as valid treatment options, there is a general agreement that they are not conducive to participation without consent.

Historically, there has been a move from long-term institutional care for persons with a mental illness to a primary focus on community care, with short periods of hospitalisation for people in acute phases of mental illness. This change came about as a result of a significant worldwide increase in the use of psychotropic and anti-depression medication in all mental health treatment and care. Previously, involuntary care was often justified on the basis of protective detention, ie, detaining people who where both dangerous and 'insane' with very little therapy or effective treatment available.

However, in the past 40 years, justification for involuntary care has been based on an assumption that some people with psychotic illnesses can be treated successfully, primarily with medication, in a hospital setting, behind locked doors because of the potential risk of harm to themselves or in a hospital setting, closely watched and monitored, because of risk of harm to themselves. More generally, it is assumed that any form of coercive care should not be for a lengthy period and that care for most people with a mental illness should not take place in a closed hospital environment, but 'in the community'.[35]

Therefore, a definition of mental illness for the purposes of the MHA should be limited to only those illnesses where treatment and care is likely to be efficacious in a closed environment. Such a definition, together with the principle of least restriction, should ensure that persons who need

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[35] Helen Killaspy 'From the asylum to community care: learning from experience' (2006) 79 and 80 *British Medical Bulletin* 245; Catherine Coleborne and Dolly Mackinnon 'Psychiatry and its Institutions in Australia and New Zealand' (2006) 18(4) *International Review of Psychiatry* 371.

involuntary treatment receive it, as against those who could be appropriately treated in the community.

Does the current definition of 'mental illness' refer to capacity?

If an explicit capacity test were introduced in the MHA, this would not involve a significant substantive change to the MHA. PIAC submits that the words 'seriously impairs' in the current definition already impose a kind of capacity test in the MHA. The legislature must have intended that the mental functioning of the person refers to the mental functioning required for everyday living. This must include the rational decision making necessary to decide whether or nor to accept or reject medical advice in relation to treatment. It is hard to envisage a case where a person who has a serious impairment of their mental functioning is capable of making decisions about their treatment and care. The evidence for this assertion lies both in the wording of the current definition and its historical predecessors.

The history of successive changes of definition in NSW mental health legislation is relevant to establish that the existing legislation provides an excellent platform for making the MHA more human rights focussed and compliant with the CRPD. The existing references to capacity need to be made clearer and therefore less susceptible to inconsistent, unpredictable or even arbitrary interpretation. PIAC does not see this as introducing a totally new or radical concept to the MHA, but simply another step in making the law more consistent with human rights principles and making the MHA more understandable to those who have to interpret and understand it – lawyers, health practitioners and consumers.

Until the *Mental Health Act 1990* (NSW) (1990 Act), there was not a definition in NSW mental health legislation for 'mental illness' separate to the definition of a 'mentally ill person'.

The *Mental Health Act 1958* (NSW) (1958 Act) defined a mentally ill person as:

> a person who owing to mental illness requires care, treatment or control for his own good or in the public interest, and is for the time being incapable of managing himself or his affairs and 'mentally ill' has a corresponding meaning.

The *Mental Health Act 1983* (NSW) (the 1983 Act) also did not separately define 'mental illness' and included a lengthy definition of a mentally ill person, which set out particular categories where a person was defined as a 'mentally ill person' either for their own protection or the 'protection of others'. The 1983 Act also included a section, similar to section 16 of the current MHA, which stated that a person was not a 'mentally ill person' if the only symptoms they displayed were behaviours such as drug use or a particular sexual orientation.

It can be argued that in the 1958 Act, the first part of the definition relied on a circular argument, as the requirement for care, treatment and control was in effect a requirement for compulsory treatment. The second part, referring to incapacity 'to manage himself or his affairs' reflected the intention of the legislature to put the issue of capacity at the forefront. Similar to the current definition, it is hard to imagine a person who is incapable of managing themselves and their affairs and yet is capable of making informed decisions about their treatment and care.

PIAC believes that the 1990 Act and the (current) MHA separated the definition of 'mental illness' from the definition of 'mentally ill person', removing the circularity of the definition in the 1958 Act. The MHA also addressed the uncertainty created by the 1990 Act, which provided no definition of 'mental illness' at all, circular or otherwise.

The 1990 Act, and consequently the unchanged (in this aspect) MHA, appears to have reintroduced the capacity test into the definition of 'mental illness', which was present between 1958 and 1990. It is arguable that the NSW Parliament believed that the capacity element was more appropriate in the definition of 'mental illness', which essentially relies on medical opinion, rather than in the definition of 'a mentally ill person', which relies appropriately on the more objective criterion of risk of harm, necessary to justify 'care, treatment and control' facilitated by detention in a psychiatric hospital or unit.

However, PIAC now submits that, both to counter existing confusion, and to comply with the CRPD, the MHA should codify the common law principle of presumption of capacity and set out a separate and comprehensive capacity test as one of the 'limbs' of an overall test for involuntary detention and care as well as separately defining 'mental illness' for the purposes of the MHA.

Why definition of mental illness must remain in the MHA as well as capacity test

It has never been the intention of mental health legislation to allow involuntary treatment of every type of mental disorder. The reality in Australia today is that many people are treated for mild mental disorders, particularly depression, by their general practitioner. There are many so-called mental disorders that have only a mild effect on a person's wellbeing and there is not any perceived need to treat them by coercive hospitalisation. Involuntary treatment, in modern times, has usually been confined to psychotic illnesses and major depressive disorders.

This is reflected in the current definition of 'mental illness' in the MHA. Historically, 'mental illness' was not separately defined in the MHA until 1990. This resulted in a situation where persons could be detained, often because of lack of alternative accommodation and care, for non-psychotic mental illnesses and disorders. Here the emphasis was on control and detention rather than treatment and care.

The 1990 Act's definition of 'mental illness', in addition to the introduction of the 'mentally disordered' provisions to allow short-term restricted protective care, represented a much more transparent process to deal with the short-term need to provide protective care before less restrictive and more appropriate options are able to be put in place. The definition of 'a mentally disordered person' (s 15) specifically states that a person does not have to have a 'mental illness' as defined by the MHA to be placed in short-term protective care.

It is therefore essential that the MHA continue to distinguish between persons with psychotic illnesses that can only, in very restricted circumstances, be treated in a hospital setting, if necessary behind locked doors, and persons with many recognised mental disorders, normally best treated in the community that may, in exceptional circumstances and for a very short time, be in need of detention and treatment in a hospital setting.

This can only be achieved with a separate definition of 'mental illness' in the MHA. That definition should focus both on identifying the relevant psychoses and the efficacy of cohesive treatment and detention for those psychoses.

PIAC proposes that the following be adopted as the definition of 'mental illness'. This definition is a combination of the existing definition in s 4 of the MHA and cl 70(b) of the Victorian Draft Bill[36]:

> *A condition that is characterised by the presence in the person of any one or more of the following symptoms:*
> *(a) delusions,*
> *(b) hallucinations,*
> *(c) serious disorder of thought form,*
> *(d) a severe disturbance of mood,*
> *(e) sustained or repeated irrational behaviour indicating the presence of any one or more of the symptoms referred to in paragraphs (a)-(d), and*
>
> *if treated in an approved mental health service would be likely to be of some benefit in either preventing the mental illness from worsening, or in alleviating any of the symptoms or effects of the illness.*

The reference in the current definition to 'serious impairment' would not be necessary if there were a comprehensive capacity test for involuntary treatment.

Should other forms of mental disorder be included in definition of mental illness?

PIAC considers it is not in the public interest to extend the definition of 'mental illness' under the MHA to cover conditions such as personality disorder, dementia and ADHD. The Discussion Paper notes (at pp21-22) that there is academic research that suggests that personality disorder can be 'treated' by 'psychological interventions'. PIAC notes that psychological services are not normally available to involuntary patients in psychiatric units and hospitals in NSW. They are usually provided in the community through public counselling services and private fee for service psychological services (now able to be accessed through Medicare).

The principle of least restriction would suggest that if these services can be provided in the community, involuntary treatment would be inappropriate. PIAC would also question the efficacy of compulsory psychological counselling or therapies, if the patient is unwilling or indifferent to participation. PIAC submits that identical arguments would apply to people diagnosed with ADHD.

With regard to dementia, PIAC is not aware of any recognised 'treatment'. Quite often people with dementia have other mental illnesses or disorders for which they may need to be involuntarily treated or detained under the MHA. PIAC notes that the problem for authorities in this situation is not lack of compulsion and powers of detention, but the limited resources available to provide secure and safe accommodation in a therapeutic setting for people with both dementia and mental illness. As stated above, emergency situations arising with people with dementia can always be dealt with by use of the 'mentally disordered' provisions in the MHA.

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[36] Above n 12

Finally, PIAC supports the retention of s 16 in the MHA, with modification in light of the suggested changes above. It is very important that the MHA clearly excludes irrelevant or prejudicial matters from considerations about 'mental illness' or 'mental disorders' under the MHA.

5.5 A new capacity test for the MHA

PIAC submits that, consistent with the CRPD, there should be in the MHA, a restatement of the common law position that there is a presumption of capacity for any adult person.

The new capacity test should require that any medical practitioner wishing to involuntarily detain a person must be satisfied that the person lacks capacity to make decisions about their own treatment and care. To continue involuntary treatment, the Tribunal must also be satisfied, to the *Briginshaw* standard,[37] that the person lacks that capacity.

PIAC submits that there should be a test for capacity, written in plain English, that clearly sets out the criteria that would be required to maintain the principle that persons who have the capacity to make their own decisions about their mental health treatment and care should not be detained. Interstate and overseas examples provide best practice models that could be used in NSW legislation.

PIAC believes that the test found in the recent draft Victorian Bill[38] best fulfils this objective and should be included in the MHA as part of the test for both involuntary detention and treatment and involuntary treatment (ie, CTOs).

PIAC submits that, before an involuntary order for detention and treatment or a CTO is made, the medical practitioner or the MHRT must be satisfied that, as per the Victorian Bill:

> *because of the person's mental illness the ability of the person to make decisions about the provision of treatment is significantly impaired as the person is unable to:*
> *(i) understand the information relevant to the decision; or*
> *(ii) retain that information; or*
> *(iii) use, weigh or appreciate that information as part of the process of making the decision.*[39]

5.6 The test for involuntary detention and care

PIAC submits that the tests for assessments by medical practitioners to establish grounds for involuntary treatment and detention (ie, to make someone an 'assessable person' under the MHA) should be:

- the person lacks capacity to make their own decisions about their care and treatment;
- the person poses a serious risk of harm to themselves or others; and

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37 *Briginshaw v Briginshaw* (1938) 60 CLR 336.

38 Above n 12.

39 Ibid cl 70.

- there are no alternative options to detention and coercive care of a less restrictive kind.

PIAC submits that if the assessed person is referred to the MHRT (or appeals to the MHRT under s 44 of the MHA), the MHRT, before it makes an involuntary order, should also be satisfied that genuine and appropriate attempts at involving the person in decision making about their care have failed.

PIAC believes that the risk of harm test should be in the MHA as part of the test for involuntary detention and care, and not as a component of the definition of a 'mentally ill person'. The current tests for involuntary detention and care are found separately in the MHA, and this leads to confusion. The MHA should list, in one section or part, the tests required to establish whether a person should be made an involuntary patient.

PIAC submits that the risk of harm test should be that the medical practitioner or the MHRT must be satisfied that (in the case of the MHRT, to the *Briginshaw* standard):

> *There are reasonable grounds for believing that detention and treatment in a mental health facility is necessary:*
> *(a) for the person's own protection from serious harm, or*
> *(b) for the protection of others from serious harm.*

This continues the existing test in the MHA, with some modification.

Finally, the principle of least restriction should form part of the test for involuntary detention and care. The existing wording in s12 should be incorporated in the criteria for involuntary detention and care, so that the medical practitioner or the MHRT (to the *Briginshaw* Standard) should have to be satisfied that:

> *No other care of a less restrictive kind, that is consistent with safe and effective care, is appropriate and reasonably available to the person as an alternative to the proposed detention and treatment in a mental health facility.*

The principle of least restriction should also be found in the objects of the MHA and in any clause similar to the existing s 68 of the MHA referring to 'principles for care and treatment'.

6. Responses to Questions in the Discussion Paper

Questions 1 - 2

PIAC has addressed this question above. All proposed amendments to the MHA should reflect the principles of supported decision making. If the current structure of the MHA is maintained, the principles of supported decision making should be included in the objects of the legislation in s 3 and the principles for care and treatment in s 68.

Questions 3 - 4

PIAC submits that, in general, the provisions dealing with substituted decision making over non-mental health issues, which are currently in the MHA, would be better placed in the *Guardianship Act 1987* (NSW) (Guardianship Act).

PIAC has noted above that the CRPD adopts a modern approach to the protection of the rights of persons with a mental illness, in a capacity-based, supported-decision making framework. The primary emphasis in the Guardianship Act on capacity better suits the assessment of whether people with mental illness who are on involuntary orders should or should not receive particular treatment for non-mental health conditions.

There is no reason why decision making about health care inside a hospital should be any different to decision making about health care outside a hospital. The current provisions of the MHA breach Article 12 of the CRPD in that they set up a discriminatory regime for dealing with people with mental illness who are on involuntary orders as against all other persons, by treating people differently on the basis of their mental health status.

The Guardianship Tribunal has power to take into account the following matters set out in s 14(2) of the Guardianship Act:

> (a) the views (if any) of:
> (i) the person, and
> (ii) the person's spouse, if any, if the relationship between the person and the spouse is close and continuing, and
> (iii) the person, if any, who has care of the person,
> (b) the importance of preserving the person's existing family relationships,
> (c) the importance of preserving the person's particular cultural and linguistic environments, and
> (d) the practicability of services being provided to the person without the need for the making of such an order.

This provision is consistent with supported decision making principles, which are in turn consistent with the CRPD.

The one exception to this situation may be dealing with emergency situations. Because of the links between hospitals and the MHRT, the procedure set out in s 99 of the MHA to provide substituted decision making, where there is a medical emergency and the patient is currently an involuntary patient, is arguably better left with the MHRT. This may be simply because there are existing direct audio-video links (AVLs) between psychiatric hospitals and the MHRT. However, if this provision remains in the MHA, the MHRT should be directed to apply the capacity test and the matters set out in s 14(2) of the Guardianship Act.

In conclusion, PIAC submits that the powers set out in ss 100, 101, 102 and 103 of the MHA would be more appropriately placed in the Guardianship Act.

A further matter of concern

PIAC is concerned with the current wording of s 101(2) of the MHA, which seems to give primary carers unfettered power as a substitute decision maker under s 101. PIAC understands the purpose of the 'primary carer' provisions is to give nominated carers, relatives or friends greater access to information. PIAC submits that the primary carer provisions of the MHA need some modification and clarification (see below).

The MHA should set up mechanisms that provide patients with clear and accessible information about the rights and obligations of primary carers before they nominate a person to this role. If s 101(2) is to remain in the MHA, it is vital that patients are made aware of the potential substituted decision making role of a primary carer set out in the MHA.

PIAC's preferred option would be to legislate for advance care directives specific to persons who would anticipate that they might, in the future, be involuntarily detained under the MHA. A person may, in this circumstance, have a preference for a separate person to have access to information as a 'primary carer' to the person they might wish to be the substitute decision maker to consent to medical procedures.

Questions 5 - 9

PIAC has addressed these questions above in Part 4 of the submission above; in particular, Part 4.3.

Questions 10 - 14

PIAC has submitted above that there should be a new test for CTOs consistent with the CRPD. If such a test based on capacity principles is introduced, PIAC has no objection to the MHRT being able to make a CTO at any hearing, including an appeal under s 44 of the MHA.

PIAC does not object to the MHRT having the power to stay orders for discharge or orders for a CTO in situations where the patient/consumer does not have appropriate arrangements in place for their safe return to the community. However, PIAC believes there is no reason why such arrangements cannot be made within seven days. PIAC believes that to detain a person for 14 days in these circumstances cannot be justified and that the MHRT should only have power to stay its orders for seven days.

Questions 15 - 16

PIAC agrees with the proposal that s 9 of the MHA be amended so that a voluntary patient must be reviewed at least once every 12 months of continuous residence, voluntarily or involuntarily, in mental health facilities for the reasons stated in the Discussion Paper.

Questions 17 - 19

PIAC has submitted above that there needs to be a different test, consistent with the CRPD, to determine whether a person should be placed on a CTO.

Once such a test is in place, PIAC does not object to the MHRT having the power at any time and in any hearing, to place someone on a CTO. PIAC does not agree that there is a need to amend the MHA to give this power to any other body or person. If a clinician or a mental health service

sees the need for the making of a CTO in an emergency situation, the MHRT has the capacity to hear matters urgently, using AVL technology if required. This occurs now with regard to applications to administer Electro Convulsive Therapy (ECT).

PIAC is concerned that if mental health services or clinicians were able 'to commence involuntary treatment in the community without a CTO approved by the MHRT', this practice would become the norm, effectively skirting the stringent safeguards in the MHA with regard to involuntary treatment and detention.

Further, PIAC does not believe there would be many situations where a CTO would be an appropriate response to an urgent situation rather than starting the process of involuntary detention set out in the MHA. The power to detain a 'mentally disordered person' under the MHA is effectively a form of short-term preventative detention and more than adequately provides for emergency situations where persons may be of harm to themselves and/or others.

Questions 20 - 21

PIAC does not object in principle to a lengthening of the period a person can be held in the circumstances discussed in the Discussion Paper. PIAC recognises that a one-hour delay may not always be practical in a rural or regional settings.

Deprivation of liberty, without formal charges, should only be permitted in exceptional circumstances. The police have options to commence criminal matters other than by arrest, particularly if they know the permanent address of a suspect and the suspect is not a threat to public safety. The very fact that the hospital fails to admit such a person is often because they do not pose a risk of harm to themselves and/or others and therefore are not 'mentally ill persons' under the MHA. Therefore, even in remote areas, police requests for the return of a person to their custody should not be in any way routine. Any legislative change should reflect this.

PIAC believes that if the period of delay is simply extended to three or four hours without qualification, this period will likely become standard practice in city as well as rural and remote areas. PIAC therefore submits that the maximum period in these circumstances should be three hours only and that the legislation should initially allow detention for a maximum of two hours, with the period only permitted to be extended to three hours in specific exceptional circumstances, set out in the legislation.

Questions 22 - 26

PIAC is in principle opposed to persons other than medical practitioners having the power to detain under the MHA, even for short periods. The definition of mental illness in s 4 of the MHA requires the expert opinion of a medical practitioner. Medical practitioners are responsible for diagnoses and consequent treatment decisions. Failure to competently or ethically carry out these decisions may lead to disciplinary action under the *Health Practitioner Regulation National Law* (NSW). Other health practitioners, although subject to ethical rules and constraints, do not make definitive diagnoses or have the authority to prescribe medication in our health system.

Even in remote areas, there are doctors available and on call to deal with emergency situations at most times. AVL also provides the opportunity for urgent psychiatric assessments. PIAC, although maintaining that face-to-face assessments are always preferable both for the consumer and the assessor, has no objection to AVL assessments in certain limited situations such as emergencies. PIAC understands that AVL assessments now occur as a matter of course in country areas.

Voluntary patients should be continually monitored to ensure that their condition does not deteriorate so they become 'mentally ill persons' under the MHA. If this is carried out appropriately, then it should be only in exceptional cases that someone who suddenly lacks capacity to make their own treatment decisions and becomes a risk of harm to either themselves or others, needs to be urgently re-assessed for the purpose of involuntary detention and treatment.

PIAC submits that the public interest in maintaining the principle of detention as a last resort overrides any possible public interest in holding persons against their will on the possibility that a medical practitioner might detain them in two or three hours' time.

There is also a clear public interest in encouraging persons with a mental illness to become voluntary patients. This is reinforced by the CRPD and its emphasis on supported decision making. PIAC submits that the only references to voluntary patients in the MHA should be to provide them with additional protections, such as regular reviews by the MHRT. Otherwise, voluntary mental health patients should have the same rights and responsibilities as 'voluntary' patients in general hospitals. Patients in general hospitals cannot be 'held' in hospitals if they choose to discharge themselves. Voluntary mental health patients should be afforded the same right – a proposition reinforced by the requirement for legal equality in Article 12 of the CRPD.

The common law, through the defence of necessity to the torts of trespass and false imprisonment, allows hospitals to detain and even restrain people if the alternative is immediate risk to life or an immediate possibility of serious harm to themselves or others. NSW Health has developed protocols to assist and guide health professionals in such circumstances.[40] These common law legal principles apply in all medical situations and could apply to an involuntary patient in such exceptional circumstances. Too often, health professionals poorly understand this legal situation. If they were better educated in the legal position in respect of such exceptional emergencies, there might be less call for changes to the law.

The danger is that if legislative change is introduced, the exceptional becomes the common and routine. PIAC believes the legal position should remain as it is, both in the MHA and the common law, and NSW Health should better educate its employees about the exceptional circumstances when they can legally restrain and detain people. This is preferable to giving non-medical practitioners the power to detain people under the MHA.

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40 NSW Health Department, *Aggression, Seclusion & Restraint in Mental Health Facilities in NSW* (2012) <http://www0.health.nsw.gov.au/policies/pd/2012/PD2012_035.html> at 7 December 2012.

5.7 Questions 27 - 33

PIAC believes that the use of AVL to conduct hearings or inquiries under the MHA should be permitted only if face-to-face contact is not possible and/or practicable. PIAC submits that this principle should be stated in the MHA.

As stated above, the use of AVL in emergency situations is preferable to widening the categories of health professionals that can 'schedule' a person under the MHA. Whether a person has a 'mental illness', as defined by the MHA, is a medical judgment and medical practitioners are subject to professional scrutiny designed to ensure that the public have faith that such diagnostic decisions are made competently and ethically.

PIAC submits that use of AVL when face-to-face contact is not possible in the circumstances is a preferable option to 'gazetting' additional health facilities. This ensures that assessments are initially made by medical practitioners who are experienced in dealing with mental illness and, if a second assessment is required, by an experienced psychiatrist. A balance has to be struck between the extra time and resources required to transfer a person to an appropriate facility and the public interest in assessments being carried out by competent and experienced clinicians.

Questions 34 - 37

PIAC has responded generally to the question of CTOs above.

In summary, PIAC submits that consumers should have the right to request a review of a CTO order by the MHRT at any time. The MHRT should have the legislated discretionary power to seek an independent psychiatric assessment of the treatment plan (and the level of medication) and have the power to consequently change it. The psychiatrically-qualified member of the Tribunal should be able to assist the Tribunal in this regard. The initial two CTOs should be limited to six month's duration, and any further extension of the CTO should be made only after an independent psychiatric assessment as outlined above.

Questions 38 - 39

PIAC, in Part 1 of this submission above, refers to the CRPD and its specific provisions that refer to the treatment of children. These principles should inform the drafting and interpretation of the MHA with regard to the treatment of children with ECT.

The British National Institute for Clinical Health And Excellence (the Institute) comments that:

> ECT is used very rarely in young people with depression, and should not be used in children aged 5–11.[41]

The Institute also makes the following recommendations regarding administration of ECT:

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[41] National Institute for Clinical Health And Excellence, *The treatment of depression in children and young people* (2005) [18] <http://www.nice.org.uk/nicemedia/live/10970/29860/29860.pdf> at 7 December 2012.

> A risk–benefit assessment for the individual should be made and documented. It should include the risks associated with the anaesthetic, whether the person has other illnesses, the possible adverse effects of ECT (particularly problems with memory), and the risks of not having treatment.
>
> Doctors should be particularly cautious when considering ECT treatment for women who are pregnant and for older or younger people, because they may be at higher risk of complications with ECT.[42]

There has been some academic, as well as consumer, questioning of the overall effectiveness of ECT.[43]

In 2004, the New Zealand Ministry of Health conducted a review of ECT. The review concluded in relation to adverse effects:

> Disturbance of memory and thinking occurs in many patients after ECT, but:
> - while this usually resolves within a few weeks, some patients may experience severe and prolonged confusion, which may be complicated by other illness in older patients;
> - a significant minority of people experience long-term effects on memory which in some cases has a disabling impact on daily life;
> - consumers who have experienced ECT have highlighted adverse effects on memory both short and long term;
> - more information is required on how best to inform consumers about this adverse effect of ECT.[44]

PIAC notes that the current Victorian exposure draft Mental Health Bill[45] adopts the NSW model where the Victorian Mental Health Tribunal can approve ECT if a patient does not have capacity to consent to this treatment.

The current Victorian draft Mental Health Bill has a separate provision for persons aged between 13 and 18 years (cl 143), with the specific provision that:

> (1) …
> (2) An application to the Mental Health Tribunal for an electroconvulsive therapy determination under this section can only be made if—
> (a) a registered medical practitioner and a registered psychiatrist (who has undertaken specialist training in the area of child and adolescent mental health

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42 National Institute for Clinical Health And Excellence, *The use of electroconvulsive therapy* (2003) <http://www.nice.org.uk/TA059publicinfo> at 7 December 2012.

43 See, eg, John Read and Richard Bentall, 'The effectiveness of electroconvulsive therapy: A literature review' (2010) 19 *Epidemiologia e Psichiatria Sociale*, 333.

44 New Zealand Ministry of Health, *Use of Electroconvulsive Therapy (ECT) in New Zealand: A Review of Efficacy, Safety and Regulatory Controls* (2004) [16] < http://www.health.govt.nz/publication/electroconvulsive-therapy-ect> at 7 December 2012.

45 Above n 12.

and is a member of the relevant sub-specialist area of the Royal Australian and New Zealand College of Psychiatrists) have certified in writing that —

(i) the administration of electroconvulsive therapy is for the benefit of the person;

(ii) all other forms of treatment reasonably available have been used and have not been successful or the administration of electroconvulsive therapy is the most appropriate treatment that is reasonably available.[46]

(b) – (d) …

Clause 144 prohibits the administration of ECT to persons less than 13 years of age.

Given the concerns and uncertainties outlined above, PIAC submits that NSW should adopt these additional safeguards in the existing provisions in Part 2, Division 3 of the MHA. This would be consistent with Article 3(h) of the CRPD and Article 7(2) of the CRPD (best interests). In addition, there should be no diminution of the other safeguards in Part 2, Division 3 of the MHA.

Questions 40 - 41

PIAC is aware that there are a number of clinicians who are of the opinion that the ban on psychosurgery in NSW should be relaxed for the procedure called 'deep brain stimulation'.[47] PIAC is unable to comment on the efficacy of that procedure, but is aware that there could be possible long-, medium- and/or short-term negative effects on patients who undergo such a procedure.[48]

PIAC supports the continuation of a general prohibition of psychosurgery in NSW. We submit that if any form of psychosurgery is permitted as a legislative exception to this general rule, NSW legislation should directly reflect Principle 11.14 of the *UN Principles for the protection of persons with mental illness and the improvement of mental health care*, which states:

> Psychosurgery and other intrusive and irreversible treatments for mental illness shall never be carried out on a patient who is an involuntary patient in a mental health facility and, to the extent that domestic law permits them to be carried out, they may be carried out on any other patient only where the patient has given informed consent and an independent external body has satisfied itself that there is genuine informed consent and that the treatment best serves the health needs of the patient.[49]

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46 Ibid.

47 Kate Sikora, 'Doctors delving deep into the brain', *The Daily Telegraph* (16 July 2010) http://www.dailytelegraph.com.au/archive/national-old/doctors-delving-deep-into-the-brain/story-e6freuzr-1225892382733 at 7 December 2012.

48 Burn D, Troster A, 'Neuropsychiatric Complications of Medical and Surgical Therapies for Parkinson's Disease' (2004) 17(3) *Journal of Geriatric Psychiatry and Neurology* 172.

49 *UN Principles for the protection of persons with mental illness and the improvement of mental health care*, above n 7.

Questions 42 - 43

PIAC takes the view that the matters dealt with by ss 91(2)(g) and 91(3) of the MHA and Regulation 13 of the Mental Health Regulations 2007 (NSW) would be better dealt with in the legislation that regulates the conduct of health professionals in conjunction with professional codes of conduct. However, PIAC does not believe that the regulation of declarations of financial interests by health professionals should be left to voluntary codes without any method of statutory enforcement.

PIAC submits that the current provisions of the MHA regarding declarations of financial interests should remain in the legislation until there is comprehensive legislation that imposes enforceable obligations on health practitioners, in particular medical practitioners, to disclose financial interests in situations where one practitioner is referring a patient to another practitioner or private entity. Legislation should state that failure to comply with a statutory obligation to disclose a financial interest amounts to 'unsatisfactory professional conduct ' and therefore potentially 'professional misconduct' under the *Health Practitioner Regulation National Law* (NSW).

Questions 44 - 45

PIAC supports the use of advance care directives (see Part 3 of this submission above).

There will inevitably be situations where some consumers will, at some point in the involuntary assessment process, state a desire to overturn their previous stated preferences for treatment in an advance care directive. The involuntary treatment provisions should only be used as a last resort and should always be subject to the closest scrutiny. Therefore, a person can and should only be detained and treated against their will if they meet the strict tests set out in the MHA.

However, advance care directives should be binding, in particular with regard to the kind of treatment a person receives. Whether a consumer has an advance care directive or not, or whether they are an voluntary or involuntary patient, they should be involved, to the maximum extent possible, in the development and implementation of their treatment plan.

PIAC has proposed in Part 4.1 of this submission above, that the commitment to supported decision making should be clearly stated as an objective of the MHA. PIAC submits that, in addition, the MHA should expressly mandate:

- direct patient involvement in the development and implementation of treatment plans when possible and practicable; and
- respect and compliance with the directives of patients who have made advance care directives about their mental health care when they do not have the capacity to participate in the development of treatment plans.

Questions 46 - 49

Currently, there is no general appeal right for persons who are refused admission to hospital because this is considered a decision based primarily on clinical need assessed by medical practitioners (with availability of beds another consideration).

It has been suggested that there should be a statutory appeal from decisions not to admit an assessed person under s 27 of the MHA. Logically, these appeals would be made by family, friends and carers rather than consumers themselves.

PIAC has no objection in principle to such an appeal right to the MHRT, but is concerned about the practical implications of such a right. PIAC considers the most significant barrier to having such an appeal process function effectively is how can such an appeal be dealt with in a timely yet effective manner. Persons are normally brought to hospital by family, friends or the police in what is perceived by them as an emergency situation.

If a person is refused admission, and there is an appeal, what happens to the person in the time between the refusal to admit and the appeal? How can their attendance at an appeal hearing be assured? Why would a person cooperate in attending such an appeal if they did not want to be admitted and/or involuntarily detained and treated? How could a person be forced to cooperate and attend an appeal hearing without detaining them or using force to bring them to an appeal hearing? Also, even if the MHRT received considerable extra funding to deal with such appeals, there would still be inevitable delays between weekend or holiday admission and the appeal hearings, which would exacerbate these problems.

PIAC would vigorously oppose any suggestion that people could be detained pending such an appeal. Any such provision would invite numerous forms of abuse, from families seeking temporary informal respite care, to persons using mental health legislation to effectively evict and detain 'unwanted' relatives or friends.

An alternative solution may be to formalise a process where friends and relatives can appeal to the Medical Superintendent of a psychiatric hospital or unit in these situations as suggested in the Discussion Paper. However, any further appeal from the Medical Superintendent to the MHRT would raise the same practical concerns set out above, including how to ensure that both the Medical Superintendent and the MHRT could always deal with such appeals in a timely manner, given the inevitable arguments for urgent admission that would be relied upon in these circumstances.

Questions 50 - 54

With regard to the primary carer provisions, PIAC submits that there is a clear public interest in families and friends being involved in the care and treatment of people with a mental illness. This clearly involves the sharing of information, and the overriding principle here should be that personal information cannot be disclosed without the consent of the consumer. If there is a conflict between these principles, the right to confidentiality and privacy should prevail.

There are exceptions to common law principles of patient confidentiality and the statutory privacy principles and, in some situations, legislative requirements to disclose otherwise personal information. However, there are no general 'in the best interest of the patient' exceptions to either the common law confidentiality principles or the statutory privacy principles.

PIAC does not consider that the provisions relating to primary carers in the MHA are in breach of fundamental principles of confidentiality and privacy. PIAC would not support any change to the MHA which allowed confidential information to be disclosed without patient consent, either contemporaneously or prospectively (eg, through advance care directives).

The *Australian Charter of Healthcare Rights*, which has been adopted by all states and territories, recognises a 'right to privacy and confidentiality of … personal information'.[50] Any exception to the maintenance of patient confidentiality under the MHA, apart from the established exceptions, would be a direct abrogation of these established patient rights and the principles of the CRPD, which requires equal treatment before the law for people with a disability.

Under the Mental Health Regulation 2007, the duration of a nomination of a primary carer is 12 months. This clearly allows a consumer to renew a nomination at any time or renew a previous nomination on admission. PIAC supports legally recognised advance care directives for persons with a mental illness, if it has been made by the consumer with full knowledge of its content and scope. PIAC would only support an extension of the duration of a nomination of a primary carer beyond 12 months in the context of enforceable advance care directives.

In response to Questions 4 and 5 above, PIAC raised concerns with the current wording of s 101(2) of the MHA, which seems to give primary carers unfettered power as a substitute decision maker under s 101. PIAC prefers a situation where consumers are able, through advance care directives, to nominate persons who are to have access to certain information if they are involuntarily detained, as well as a potential substitute decision maker if they lack capacity to make certain decisions, including about their health care. These will probably be the same person or persons, but not necessarily so.

PIAC also has concerns about s 72(7) of the MHA, which states:

> An authorised medical officer or a director of community treatment is not required to give effect to a nomination, or a variation or revocation of a nomination, if the officer or director reasonably believes:
> (a) that to do so may put the patient or nominated person or any other person at risk of serious harm, or
> (b) that the person who made the nomination, variation or revocation was incapable of making the nomination, variation or revocation.

PIAC accepts that, particularly for reasons set out in s 72(7)(a), there should be some discretion in the hands of clinicians whether to accept someone as an acceptable primary carer. However, PIAC regards s 72(7)(b) as both unnecessary and contradictory. The provisions are designed for the families of involuntary patients, who, because of the definition of mental illness in the MHA are necessarily 'severely impaired' in their 'mental functioning' (s 4). To effectively impose a discretionary capacity test on the nomination of a primary carer, as s 72(7)(b) seems to achieve, potentially would exclude the vast majority, if not all, involuntary patients (and in

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[50] Australian Commission on Safety and Quality in Health Care, *Australian Charter of Healthcare Rights* http://www.safetyandquality.gov.au/our-work/national-perspectives/charter-of-healthcare-rights/ at 7 December 2012.

consequence, deny their carers access to information). PIAC does not suggest that this has occurred since the introduction of the primary carer provisions in the MHA, but the danger remains of potential arbitrary use of this provision.

PIAC submits that s 72(7)(b) of the MHA should be repealed. The only ground to reject the nomination of a primary career should be serious risk of harm to the patient or others (including the nominated carer). PIAC also suggests that there be established a right of appeal to the MHRT by the patient if their nomination of a primary carer is refused under this provision. This would be a safeguard against both arbitrary decision making and possible misinformation about risks of harm involving a potential primary carer.

Questions 55 - 58

PIAC believes that the role and powers of Official Visitor (OVs) should be strengthened and broadened, particularly in relation to inspections.

Australia has indicated its intention to ratify the *Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment* (OPCAT).[51] The Commonwealth Parliament's Joint Standing Committee on Treaties (JSCOT) has in 2012 recommended that Australia ratify OPCAT.[52]

OPCAT requires that National Preventative Mechanisms (NPMs), usually independent inspectorates, be set up to monitor all places of detention and 'make recommendations to the relevant authorities with the aim of improving the treatment and the conditions of the persons deprived of their liberty,' which competent authorities are required to consider (Article 19(b)).

Article 4.1 of OPCAT defines places of detention as any place under the jurisdiction or control of a state 'where persons are or may be deprived of their liberty, either by virtue of an order given by a public authority or at its instigation or with its consent or acquiescence'.

This provides a broad definition of places coming under OPCAT's jurisdiction. It means that places such as locked wards of psychiatric facilities in NSW would be covered by OPCAT. The key to OPCAT is that, through Article 20, the protocol covers all places of detention, and that the emphasis on prevention and preventive mechanisms that is found throughout the protocol gives the NPMs a very broad mandate in terms of what they do and where they do it.

The OVs, with enhanced powers and independence, would be well placed to fulfil the NPM role for NSW psychiatric hospitals and units. If OVs were to fulfil the NSW NPM role for mental health facilities, the powers and structure of the OV Office would require change. OPCAT requires

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51 United Nations, *Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment*, GA RES/57/199.

52 Joint Standing Committee on Treaties, Parliament of the Commonwealth of Australia*, Report 125*, June 2012, 37-52.

NPMs to be functionally independent and the current direct appointment of OVs by the Ministry of Health would probably not be seen as sufficient functional independence for OPCAT's purposes.

Article 20(a) of OPCAT provides that a NPM should have:

> Access to all information concerning the number of persons deprived of their liberty in places of detention as defined in article 4, as well as the number of places and their location.

The inspection powers of OVs would certainly have to be significantly strengthened and overseas examples of the functioning of OPCAT suggests that the power to make unannounced inspections is essential to effective oversight of places of detention.

If Australia ratifies OPCAT and the OV Office becomes an NPM under OPCAT, this will strengthen and enhance its powers. OPCAT's focus on prevention means that an NPM plays a collaborative, not a confrontational, role with the relevant authorities that manage places of detention. Overseas experience suggests that this leads to positive systemic change in places of detention, including in the mental health sector.

Questions 59 - 62

Delays in initial inquiries under the MHA

Since 2010, PIAC has held concerns about delays in initial inquiries under s 27 of the MHA.[53] Section 27 mandates that these inquiries should take place 'as soon as practicable'.

When the NSW Parliament passed amendments to the MHA in 2008 (*Courts and Crimes Legislation Further Amendment Act 2008*, Schedule 16), they were not seen as controversial. These amendments effectively replaced the role of visiting magistrates conducting initial inquiries under the MHA, giving that role to the MHRT. There was also another amendment facilitating the conduct of MHRT hearings by AVL technology, which was already being extensively used by the Tribunal in the conduct of hearings.

In February 2010, the Hon Greg James QC, the then President of the MHRT, wrote to the NSW Area Directors of Mental Health advising that when the amendments came into effect, mental health inquiries could be expected to take place during the third or fourth week of detention of an individual.

Previous practice since 1958, with very rare exceptions over the Christmas period, was that visiting magistrates held initial inquiries under the MHA, all over NSW, at all psychiatric hospitals and units on one designated day per week. That effectively meant that a patient who was detained after they were 'scheduled' by two doctors, including one psychiatrist, was seen by a magistrate within approximately one week. Since 1988, such patients have been entitled to free legal representation from the Mental Health Review Tribunal at this initial Inquiry.

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53 Peter Dodd, *Delays in inquiries under the MHA: a cause for concern* (Issues Paper) (2010) <http://www.piac.asn.au/publication/2011/11/delays-inquiries-under-mental-health-act> at 7 December 2012.

PIAC and many other organisations were concerned that delays of up to four weeks could not be seen as occurring 'as soon as practicable' and removed a long-standing right of assessed persons under the MHA to have a timely independent review of their status under the MHA.

Because of these widespread concerns, the NSW Government set up a Mental Health Inquiries Monitoring Group, of which PIAC was a member, as well as funding an Evaluation of Efficacy and Cost of the Mental Health Inquiry System conducted by the consultants, Communio. The final report from this evaluation was released in March 2012 (the Communio Report).[54] At the same time, the Government announced additional funding which effectively meant that s 27 reviews took place within two weeks of the initial hospital assessment. This followed the recommendation in the Communio Report:

> **Summation**
> The question of timeliness of the inquiry is the most controversial and dominant issue in relation to the new inquiry model. By far the largest number of stakeholders including consumers, carers, lawyers and psychiatrists expressed high levels of concern at the current timeframe. The timeframe is considered to be denying the rights of consumers.
>
> Trends across Australian and international jurisdictions are towards greater recognition of the human rights of mental health consumers. The NSW system does reflect the current human rights trends as reflected by the timing of the inquiry
>
> **Recommendation**
> Prepare a more detailed business case in relation to reducing the timeframe of inquiries using, [sic] to two weeks.[55]

PIAC publicly welcomed this as an improvement on the previous situation but remains concerned that the previous right to a timely independent inquiry within a week of assessment has not been restored. PIAC submits that, with AVL technology, there is no place in NSW where an initial inquiry could not be heard within a week of assessment.

The Communio Report also recommended that the issue of timing of inquiries under the MHA should be further considered 'when the NSW MHA is reviewed'.[56]

For the reasons set out above, PIAC submits that s 27(d) of the MHA should be amended to provide that:

> The person must be brought before the Tribunal as soon as practicable after admission but no later than seven days after admission.

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54 Mental Health and Drug & Alcohol Office (MHDAO), NSW Ministry of Health, *Evaluation of Efficacy and Cost of the Mental Health Inquiry System* (2012) http://www0.health.nsw.gov.au/news/2012/20120315_00.html at 7 December 2012.

55 Ibid 36.

56 Ibid 36.

It should be noted that, if the current s 33 of the MHA were retained, there would remain the power to delay actions under s 27, including bringing an assessed person before the MHRT for an inquiry because of illnesses or conditions (non-mental health) of the assessed person.

7. Summary of Recommendations

Recommendation 1

Mental health legislation in NSW should require mental health practitioners to make their decisions and act in accordance with the human rights afforded to persons with a mental illness under international law.

Recommendation 2

The option of advance care directives should be incorporated into NSW mental health laws. The MHA should expressly mandate:

- direct patient involvement in the development and implementation of treatment plans when possible and practicable; and
- respect and compliance with the directives of patients who have made advance care directives about their mental health care when they do not have the capacity to participate in the development of treatment plans.

Recommendation 3

The MHA should reflect the CRPD in recognising that there should be a presumption that persons with potential cognitive disabilities have legal capacity and that any form of substitute decision making, which includes CTOs, should be limited to measures of last resort and must be applied only for the shortest time possible.

Recommendation 4

The MHA should clearly state that the presumption of capacity applies to all of its provisions, including those relating to CTOs.

Recommendation 5

The structure and objects provision of the MHA should be amended, by making a commitment to supported decision making and the use of involuntary detention as an option of last resort. The principles of supported decision making should be included in the objects of the MHA in s 3 and the principles for care and treatment in s 68.

Recommendation 6

To successfully apply for a CTO, a hospital or community mental health service should have to establish that the consumer did not have the capacity to make decisions about their own treatment, as well as satisfy ss 53(3) and 53(5) of the MHA.

Recommendation 7

CTOs should initially be limited to a period of six months. After two CTOs have been granted, and before a third CTO is considered, an independent review of the CTO should be mandated, where an independent psychiatrist provides a report on the efficacy of the treatment plan and reviews the current level of medication.

Recommendation 8

The MHRT should have a discretionary power to request such a review at any time, including if and when a patient requests a review of a CTO order.

Recommendation 9

The MHRT should have the power to amend the CTO in accordance with any findings in such a review. Only after such a review, should the MHA allow CTOs of more than 12 months' duration.

Recommendation 10

The definition of mental illness for the purposes of the MHA should be limited to only those illnesses where treatment and care are likely to be efficacious in a closed environment.

Recommendation 11

The MHA should define 'mental illness' as follows:

> *A condition that is characterised by the presence in the person of any one or more of the following symptoms:*
>
> *(a) delusions,*
>
> *(b) hallucinations,*
>
> *(c) serious disorder of thought form,*
>
> *(d) a severe disturbance of mood,*
>
> *(e) sustained or repeated irrational behaviour indicating the presence of any one or more of the symptoms referred to in paragraphs (a)-(d),*
>
> *and if treated in an approved mental health service would be likely to be of some benefit in either preventing the mental illness from worsening, or in alleviating any of the symptoms or effects of the illness.*

Recommendation 12

Before an involuntary order for detention and treatment or a CTO is made, the MHA should provide that a medical practitioner or the MHRT must be satisfied that:

> *because of the person's mental illness the ability of the person to make decisions about the provision of treatment is significantly impaired as the person is unable to:*
>
> *(i) understand the information relevant to the decision; or*
>
> *(ii) retain that information; or*
>
> *(iii) use, weigh or appreciate that information as part of the process of making the decision.*

Recommendation 13

The tests for assessments by medical practitioners to establish grounds for involuntary treatment and detention (ie, to make someone an 'assessable person' under the MHA) should be:

- *the person lacks capacity to make their own decisions about their care and treatment;*
- *the person poses a serious risk of harm to themselves or others; and*
- *there are no alternative options to detention and coercive care of a less restrictive kind.*

Recommendation 14

The existing wording in s 12 of the MHA should be incorporated in the criteria for involuntary detention and care, so that the medical practitioner or the MHRT (to the Briginshaw *standard) should have to be satisfied that no other care of a less restrictive kind, that is consistent with safe and effective care, is appropriate and reasonably available to the person as an alternative to the proposed detention and treatment in a mental health facility.*

Recommendation 15

The principle of least restriction should be set out in the general objects clause of the MHA and in any clause similar to the existing s 68 of the MHA referring to 'principles for care and treatment'.

Recommendation 15

If an assessed person is referred to the MHRT (or appeals to the MHRT under s 44 of the MHA), the MHRT, before it makes an involuntary order, should also be satisfied that genuine and appropriate attempts at involving the person in decision making about their care have failed.

Recommendation 16

The risk of harm test should be that the medical practitioner or the MHRT must be satisfied that (in the case of the MHRT, to the Briginshaw Standard):

> *There are reasonable grounds for believing that detention and treatment in a mental health facility is necessary:*
>
> *(a) for the person's own protection from serious harm, or*
>
> *(b) for the protection of others from serious harm.*

Recommendation 17

The powers set out in ss 100, 101, 102 and 103 of the MHA would be more appropriately placed in the Guardianship Act*.*

Recommendation 18

The MHRT should only have power to stay its orders for seven days.

Recommendation 19

Section 9 of the MHA should be amended so that a voluntary patient must be reviewed at least once every 12 months of continuous residence, voluntarily or involuntarily, in mental health facilities.

Recommendation 20

In circumstances where people are held in mental health facilities after assessment and subsequent discharge where police want to take them back into custody, the maximum period of additional detention in these circumstances should be three hours and the legislation should initially allow detention for a maximum of two hours, with the period only permitted to be extended to three hours in specific exceptional circumstances, set out in the legislation.

Recommendation 21

The MHA should provide that that use of AVL to conduct hearings or inquiries under the MHA should only be permitted if face-to-face contact is not possible and/or practicable.

Recommendation 22

The MHA should be amended to provide that ECT should be administered to persons 13 years to 18 years, only if the MHRT is satisfied that a registered medical practitioner and a registered psychiatrist (who has undertaken specialist training in the area of child and adolescent mental health and is a member of the relevant sub-specialist area of the Royal Australian and New Zealand College of Psychiatrists) have certified in writing that —

(i) the administration of electroconvulsive therapy is for the benefit of the person;

(ii) all other forms of treatment reasonably available have been used and have not been successful or the administration of electroconvulsive therapy is the most appropriate treatment that is reasonably available.

Recommendation 23

The MHA should prohibit the administration of ECT to persons less than 13 years of age.

Recommendation 24

A general prohibition of psychosurgery in NSW should be continued. If any form of psychosurgery is permitted as a legislative exception to this general rule, NSW legislation should directly reflect Principle 11.14 of the UN Principles for the protection of persons with mental illness and the improvement of mental health care*, which states:*

> *Psychosurgery and other intrusive and irreversible treatments for mental illness shall never be carried out on a patient who is an involuntary patient in a mental health facility and, to the extent that domestic law permits them to be carried out, they may be carried out on any other patient only where the patient has given informed consent and an independent external body has satisfied itself that there is genuine informed consent and that the treatment best serves the health needs of the patient.*

Recommendation 25

The current provisions of the MHA regarding declarations of financial interests should remain in the legislation until there is comprehensive legislation that imposes enforceable obligations on health practitioners, in particular medical practitioners, to disclose financial interests in situations where one practitioner is referring a patient to another practitioner or private entity. Legislation

should state that failure to comply with a statutory obligation to disclose a financial interest amounts to 'unsatisfactory professional conduct ' and therefore potentially 'professional misconduct' under the Health Practitioner Regulation National Law (NSW).

Recommendation 26

Paragraph 72(7)(b) of the MHA should be repealed.

Recommendation 27

Paragraph 27(d) of the MHA should be amended to provide that:

> *The person must be brought before the Tribunal as soon as practicable after admission but no later than seven days after admission.*