

A submission on the issues raised by the review of New South Wales Mental Health Act 2007

Part I: Criteria for detention and treatment

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Foreword

Today, when people with mental illness present to hospitals in crisis needing care, our legislation directs doctors, not to work with patients to help them make decisions about medical treatment or to consider the patient's overall wellbeing, but rather to do what no doctor can - to divine that person's future. If the forecast is "serious harm", the law gives full control of the person's journey to recovery to others, regardless of any abilities the person may have to direct or even participate in their own recovery. Clinical decisions are solely the province of the medicos, and no negotiation with patients need be entered into. If the doctor does not foresee serious harm, then the reverse is true. Even if the person's level of understanding and ability to participate in decision-making is severely impaired, they and their families are on their own, at least until a serious harm – which in the worst cases might include acts of violent desperation - eventually comes to pass.

In New South Wales we now have the opportunity to re-make our mental health legislation into a modern Act that takes into account contemporary understandings of mental illness and of the right of all persons to equal treatment under the law, non-discrimination and to the highest attainable standard of health. Many changes have taken place since the 1980s when the framework for the *Mental Health Act 2007* was created. Australia's ratification of the Convention on the Rights of Persons with Disabilities is chief among them, and the requirements of the CRPD have greatly influenced the recommendations in this submission. In addition, a broad commitment to recovery in mental health services, and new understandings of patient safety and risk categorisation all provide further energy and purpose in calls for a change.

Our current mental health laws are antithetical to recovery, and in creating conditions under which people with mental illness are subject to involuntary treatment in circumstances where other people are not, they constitute unacceptable discrimination in an age that recognises the rights of disabled persons to equal treatment.

Legislative reform could see real improvements in the delivery of mental health care in New South Wales that would realise real benefits to people living with mental illness, to their families, and to society as a whole.

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Executive Summary

The Centre for Values, Ethics and the Law in Medicine is pleased to provide this submission on the issues raised by the review of the *Mental Health Act 2007* (NSW) (the MHA). The submission is based upon the issues raised in the *Discussion Paper: Issues arising under the NSW Mental Health Act 2007*.¹ Part I of the submission deals with issues relating to the criteria for detention and treatment as addressed in parts 4, 6, 7, 17 and 20 of the Discussion Paper. Part II focuses on other matters such as treatment for conditions other than mental illness, electroconvulsive therapy and psychosurgery.

The proposed revision of the *Mental Health Act 2007* (NSW) will be the first re-drafting of the State's mental health legislation under the influence of the United Nations *Convention on the Rights of Persons with Disabilities*² (CRPD) and offers the opportunity for the first major re-drafting since 1990. The revision provides an opportunity for an extensive modernisation of the mental health laws of New South Wales and a chance to set out innovative measures to better protect the health and rights of people living with mental illness.

The authors provide a number of recommendations that will better protect patient rights, whilst providing a framework to better protect people who are vulnerable in certain circumstances. This will be achieved by legislation that is centred around a presumption of decision-making capacity, facilitates supported decision-making wherever decision-making capacity is impaired, and encourages voluntary treatment wherever possible. Where people are unable to make their own decisions, even with support, substituted decision-making should be permissible in circumstances where the will and preference of the person is the paramount consideration, with the goal of supporting and enhancing the person's overall wellbeing. The recommendations also take account of community concerns about the safety of others where people with mental illness are thought to present a risk of violence to persons.

¹ Mental Health and Drug & Alcohol Office, *Discussion Paper: Issues Arising under the NSW Mental Health Act 2007* (2012).

² *Convention on the Rights of Persons with Disabilities*, opened for signature 30 March 2007, (entered into force 3 May 2008).

Our recommendations are summarised here:

Recommendation 1: *Current provisions that centre coercive treatment decisions for people with mental illness on the basis of protection from serious harm should be removed from a revised Act.*

Recommendation 2: *The MHA should incorporate a series of new provisions that include:*

- a) a formalisation of the presumption of capacity;*
- b) a requirement that all persons be provided with appropriate support in making their own treatment decisions;*
- c) a requirement that substituted decision-making (including compulsory treatment orders) can only occur where a person can be shown to lack decision-making capacity and where supported decision-making has failed; and*
- d) the introduction of guidelines for substituted decisions (including compulsory treatment orders) that require that the will and preferences of the person must be respected and be given effect to, to the greatest extent possible, and that in any case, must be shown to be manifestly necessary to promote the person's wellbeing, broadly conceived .*

Recommendation 3: *Community Treatment Orders should only be made in the circumstances applying to inpatient treatment orders (consistent with Recommendation 2 above), as a less restrictive alternative to an inpatient order.*

Recommendation 4: *Community Treatment Orders should also apply for the shortest period of time necessary and must aim to restore the person's ability participate in decision-making, and to personally consent to ongoing treatment (or otherwise) as quickly as possible.*

Recommendation 5: *Community Treatment Orders must receive timely and regular oversight be an independent tribunal that is equivalent to the review procedure for inpatient compulsory treatment.*

Recommendation 6: *The NSW Government should commission research into the use of the mentally disordered provisions so as to better inform the review process. Particular consideration should be given to the criteria for detention and the length of detention.*

Recommendation 7: *Assessable persons must be afforded prompt, automatic, independent review by the Mental Health Review Tribunal that should occur no more than 7 days after a compulsory treatment order is made.*

Recommendation 8: *The Tribunal should be empowered to review treatment plans to ensure that patient concerns and preferences about treatment have been properly taken into account and to verify that the treatment plan will promote the person's wellbeing.*

Recommendation 9: *If, and only if, the MHA is amended so that it reflects recommendations set out in Recommendation 2, a further amendment be made to allow rapid review by the medical superintendent of any decision to discharge a patient in circumstances where family or carers believe that the original decision has not taken proper account of the person's decision-making capacity or promotion of wellbeing properly understood.*

Recommendation 10: *That a revised MHA include formal processes for future care planning for people with mental illness. This may include formalising processes for people to describe goals for treatment as well as general values, wishes and preferences regarding treatment. Further consideration should also be given to whether binding advance care directives should also be included in future care planning and the circumstances, if any, in which these should be able to be overridden, bearing in mind that a right to make binding advance care directives is generally available to all persons at common law.*

Recommendation 11: *The Tribunal should be empowered to oversee the process provided for supported decision-making in voluntary patients to ensure that it is sufficient, and is properly applied.*

Recommendation 12: *Where another person has concerns about the adequacy of the consent process in respect of a voluntary patient, the MHA should provide a mechanism by which that person could refer the matter to the Tribunal for review.*

Recommendation 13: *Guidelines relating to voluntary admission may be required to ensure that consent is properly obtained and is free from coercion or undue influence, including, for example, the threat of detention if voluntary admission is not agreed to.*

Note: Recommendations 14 – 25 appear in Part 2

Recommendation 14: *The definition of mental illness should be amended to clearly include the phenomenology exhibited in anorexia nervosa and to delete the word “irrational” from criterion (e).*

Recommendation 15: *Provisions in the MHA relating to non-psychiatric treatment should include a formalisation of the presumption of capacity; a requirement that all persons be provided with appropriate support in making their own treatment decisions; a requirement that substituted decision-making can only occur where a person can be shown to lack decision-making capacity and where supported decision-making has failed; and the introduction of guidelines for substituted decisions that require that the will and preferences of the person must be respected and be given effect to, to the greatest extent possible, and that in any case, must be shown to be manifestly necessary to promote the person’s wellbeing, broadly conceived.*

Recommendation 16: *The MHA should allow clinicians to briefly detain a patient when there is reason to believe that he or she could and should be treated under the Act.*

Recommendation 17: *Accredited persons should be permitted to complete one of the Form 1 assessments, but that all Form 1 assessments should involve (at least) a telephone consultation with a psychiatrist.*

Recommendation 18: *The review should clarify the processes around discharge of an assessable person, whom a clinician feels no longer meets the criteria for compulsory treatment.*

Recommendation 19: *Patients should be permitted to participate as fully as possible in decisions concerning treatment. Patients who are the subject of compulsory orders may still retain decision-making capacity sufficient to allow them to make decisions about medication and other treatments. Those with impaired decision-making capacity should be offered support, and where a substituted decision is necessary in respect of some acutely ill patients who lack decision-making capacity, a substituted decision about medication could be made which respects the known will and preferences of the person. The Tribunal should*

also have a power to review treatment plans as recommended in Part 1 of this submission.

Recommendation 20: *There should be no outright ban on particular therapies in children and young people, including ECT. However some special therapies (including ECT) should require approval by the Mental Health Review Tribunal or the Supreme Court.*

Recommendation 21: *The ban on psychosurgery in New South Wales should be removed.*

Recommendation 22: *The term “psychosurgery” should be replaced with “neurosurgery for psychiatric conditions”.*

Recommendation 23: *Any use of psychosurgery should be subject to approval by an independent tribunal in which the patient is represented by his or her own advocate, where the patient lacks capacity to provide his or her own consent, whether or not the patient is refusing treatment.*

Recommendation 24: *The revision process should take account of the need to provide compulsory treatment in the emergency department setting and in the setting of the general medical and surgical wards.*

Recommendation 25: *Provisions regarding seclusion and restraint should be added to the MHA in a manner that mirrors those of other jurisdictions.*

1 About the authors

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Sascha Callaghan is a lawyer and research scholar at the Centre for Values, Ethics and the Law in Medicine and a Lecturer at the School of Public Health and Community Medicine at the University of New South Wales. She has also published extensively in the area of mental health law and is undertaking doctoral research into the coercive treatment of persons with mental illness.

2 A note on language

2.1 Capacity

Capacity is a broad concept that encompasses a variety of meanings. In this document, we have chosen to use the term “decision-making capacity” to refer to the cognitive ability to make a decision. The law defines level of capacity required to make a decision differently depending on the decision being made (to enter into a contract, to make a will, to consent to sex and so on).

Since the 1990’s the case law in relation to *medical* decision-making has predominantly favoured formulations that provide that a person will have decision-making capacity if he or she is able to comprehend and retain the information which is material to the decision, in particular as to the consequences of the decision; and to use and weigh the information as part of the process of making the decision.³ What we have called decision-making capacity is also sometimes called “mental capacity”, for example under the *Mental Capacity Act 2005* (UK). The *Mental Capacity Act* uses a definition of capacity modelled on the common law test.⁴

We note that by contrast to decision-making capacity, or mental capacity, the CRPD refers to the exercise of “legal capacity”. This term is used in Article 12 (discussed in section 4.1 of this submission), in the context of the requirement that state parties

³ *Hunter and New England Area Health Service v A* [2009] NSWSC 761, 25.

⁴ Section 3(1) of the *Mental Capacity Act 2005* (UK) provides that a person is unable to make a decision for himself if he is unable (a) to understand the information relevant to the decision, (b) to retain that information, (c) to use or weigh that information as part of the process of making the decision, or (d) to communicate his decision (whether by talking, using sign language or any other means).

recognise that persons with disabilities enjoy *legal capacity* on an equal basis with others in all aspects of life.

While the meaning of “legal capacity” is not defined, it would appear to refer to the right to have a decision recognised in law, and is used to support the general principle established in the CRPD that disability alone should not disqualify a person from being able to make decisions for themselves and for those decisions to be respected in law.⁵ Furthermore, all reasonable efforts should be made to assist people with impaired decision-making capacity to make their own, legally enforceable decisions rather than having decisions imposed on them by another person or decision-making body.

2.2 Mental illness and disability

In this document we have used the term “mental illness” in the general sense to encompass what the National Mental Health Commission has described as “disturbances of mood or thought that can affect behaviour and distress the person or those around them, so the person has trouble functioning normally”.⁶ Mental illnesses include anxiety disorders, depression and schizophrenia.

We have used the term “patient” for a person who is currently engaged in a therapeutic relationship, and have described those who have an ongoing lived experience of mental illness more generally as either “people with mental illness” or “people living with mental illness”. We recognise, however, that members of the community experience mental illness in different ways and some may prefer a different description of their circumstances or experiences.

One alternative, which has gained currency, is the term “psychosocial disability”. This is broad term that is intended to reflect a social model of cognitive difference covering a wide range of conditions and experiences, including those described as mental illness under the MHA. This language also captures the broad conceptualisation of disability used in the CRPD.

⁵ Bernadette McSherry, 'Legal Capacity under the Convention on the Rights of Persons with Disabilities' (2012) 20 *Journal of Law and Medicine* 22.

⁶ National Mental Health Commission, *A Contributing Life: The 2012 National Report Card on Mental Health and Suicide Prevention* (2012).

A social model of disability recognises that “impairments” are partly socially constructed and are often only experienced negatively because of interaction with the environment.⁷

2.3 Compulsory, coercive and involuntary treatment

The MHA refers to coercive treatment required under the Act as “involuntary treatment”. Generally people are said to have to undergo treatment involuntarily if the treatment is imposed contrary to a decision they have made. While this term may be appropriate to coercive treatment imposed when a person has decision-making capacity, it is not when treatment is only imposed when a person lacks decision-making capacity.

For this reason we have used the term “compulsory treatment” for any treatment imposed without the consent of a person who lacks decision-making capacity, and we have used “coercive treatment” as an umbrella term to cover both.

3 Background to the review

The New South Wales *Mental Health Act 2007* represented an important, but largely incremental revision of the *Mental Health Act 1990* (NSW). Since the 1990s and even since 2007, a number of significant changes have occurred in the intellectual landscape in which mental health laws are situated.

Most significantly, in July 2008 the Australian government ratified the United Nations *Convention on the Rights of Persons with Disabilities* (the CRPD).⁸ The CRPD committed the Commonwealth to a number of human rights measures, including to ensure that persons with disabilities enjoy legal capacity on an equal basis with others, to provide access by persons with disabilities to the support in exercising their legal capacity,⁹ and to modify or

⁷ World Network of Users and Survivors of Psychiatry, *Psychosocial Disability* (2008). Available at http://www.chrusp.org/media/AA/AG/chrusp-biz/downloads/199123/Psychosocial_disability.docx.

⁸ *Convention on the Rights of Persons with Disabilities*, opened for signature 30 March 2007 (entered into force 3 May 2008).

⁹ *Convention on the Rights of Persons with Disabilities*, opened for signature 30 March 2007, art 12.3 (entered into force 3 May 2008). art 12.3.

abolish existing laws and practices that constitute discrimination against persons with disabilities.¹⁰

Recent years have also seen an increase in the influence of the recovery movement and a burgeoning academic critique of legislative schemes in which decisions about whether to give coercive psychiatric treatment are based on an assessment of the patient's risk of future harm.¹¹

As a result of these developments, support has grown for an approach that first and foremost, presumes that people with mental illness have decision-making capacity. Under this approach, people with a mental illness who have this capacity would be permitted to consent to, or to refuse, treatment in the same way as any other patient. The approach also demands that all patients, including those who have or may have impaired decision-making capacity, must be offered any support required to enable them to make their own decisions in relation to medical treatment. No person will be treated as being unable to make his or her own decisions unless such support has been made available and has failed.

¹⁰ *Convention on the Rights of Persons with Disabilities*, opened for signature 30 March 2007, art 4(1)(b) (entered into force 3 May 2008). In New South Wales, the rights of persons with disabilities (including mental illness) are also protected by the *Disability Discrimination Act 1992* (Cth) and the *Anti-Discrimination Act 1977* (NSW). This legislation prohibits discrimination in the areas of employment; education; provision of good and services; accommodation; access to premises; activities of clubs and professional and other organisations; and sport. The Commonwealth Act gives effect to the Convention and aims "to ensure, as far as practicable, that persons with disabilities have the same rights to equality before the law as the rest of the community" (s 3). In addition, the Convention promotes and protects specific human rights, including the right to equal treatment before the law, health and liberty of movement, for persons with disabilities.

¹¹ Christopher James Ryan, Sascha Callaghan & Matthew M. Large, 'Better Laws for Coercive Psychiatric Treatment: Lessons from the Waterlow Case' (2012) 20 *Australasian Psychiatry* 283; Sascha Callaghan & Christopher James Ryan, 'Rising to the Human Rights Challenge in Compulsory Treatment – New Approaches to Mental Health Law in Australia' (2012) 46 *Australian and New Zealand Journal of Psychiatry* 611; Christopher James Ryan, 'One Flu over the Cuckoo's Nest: Comparing Legislated Coercive Treatment for Mental Illness and Other Illness' (2011) 8 *Journal of Bioethical Inquiry* 87; Christopher Ryan, Olav Nielssen, Michael Paton & Matthew Large, 'Clinical Decisions in Psychiatry Should Not Be Based on Risk Assessment' (2010) 18 *Australasian Psychiatry* 398; Matthew M. Large, Christopher James Ryan, Michael Paton, Olav Nielssen & Swaran Singh, 'The Predictive Value of Risk Categorization in Schizophrenia' (2011) 19 *Harvard Review of Psychiatry* 25; Christopher James Ryan, 'Minority Report' (2009) 157 *Openmind Magazine* 16; M. Large, C. J. Ryan, O. Nielssen & R. Hayes, 'The Danger of Dangerousness. An Argument against the Dangerousness Criterion in Mental Health Acts' (2008) 34 *Journal of Medical Ethics* 877; M. Large, O. Neilssen, C. J. Ryan & R. Hayes, 'Mental Health Acts That Require Dangerousness for Involuntary Admission May Delay the Initial Treatment of Schizophrenia' (2008) 43 *Social Psychiatry and Psychiatric Epidemiology* 251.

Only when a person has been shown to lack decision-making capacity, will substituted decisions be permitted. All such decisions must respect the will and preferences of the person and must give effect to these to the fullest extent possible, with the goal of promoting the person's overall wellbeing.

4 Principles that underpin coercive intervention

4.1 The impact of the United Nations Convention on the Rights of Person's with Disabilities¹²

In 2012 the starting point of any discussion on mental health law reform must be the CRPD. As the Discussion Paper highlights, having adopted the CRPD, Australia is "required to adopt strategies to pursue [its] general obligations, and ensure the full realisation of all human rights for all people with disabilities".¹³ International law requires that signatory states must conform to treaty requirements when making new laws and Australian courts have determined that existing local laws will be interpreted in a manner that is consistent with treaty obligations where there is any ambiguity as to their meaning.¹⁴

These obligations have had a profound impact on the deliberations surrounding the reform of mental health legislation both in Australia¹⁵ and internationally.¹⁶ The bills currently being

¹² See: Mental Health and Drug & Alcohol Office, above n 2, 17.

¹³ Ibid.

¹⁴ *Minister of State for Immigration & Ethnic Affairs v Teoh* [1995] HCA 20, [26]; Glen Cranwell, 'Treaties and Australian Law - Administrative Discretions, Statutes and the Common Law' (2001) 1 *Queensland University of Technology Law and Justice Journal* 49.

¹⁵ Statewide and Mental Health Services, *Mental Health Bill 2011 (Exposure Draft). Explanatory Guide* (2011); Victorian Department of Health, *A New Mental Health Act for Victoria. Summary of Proposed Reforms* (2012); Mental Health Commission of Western Australia, *Summary Overview of the Draft Mental Health Bill 2011* (2011); Australian Capital Territory Government, *The Framework of Mental Health and Related Legislation in the ACT. An Options Paper* (2009).

¹⁶ See for example: Steering Group on the Review of the Mental Health Act 2001 (Ireland), *Interim Report* (2012); Maura McCallion & Ursula O'Hare, 'A New Legislative Framework for Mental Capacity and Mental Health Legislation in Northern Ireland: An Analysis of the Current Proposals' (2010) *Journal of Mental Health Law* 84; C. L. Narayan, M. Narayan & D. Shikha, 'The Ongoing Process of Amendments in MHA-87 and PWD Act-95 and Their Implications on Mental Health Care' (2011) 53 *Indian J Psychiatry* 343; Gerard Quinn, 'Perspectives of the Paradigm Shift of Article 12 CRPD' (Paper presented at the HPOD Conference, Harvard Law School, 20 February 2010); Peter Bartlett, 'A Mental

considered by, or before, the Tasmanian,¹⁷ Victorian,¹⁸ Australian Capital Territory¹⁹ and Indian²⁰ parliaments, and legislative review processes being undertaken in Ireland²¹ and Northern Ireland,²² foreshadow significant reforms that can be directly traced to the impact of the CRPD.

Article 1 of the CRPD makes it clear that it is intended to apply to people living with mental illness, and outlines the CRPD's intended scope:²³

The purpose of the present Convention is to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity. Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.

The rights protected under the CRPD (and other UN treaties) go directly to the central concerns of legislators. They include the right to: freedom from discrimination and equality before the law;²⁴ protection from cruel, inhuman or degrading treatment;²⁵ freedom of

Disorder of a Kind or Degree Warranting Confinement: Examining Justifications for Psychiatric Detention' (2012) 16 *International Journal of Human Rights* 831.

¹⁷ Mental Health Bill 2012 (Tas).

¹⁸ Mental Health Bill 2010 (Vic) (Exposure Draft).

¹⁹ Mental Health (Treatment and Care) Amendment Bill 2012 (First Exposure Draft).

²⁰ Mental Health Care Bill 2011 (India).

²¹ Steering Group on the Review of the Mental Health Act 2001 (Ireland), *Interim Report* (2012).

²² Northern Ireland Assembly, *Mental Health: Legislative Update* (2010).

²³ *Convention on the Rights of Persons with Disabilities*, opened for signature 30 March 2007, art 1, (entered into force 3 May 2008).

²⁴ *Convention on the Rights of Persons with Disabilities*, opened for signature 30 March 2007, arts 5, 12, (entered into force 3 May 2008); *The Universal Declaration of Human Rights*, GA Res 217 A (III), art 7, (1948); *International Covenant on Civil and Political Rights*, opened for signature 19 December 1966, 999 UNTS 171, art 26 (entered into force 23 March 1976).

²⁵ *Convention on the Rights of Persons with Disabilities*, opened for signature 30 March 2007, art 15, (entered into force 3 May 2008); *The Universal Declaration of Human Rights*, GA Res 217 A (III), art 5,

movement;²⁶ freedom from arbitrary detention;²⁷ respect for physical and mental integrity on an equal basis with others;²⁸ respect for privacy;²⁹ equal access to health services including on the basis of free and informed consent;³⁰ humane treatment when deprived of liberty;³¹ and a fair hearing by an impartial tribunal to decide rights recognised by law.³²

Among all of these it is article 12 of the CRPD that has the greatest potential impact on mental health law reform and which has sparked the most academic debate.

Article 12 is headed, “Equal recognition before the law” and states (in part):³³

1. States Parties reaffirm that persons with disabilities have the right to recognition everywhere as persons before the law.
2. States Parties shall recognize that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life.

(1948); *International Covenant on Civil and Political Rights*, opened for signature 19 December 1966, 999 UNTS 171, art 7 (entered into force 23 March 1976).

²⁶ *Convention on the Rights of Persons with Disabilities*, opened for signature 30 March 2007, art 14, (entered into force 3 May 2008); *The Universal Declaration of Human Rights*, GA Res 217 A (III), art 13, (1948); *International Covenant on Civil and Political Rights*, opened for signature 19 December 1966, 999 UNTS 171, arts 9-12 (entered into force 23 March 1976).

²⁷ *The Universal Declaration of Human Rights*, GA Res 217 A (III), art 9, (1948); *International Covenant on Civil and Political Rights*, opened for signature 19 December 1966, 999 UNTS 171, art 9 (entered into force 23 March 1976).

²⁸ *Convention on the Rights of Persons with Disabilities*, opened for signature 30 March 2007, art 17, (entered into force 3 May 2008).

²⁹ *Convention on the Rights of Persons with Disabilities*, opened for signature 30 March 2007, art 22, (entered into force 3 May 2008).

³⁰ *Convention on the Rights of Persons with Disabilities*, opened for signature 30 March 2007, art 25, (entered into force 3 May 2008).

³¹ *Convention on the Rights of Persons with Disabilities*, opened for signature 30 March 2007, art 14, (entered into force 3 May 2008); *International Covenant on Civil and Political Rights*, opened for signature 19 December 1966, 999 UNTS 171, art 10 (entered into force 23 March 1976).

³² *The Universal Declaration of Human Rights*, GA Res 217 A (III), art 10, (1948); *Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care*, GA Res 46/119, principle 17, (1991).

³³ *Convention on the Rights of Persons with Disabilities*, opened for signature 30 March 2007, art 12.1-12.4, (entered into force 3 May 2008).

3. States Parties shall take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity.

4. States 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.

The effect of Article 12 has been the source of much discussion, and while it is clear that Article 12 mandates a supported decision-making model for persons with disabilities, the precise implications for substituted decision-making are still being debated. Some legal commentators argue that the CRPD prohibits all substitute decision-making for people with mental illness.³⁴ However the more usual interpretation is, as described by the authors of the Discussion Paper, that the CRPD demands a presumption that people living with mental illness "are capable of making their own decisions ..., that any other form of decision-making must be seen as a measure of last resort" and that there must be a shift in "focus from substituted decision-making to supported decision-making".³⁵

³⁴ Tina Minkowitz, 'The United Nations Convention of the Rights of Persons with Disabilities and the Right to Be Free from Non-Consensual Psychiatric Interventions' (2007) 34 *Syracuse Journal of International Law and Commerce* 405; Eilionóir Flynn & Anna Arstein-Kerslake, 'Equal Recognition before the Law: Exploring a Support Model of Legal Capacity' (Paper presented at the Kent Critical Law Society Conference, University of Kent, Canterbury, 2012) available from http://www.nuigalway.ie/disability-rights/downloads/kent_presentation.docx.

³⁵ Mental Health and Drug & Alcohol Office above n 2, 17. See also: McSherry, above n 5; Callaghan & Ryan, 'Rising to the Human Rights Challenge in Compulsory Treatment', above n 11; Amita Dhanda, 'Legal Capacity in the Disability Rights Convention: Stranglehold of the Past or Lodestar for the Future?' (2007) 34 *Syracuse Journal of International Law and Commerce* 429; Anna Lawson, 'The United Nations Convention on the Rights of Persons with Disabilities: New Era or False Dawn?' (2007) 34 *Syracuse Journal of International Law and Commerce* 563.

Current coercive treatment provisions under the MHA are inconsistent with the provisions of the CRPD. The current provisions take no account of the decision-making capacity of mentally ill persons nor do they require or facilitate supported decision-making to enable as many patients as possible to exercise choice over their own treatment.³⁶ Instead the provisions allow substituted decision-making by doctors wherever “there are reasonable grounds for believing that care, treatment or control of the person is necessary” for either the person’s own or other’s “protection from serious harm”.³⁷ These provisions do not presume capacity, they do not provide an avenue for decision-making support, and they permit involuntary treatment for persons who may well be able to make decisions for themselves.

When examining the implications of the CRPD, the Discussion Paper focuses on the Convention’s emphasis on supported decision-making and seeks comment “outlining whether the amendments to the Act should be made to focus more on supported decision-making rather than substituted decision-making”.³⁸ We would comment that amendments

³⁶ It is sometimes argued that the definition of mental illness in the MHA implies that that a mentally ill person will always lack decision-making capacity. People advancing this argument note that under section 3 the MHA a “mental illness means a condition that *seriously impairs, either temporarily or permanently, the mental functioning of a person ...*” (s 3 emphasis added) and suggested that this is equivalent to a statement that mental illness is a condition that necessarily deprives a person of the capacity to make decisions regarding psychiatric treatment. To our minds this approach cannot be correct. First, and most obviously, the definition makes no specific reference to decision-making capacity. Second, the presence or absence of decision-making capacity refers the presence or absence of the ability to make a specific decision. If the section 3 definition were to be taken as implying that a person who suffered a mental illness (so defined) would lack the capacity to make decisions around the receipt of psychiatric treatment, it must imply that such a person would lack the capacity to make *any* decision around the receipt of psychiatric treatment. If this is supposed to represent a statement of fact, it cannot be sustained, as it is known that people with severe mental illness may lose the ability to make some treatment decisions, but retain the ability to make others. If this is supposed to be taken as legal provision, such that people with “mental illness” (so defined) will be taken as lacking decision-making capacity regardless of their actual ability, then it represents a determination of the presence of legal capacity based on the mentally ill person’s membership of the class “mentally ill person” and as such would be contrary to the requirements of the CRPD.

Even it if were the case that the MHA’s definition of mental illness could be regarded as implying a lack of decision-making capacity to specific decisions, it is clear that the Act would be significantly improved by revision of this definition to make this postulated provision much clearer.

For further discussion of this issue see Ryan, 'Capacity as a Determinant of Non-Consensual Treatment of the Mentally Ill in Australia', above n 11.

³⁷ *Mental Health Act 2007 (NSW)*, s14.

³⁸ Mental Health and Drug & Alcohol Office, above n 2, 18.

that focus on facilitation of supported decision-making must be a major part of the review but that the requirements of the CRPD go well beyond this, as described in the recommendations in the sections below.

4.2 Discrimination

The provisions of the MHA permit the coercive treatment of people living with mental illnesses on a fundamentally different basis to that applying to others under statute and the common law.

The common law provides that medical assessment or treatment of an adult with decision-making capacity will only be lawful if it is consented to, and detaining patients against their will or providing treatment without consent is a trespass.

Guardianship schemes in every Australian jurisdiction permit substituted decision-making only in respect of persons who lack decision-making capacity, and the conditions under which such decisions can be made are controlled in various ways in each jurisdiction. It is important to note that guardianship schemes themselves are the subject of considerable scrutiny currently, in terms of compliance with the CRPD – particularly the extent to which decision-making capacity is presumed under these schemes, and whether appropriate support is made available to all persons to enable independent decision-making wherever possible. Even so, no Australian guardianship legislation permits coercive treatment of persons who retain decision-making capacity as defined by the common law.

By contrast, the coercive treatment regime under the MHA operates without regard to the ability of persons with mental illness to make their own decisions, and in so doing, fails to protect the right to autonomy, and physical and mental integrity of persons with mental illness on an equal basis with others.

In providing a legislative basis for discrimination against people living a mental illness, the provisions of the MHA not only run counter to the provisions of the CRPD,³⁹ but may also be contrary to Australian domestic law.

³⁹ *Convention on the Rights of Persons with Disabilities*, opened for signature 30 March 2007, arts 5, 12, 17 (entered into force 3 May 2008).

The *Disability Discrimination Act 1992* (Cth) gives effect to the CRPD⁴⁰ and aims “to ensure, as far as practicable, that persons with disabilities have the same rights to equality before the law as the rest of the community”.⁴¹ It prohibits, among other things, discrimination in the terms on which goods or services are provided to an individual with a disability.⁴² It is likely that this section would be taken as applying to the manner in which mental health care is provided.⁴³ This apparent inconsistency between the Commonwealth antidiscrimination law and the MHA leaves a potential avenue for challenge to the current provisions of the MHA.⁴⁴ Similar action would also likely be possible under the proposed Commonwealth Human Rights and Anti-Discrimination Act.⁴⁵

Inconsistency of the MHA with the CRPD would also raise an avenue for challenge through the *Australian Human Rights Commission Act 1986* (Cth).

Regardless of any possibility of legal challenge however, discriminating against people with mental illness purely on the basis that they have a mental illness,⁴⁶ is ethically indefensible. In addition, such discrimination could be expected to contribute to the ongoing stigma associated with mental illness.⁴⁷ The *National Mental Health Statement of Rights and Responsibilities* explicitly states that “[a]n individual has the right to expect that the law will

⁴⁰ *Disability Discrimination Act 1992* (Cth) s 12(8).

⁴¹ *Disability Discrimination Act 1992* (Cth) s 3(c).

⁴² *Disability Discrimination Act 1992* (Cth) s 24.

⁴³ See for example: *Purvis v State of New South Wales (Department of Education and Training)* [2003] 62, [17-20] (McHugh and Kirby JJ).

⁴⁴ Potential precedent for this type of claim is provided by the successful challenge to the provisions of the *Infertility Treatment Act 1995* (Vic) in *McBain v Victoria* [2000] FCA 1009 the grounds of inconsistency with the *Sex Discrimination Act 1984* (Cth). Though not directly relevant, it is also interesting to note that, in a recent German case, similar provisions of regional mental health legislation were struck down with immediate effect when the Federal Constitutional Court found the provisions inconsistent the German constitution. See BVerfG, 2 BvR 633/11 of October 12, 2011 available at http://www.bverfg.de/en/decisions/rs20111012_2bvr063311.html; Annegret Kämpf, 'Capacity and the Convention on the Rights of Persons with Disabilities in Australia and Germany' (Paper presented at the 2nd World Congress on Adult Guardianship, Melbourne, 2012).

⁴⁵ Human Rights and Anti-Discrimination Bill 2012 (Cth).

⁴⁶ This phenomenon has been called “sanism”. See Michael L. Perlin, 'On "Sanism"' (1992) 46 *Southern Methodist University Law Review* 373.

⁴⁷ Matthew M. Large & Christopher James Ryan, 'Sanism, Stigma and the Belief in Dangerousness' (2012) 46 *Australian and New Zealand Journal of Psychiatry* 1099.

not discriminate against him or her on the basis of them suffering or previously suffering a mental health problem or mental disorder”.⁴⁸

4.3 The impact of the recovery principles

The recovery movement, which originated in the views of consumers,⁴⁹ is emerging as a major influence on the way that mental health services are being re-organised and delivered around the world.⁵⁰ Discussions about mental health policy reform increasingly refer to the “the recovery model” or simply “recovery”, and consumer groups are now calling for mental health systems which have a recovery focus.

While “recovery” does not have a single clearly defined meaning, broadly speaking, it refers to the process of living with and managing psychosocial disability and/or periods of acute illness. Recovery is not an end-point. It does not involve a particular goal such as a “cure” for psychosocial disability in every case. Rather it concerns itself with supporting an individual’s recovery journey.

Perhaps most importantly, a person’s recovery is driven by that person him or herself, rather than by health services or other decision-makers – although health services, carers, family and friends are involved in the process as supporters. Accordingly, recovery focused care emphasises personal goal setting, and care, treatment and support offerings in which people take an active role in decisions that affect their lives.⁵¹ To this end, the recovery literature overwhelmingly emphasises the importance of empowerment, autonomy, self-

⁴⁸ Mental Health Consumer Outcomes Task Force, *National Mental Health Statement of Rights and Responsibilities* (1991) available from [http://www.health.gov.au/internet/main/publishing.nsf/content/1FE72FD78779BB44CA2572060026BC9E/\\$File/rights.pdf](http://www.health.gov.au/internet/main/publishing.nsf/content/1FE72FD78779BB44CA2572060026BC9E/$File/rights.pdf).

⁴⁹ Shulamit Ramon, Bill Healy & Noel Renouf, 'Recovery from Mental Illness as an Emergent Concept and Practice in Australia and the UK' (2007) 53 *International Journal of Social Psychiatry* 108.

⁵⁰ Ibid.

⁵¹ Patricia E. Deegan, 'Recovery: The Lived Acceptance of Rehabilitation' (1988) 11 *Psychosocial Rehabilitation Journal* 11; William A. Anthony, 'Recovery from Mental Illness: The Guiding Vision of the Mental Health Service System' (1993) 16 *Psychosocial Rehabilitation Journal* 11.

determination and self-agency, inter-dependency and self-help, risk taking and protection of human rights in recovery oriented care.⁵²

Consumer groups continue to take a central role in defining recovery for mental health policy. In New South Wales, the NSW Consumer Advisory Group and the Mental Health Coordinating Council have released a document laying out their view of the principles of recovery orientated service delivery. This document emphasises empowerment, self-determination, provision of a variety of treatment options, consumer participation, family and peer support, a balance between risk and growth and the protection of human rights.⁵³

Recovery principles are now, in one form or another, central to both Commonwealth and New South Wales Government policy on mental health service delivery:

- The first priority of the recently released Roadmap for National Mental Health Reform is the promotion of “a person-centred, recovery-orientated approach” allowing people “flexibility, choice and control over their recovery pathway”.⁵⁴
- The shortly to be finalised *NSW Mental Health Services Competency Framework* provides that “working with clients, families and carers in recovery-focussed ways” must be a universal competency of all public sector mental health professionals working in mental health services.⁵⁵

⁵² M. Slade, M. Leamy, F. Bacon, M. Janosik, C. Le Boutillier, J. Williams & V. Bird, 'International Differences in Understanding Recovery: Systematic Review' (2012) *Epidemiology and Psychiatric Sciences* (published online 15 March); Ramon, Healy & Renouf, above n 49; Debra Rickwood, *4As Framework for Preventing Further Episodes of Mental Illness* (2005); Retta Andresen, Lindsay Oades & Peter Caputi, 'The Experience of Recovery from Schizophrenia: Towards an Empirically Validated Stage Model' (2003) 37 *Australian and New Zealand Journal of Psychiatry* 586; Kim T. Mueser, Patrick W. Corrigan, David W. Hilton, Beth Tanzman, Annette Schaub, Susan Gingerich, Susan M. Essock, Nick Tarrier, Bodie Morey, Suzanne Vogel-Scibilia & Marvin I. Herz, 'Illness Management and Recovery: A Review of the Research' (2002) 53 *Psychiatric Services* 1272; Daniel B. Fisher, 'Health Care Reform Based on an Empowerment Model of Recovery by People with Psychiatric Disabilities' (1994) 45 *Hospital and Community Psychiatry* 913; Steven J. Onken, Catherine M. Craig, Priscilla Ridgway, Ruth O. Ralph & Judith A. Cook, 'An Analysis of the Definitions and Elements of Recovery: A Review of the Literature' (2007) 31 *Psychiatric Rehabilitation Journal* 9.

⁵³ New South Wales Consumer Advisory Group - Mental Health Inc, *Literature Review on Recovery* (2009).

⁵⁴ Council of Australian Governments, *The Roadmap for National Mental Health Reform 2012-2022* (2012).

⁵⁵ New South Wales Ministry of Health, *NSW Mental Health Services Competency Framework - Draft* (2012) (available from http://www0.health.nsw.gov.au/resources/mhdao/pdf/h12_6540712_mental_

- The New South Wales *Community Mental Health Strategy* requires that “[c]linicians work in partnership with consumers to develop and monitor their individual Care Plan goals”.⁵⁶
- The Commonwealth’s National Mental Health Plan places “recovery” in its first priority area.⁵⁷
- The National Standards for Mental Health Services demand a recovery orientated mental health practice that “empowers individuals so they recognise that they are at the centre of the care they receive”; “supports and empowers individuals to make their own choices about how they want to lead their lives and acknowledges choices need to be meaningful and creatively explored”; “supports individuals to build on their strengths and take as much responsibility for their lives as they can at any given time”, “promotes and protects individual’s legal, citizenship and human rights”; and requires “working in partnership with individuals and their carers to provide support in a way that makes sense to them”.⁵⁸

While the Discussion Paper does not refer to the recovery principles expressly, the elements of the recovery philosophy are clearly a concern of its authors.⁵⁹ The importance of recovery and the incorporation of its principles into legislation was a prominent feature of some of the community consultation forums and recovery principles have formed a central plank of the deliberations on mental health legislation in other jurisdictions.⁶⁰

The involuntary treatment provisions of the MHA which impose substituted decision-making on people living with mental illness, regardless of decision-making capacity and without

health.pdf).

⁵⁶ New South Wales Department of Health, *NSW Community Mental Health Strategy 2007-2012. From Prevention and Early Intervention to Recovery* (2007), 10.

⁵⁷ Commonwealth of Australia, *Fourth National Mental Health Plan. An Agenda for Collaborative Government Action in Mental Health 2009-2014* (2009).

⁵⁸ Australian Government, *National Standards for Mental Health Services 2010* (2010), 42-43.

⁵⁹ Mental Health and Drug & Alcohol Office, above n 2.

⁶⁰ State Government of Victoria, *Exposure Draft Mental Health Bill 2010. Explanatory Guide* (2010); Legislative Assembly for the Australian Capital Territory, *ACT Mental Health (Treatment and Care) Act Amendment Bill 2012 (First Exposure Draft). Draft Explanatory Statement* (2012); Tasmanian Department of Health Human Services, *Review of the Mental Health Act 1996. Discussion Paper* (Tasmanian Department of Health and Human Services 2007); Steering Group on the Review of the Mental Health Act 2001 (Ireland), *Interim Report* (2012).

attention to the need for decision-making support, is antithetical to recovery's emphasis on empowerment, autonomy and self-determination.

4.4 The impact of a new understandings of risk of harm and patient safety ⁶¹

The discussion paper notes that, the MHA *“currently relies on medical practitioners to make decisions about the need for a mentally ill or disordered person to be detained and involuntarily treated ... , based on the person's risk of harm to themselves or others”*.⁶² The Act stipulates that a mentally ill person can only be treated without consent where *“there are reasonable grounds for believing that care, treatment or control of the person is necessary”* for either their own or other's *“protection from serious harm”*.⁶³

However since the 1980's when this phrasing was originally conceived,⁶⁴ there have been three significant shifts in the way that risk is understood in relation to mental health legislation.

First, as the discussion paper notes, there has been a recognition that *“[h]istorically, mental health systems have addressed risk and the avoidance of risk in such a way as to unreasonably restrict the lives and opportunities of the many who have severe mental illness”*.⁶⁵ Normally we allow persons to assess their own risk of harm and to make their own decisions in relation to those risks. Risk of harm to a person themselves is not normally thought to be a sufficient warrant to detain a person or to give a person medical treatment without their consent. Also, the compiling of risk factors for harm to others has never been considered a sufficient warrant for preventative detention in any other societal grouping –

⁶¹ Mental Health and Drug & Alcohol Office, above n 2, section 4.2.

⁶² Ibid, 16.

⁶³ *Mental Health Act 2007* (NSW), s14.

⁶⁴ The provision above originally appeared (essentially) unaltered as section 9 of the *Mental Health Act 1990* (NSW). Indeed the provision is very similar section 5 of the never promulgated *Mental Health Act 1983* (NSW).

⁶⁵ Gregor Henderson Limited, *Informing the Development of a Quality Assurance Framework for Mental Health in Western Australia. Interim Report May/June 2011* (2011), available from http://www.mentalhealth.wa.gov.au/Libraries/pdf_docs/WA_QA_Interim_Report_FINAL_DRAFT_12_June_2011_2.sflb.ashx.

for example, profiling of potentially violent people, or other people thought to be “likely” to commit crimes, is not considered to be an adequate basis to preventatively detain people in the general population. The fact that this has been a feature of involuntary treatment schemes for mental illness would appear to be more evidence of a history of stigmatisation and discrimination than a reflection of the “dangerousness” of persons with mental illness.

Second, experts in the discipline of patient safety, which originated in procedural medicine and is only now beginning to influence psychiatry, are suggesting that psychiatry’s preoccupation with risk may, paradoxically, be compromising the wellbeing of persons presenting to hospitals with a diagnosis of psychiatric illness. Qualitative research in the UK has demonstrated that, under the influence of a preoccupation with risk, psychiatrists “*had become cautious about sending home patients who had voiced suicidal thoughts even though that patient may improve more quickly in their home environment and notwithstanding the issue of a lack of beds*”.⁶⁶

Similarly, it has been suggested that an unjustified focus on an assessment of ‘risk of harm’ is one of the reasons why persons who are experiencing their first episode of psychosis go much longer without effective treatment in jurisdictions where mental health legislation includes “risk of harm” as a criterion for coercive treatment.⁶⁷ It may be that persons presenting to hospital with a psychotic illness that renders them unable to make a decision for themselves in relation to treatment, may be barred access to treatment that would manifestly improve their wellbeing, where they are not thought to be at sufficient ‘risk of harm’ to trigger unconsented treatment.⁶⁸

Other elements of the patient safety literature emphasise the importance of communication and negotiation with the patient and incorporation of patient values into management planning. Under this analysis, the method of supported decision-making, where patients and

⁶⁶ Philip Linsley & Russell Mannion, 'Risky Behaviour and Patient Safety: A Critical Cultivist Perspective' (2009) 23 *Journal of Health Organisation and Management* 494, 502.

⁶⁷ Large, Neilssen, Ryan & Hayes, 'Mental Health Acts That Require Dangerousness', above n 11.

⁶⁸ Large, Ryan, Nielssen & Hayes, 'The Danger of Dangerousness', above n 11.

their nominated supporters (such as family and friends) become active participants in their treatment decisions, also maximises the chances of optimal outcomes.⁶⁹

Finally, an increasingly sophisticated interpretation of the mechanics of risk assessment when people with mental illness present to mental health facilities is beginning to influence views about how sound risk assessment is as a basis for involuntary treatment. Studies that analyse existing, often contradictory risk-based studies have revealed that, even using the best tools available, it is impossible to usefully categorise psychiatric patients who present for care into those who are at high risk and those who are at low risk of future serious harm to themselves or others.⁷⁰ The low base rate of events such as suicide, serious assault of others and homicide, mean that attempts to categorise patients according to those who are at highest risk of suffering or perpetrating these very rare events leads to unacceptably high number of false positives (the incorrect categorisation of people at high risk of harm which they will not, in fact, go on to suffer) while still failing to correctly identify the majority of patients that do go on to cause or suffer serious harm.⁷¹

Viewed in the light of these developments, the likelihood of harm provisions in the MHA not only place an impossible burden upon clinicians to usefully categorise psychiatric patients

⁶⁹ A. Kanerva, J. Lamintakanen & T. Kivinen, 'Patient Safety in Psychiatric Inpatient Care: A Literature Review' (2012) *Journal of Psychiatric and Mental Health Nursing* (published on line 11 July); Cornelia M. Ruland, 'Improving Patient Safety through Informatics Tools for Shared Decision Making and Risk Communication' (2004) 73 *International Journal of Medical Informatics* 551.

⁷⁰ Matthew Large, Swapnil Sharma, Elizabeth Cannon, Christopher Ryan & Olav Nielssen, 'Risk Factors for Suicide within a Year of Discharge from Psychiatric Hospitals: A Systematic Meta-Analysis' (2011) 45 *Australian and New Zealand Journal of Psychiatry* 619; Matthew Large, Glen Smith, Swapnil Sharma, Olav Nielssen & Swaran Singh, 'Systematic Review and Meta-Analysis of the Clinical Factors Associated with the Suicide of Psychiatric Inpatients' (2011) 124 *Acta Psychiatrica Scandinavica* 18; Douglas Mossman, 'The Imperfection of Protection through Detection and Intervention. Lessons from Three Decades of Research on the Psychiatric Assessment of Violence Risk' (2009) 30 *Journal of Legal Medicine* 109; Jay P. Singh, Mark Serper, Jonathon Reinharth & Seena Fazel, 'Structured Assessment of Violence Risk in Schizophrenia and Other Psychiatric Disorders: A Systematic Review of the Validity, Reliability, and Item Content of 10 Available Instruments' (2011) 37 *Schizophrenia Bulletin* 899.

⁷¹ Ryan, Nielssen, Paton & Large, 'Clinical Decisions in Psychiatry Should Not Be Based on Risk Assessment' n 11; Matthew M. Large & Olav B. Nielssen, 'Risk Factors for Inpatient Suicide Do Not Translate into Meaningful Risk Categories - All Psychiatric Inpatients Are High-Risk' (2012) 73 *Journal of Clinical Psychiatry* 1034; Matthew Large & Christopher James Ryan, 'Screening for Suicide: A Comment on Steeg et al.' (2012) 42 *Psychological Medicine* 2011; Matthew Large, Christopher Ryan & Olav Nielssen, 'The Validity and Utility of Risk Assessment for Inpatient Suicide' (2011) 19 *Australasian Psychiatry* 507; Large, Ryan, Paton, Nielssen & Singh, 'The Predictive Value of Risk Categorization in Schizophrenia', above n 11.

into those who are at relatively high and relatively low risk of harm, but may also contribute to unreasonable restrictions on the freedom of those with mental illness and a decline in patient safety and the quality of patient care.

Genuine concerns about a person's future safety, or violent behaviour will still be relevant where a person is shown to lack decision-making capacity. Substitute decision makers would be expected to consider and account for these concerns in a broader understanding of what would contribute to the person's wellbeing whilst respecting that person's will and preferences to the greatest extent possible. This is described in more detail in sections 5.3 and 5.4 below.

5 Reform of the coercive intervention provisions governing the care of people with mental illness

As the Discussion Paper foreshadows and as we have explained above, the involuntary treatment provisions of the MHA are no longer appropriate in modern mental health legislation. We recommend that revised legislation should actively reflect the widely accepted preference for voluntary treatment and supported decision-making, with compulsory treatment limited to circumstances where a person is unable to make decisions for themselves.

This would require a presumption of decision-making capacity, provision of support for decision-making, and a restriction of compulsory treatment to those cases where a person has been shown to lack decision-making capacity and where support has failed to enable that person to make their own decision about treatment.

Provisions that require clinicians and tribunals to base compulsory treatment solely on an estimate of a mentally ill person's future likelihood of "serious harm" are antithetical to equitable rights-based treatment and should be removed.

This would establish a scheme for medical treatment for persons with mental illness that is equivalent to others under the law, as required by the CRPD.⁷²

5.1 Provision of support for decision-making

The CRPD requires that persons with disabilities, including mental illness, should be given access “to the support they may require in exercising their legal capacity”.⁷³

What exactly “supported decision-making” requires is still the subject of much policy discussion in Australia and internationally, however broadly speaking the purpose of providing decision-making support is to ensure that persons with mental illness are not deprived of the right to make decisions for themselves, merely because they are not offered sufficient support at the time the decision was required.

Decision-making support could be expected to include things such as careful communication of information using language that can be easily understood by a person, making efforts to address sources of concern or distress that may be impacting a person’s decisions, spending adequate time explaining a person’s options, listening to the person’s perspective and preferences, and working on alternatives that might be more acceptable to the person.

A requirement to engage in supported decision-making currently forms part of the process that a substitute decision maker must undertake when determining a person’s best interests under the *Mental Capacity Act 2005* (UK). Subsection 4(4) of that Act requires that the substitute decision maker “*must, so far as reasonably practicable, permit and encourage the person to participate, or to improve his ability to participate, as fully as possible in any act done for him and any decision affecting him*”.⁷⁴

However an ever greater emphasis on supported decision making is emerging in more recent law reform discussions around decision making involving people with disabilities. For

⁷² *Convention on the Rights of Persons with Disabilities*, opened for signature 30 March 2007, Arts 5, 12 (entered into force 3 May 2008).

⁷³ *Convention on the Rights of Persons with Disabilities*, opened for signature 30 March 2007, Art 12.3 (entered into force 3 May 2008).

⁷⁴ *Mental Capacity Act 2005* (UK), s 4(4).

example, in Australia the Victorian Law Reform Commission has recommended extensive changes to current guardianship legislation that would effect a much greater emphasis on supported decision-making over substituted decisions, than currently exists under the *Guardianship and Administration Act 1986* (Vic). As the Commission explains:

“Supported decision-making recognises the interdependent nature of most people’s lives. Most people make important decisions with personal support (such as advice from family, friends or mentors), or sometimes with professional support (for example, doctors or accountants). Some people with disabilities sometimes need additional support to make important decisions.

Supported decision-making differs from substitute decision-making in two main ways:

- *A substituted decision is made on behalf of a person with impaired decision-making ability, whereas a supported decision means that someone has been helped to make it themselves.*
- *A substitute decision maker is authorised to make a decision for the represented person, which is deemed the decision of the represented person. By contrast, in supported decision-making arrangements, the assisted person continues to be the person authorised to make decisions, either alone (but with support) or together with a co-decision maker.”⁷⁵*

The Commission goes on to consider some possible arrangements that might enhance supported decision-making including the development of a new legal mechanism, which it calls “co-decision-making”. Under this model, a ‘supporter’ would be made available to assist people with impaired decision-making ability to continue to exercise legal capacity. These supporters would not be substitute decision makers, and would not have the power to make decisions on behalf of a person, but they would be able to do things to help the person to make their own decisions.

⁷⁵ Victorian Law Reform Commission, *Guardianship* (2012), [8.6] – [8.7]. Available at <http://www.lawreform.vic.gov.au/projects/guardianship-final-report>.

These ideas reflect the more nuanced view of capacity and decision-making for people with cognitive disabilities, foreshadowed in the CRPD, which requires that before a person can be considered to have lost the capacity to make their own decisions, and therefore to be legally prevented from exercising control over their own lives, support must be provided to enable people to participate in decision-making and to retain autonomy, to the greatest extent possible. These goals apply equally to people with mental illness.

5.2 Presumption of capacity and incapacity-based compulsory treatment

Both the Victorian and Tasmanian parliaments are also considering mental health bills that seek to confine involuntary treatment strictly to persons who have been shown to lack capacity to make their own treatment decisions.⁷⁶ Both these bills begin with a presumption of capacity that must be displaced before a compulsory treatment order can be made. The starting point of presumption of capacity means that there must be an appropriate trigger to initiate a capacity assessment, and that capacity assessment must not be used arbitrarily as a means of controlling the decisions of persons with mental illness. Reasonable triggers might include harmful behaviour or choices that seem inconsistent with the person's previously held values.⁷⁷ However, where a person is shown to retain capacity, the person must be permitted to make their own decisions.

Under the Tasmanian Mental Health Bill 2012, a person lacks the requisite 'mental capacity' to make a treatment decision for him or herself if, because of an impairment of or disturbance in the functioning of the mind or brain, he or she is unable to (cl. 7):

- (i) understand information relevant to the decision; or
- (ii) retain information relevant to the decision; or
- (iii) use or weigh information relevant to the decision; or

⁷⁶ Mental Health Bill 2010 (Vic) (Exposure Draft) cls. 64(d), 70(c), 71(c); Mental Health Bill 2012 (Tas) cls. 25, 40.

⁷⁷ Peteris Darzins, William Molloy & David Strang, 'What Is Capacity?', in Peteris Darzins, William Molloy & David Strang (eds.), *Who Can Decide?—the Six Step Capacity Assessment Process* (2000).

(iv) communicate the decision (whether by speech, gesture or other means).

Similarly, the Victorian Mental Health Bill (Exposure Draft) 2010 provides that a person can only be made subject to a compulsory order if, because of their mental illness, their ability to make decisions about the provision of treatment is significantly impaired (cls. 64(d), 70(c), 71(c)). This 'significant impairment' is defined as an inability 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; or

(iv) communicate the decision in a manner such that another person can understand what the decision is.

The authors recommend that a presumption of decision-making capacity, and a similar definition of decision-making capacity also be included in any new NSW legislation.

5.3 The basis for substituted decisions, including consent to coercive treatment

Even with the provision of decision-making support, there will be circumstances in which a person's decision-making capacity is impaired to the extent that a substituted decision will be required. Other new provisions would be required to govern the mechanism by which substituted decision makers could operate. Consistent with the CRPD, these mechanisms would need to include safeguards that would

*"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, [and] are proportional and tailored to the person's circumstances, ..."*⁷⁸

⁷⁸ *Convention on the Rights of Persons with Disabilities*, opened for signature 30 March 2007, Art 12.4 (entered into force 3 May 2008).

There are numerous legislative models for this approach though it is fair to say that no jurisdiction has yet framed mental health legislation entirely consistent with these obligations.

One current model is the *Mental Capacity Act 2005* (UK). Section 1 of this Act stipulates that “[a]n act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests”.⁷⁹ In determining the person’s best interests, the substitute decision maker (referred to as “he”) is required to take the following steps:⁸⁰

1. He must consider—

- (a). whether it is likely that the person will at some time have capacity in relation to the matter in question, and
- (b). if it appears likely that he will, when that is likely to be.

2. He must consider, so far as is reasonably ascertainable—

- (a) the person’s past and present wishes and feelings (and, in particular, any relevant written statement made by him when he had capacity),
- (b) the beliefs and values that would be likely to influence his decision if he had capacity, and
- (c) the other factors that he would be likely to consider if he were able to do so.

3. He must take into account, if it is practicable and appropriate to consult them, the views of—

⁷⁹ *Mental Capacity Act 2005* (UK), s 1(5).

⁸⁰ *Mental Capacity Act 2005* (UK), s 4 (certain subsections have been omitted).

- (a) anyone named by the person as someone to be consulted on the matter in question or on matters of that kind,
- (b) anyone engaged in caring for the person or interested in his welfare,
- (c) any donee of a lasting power of attorney granted by the person, and
- (d) any deputy appointed for the person by the court, as to what would be in the person's best interests and, in particular, as to the matters mentioned in [step 2].

Step 3(a) above formalises the role of family and friends in compiling the information relevant for a substituted decision maker to come to a decision, taking into account a key component of the recovery philosophy, which envisages family and peers as having a crucial role in supporting a person's recovery.

However, the above formulation may still not adequately protect the autonomy of the person for whom a substituted decision is being made, because it does not establish the primacy of the known wishes, attitudes and values of the person themselves in line with the Article 12 of the CRPD.

In its recent report on adult guardianship, the Victorian Law Reform Commission suggested that the requirements of the CRPD would be best be achieved by implementing a qualified "substituted judgement" test for adults who had lost capacity and for whom a decision needed to be made by another person. The rationale involved in substituted judgement stands in contrast to traditional "best interests" tests which have been criticised for being overly paternalistic, to the extent that they seem to apply objective standards to decisions intimately affecting a person's life, and which may not reflect the person's own views⁸¹. By

⁸¹ Victorian Law Reform Commission, above n 75, [17.120] – [17.121]. It is worth noting that many legislated best interests tests in Australian guardianship legislation do include a requirement that persons known wishes be taken into account. While this was acknowledged by the Commission it took the view that the change in emphasis required by the CRPD to more firmly centre adult substituted decision-making on the "will and preferences" of the person themselves, would be best achieved through a change in language. See also Department of Health (Northern Ireland). *Interim Report of the Steering Group on the Review of the Mental Health Act 2001*. Belfast: 2012. 10-11.

contrast, substituted judgement aims to implement the decision the person would make themselves if they were able to do so. According to the Commission:

“Making the decision the person would make themselves requires substitute decision makers to consider the expressed wishes of the person— both past and present—and to place these wishes in the context of the person’s current circumstances and the decision that needs to be made.”⁸²

The Commission stated that in its view *“substituted judgment should be the starting point and the paramount consideration for substitute decisions”⁸³* but acknowledged that there were a number of limitations to this approach. For example, substituted judgement might be impossible in some cases. This might occur in cases where the person had lost capacity to the point that their wishes are not known and could not be ascertained even with support; or where the person’s circumstances have changed so much that what the person would choose if they had capacity might be impossible to determine by reference to past preferences. Also, even when substituted judgement was possible, it will inevitably involve at least some subjectivity on the part of the substituted decision maker in determining “what the person would have wanted” – meaning that the substituted decision maker’s own beliefs and values will affect their interpretation - unless a decision on the issue to hand had been clearly expressed previously.

The Commission also expressed concern about occasions where a person’s known will and preference (which would include views they are currently expressing) might be manifestly self-destructive. In this respect the Commission’s stated that:

“There may be circumstances where a strict application of the substituted judgment principle leads to unacceptable harm to the person.

An example might be a situation where a person has always been adamant that, no matter what the circumstances, they wish to remain in their own home for the rest of their life. Even in circumstances of advanced dementia, it might be clear that the

⁸² Victorian Law Reform Commission, above n 75, [17.105].

⁸³ Ibid, [17.126].

person would have wanted to remain at home despite the risks to their safety and wellbeing, but a substitute decision maker might determine that this would involve unacceptable risk of harm to the person.

The Commission believes that there must be a point—often difficult to determine in practice—at which it is permissible for a substituted decision maker to move away from a substituted judgment approach in order to protect a represented person from harm.”⁸⁴

In the context of mental illness, we would be cautious about the Commission’s formulation of a need to “protect a represented person from harm” for the reasons we have outlined in section 4.4. We would also reject any implication that a person’s competently expressed will and preference, such as might be laid out in a valid advance directive, could be overborn merely because it was not, in the view of others, seen to be in the person’s interests.

Nevertheless, we acknowledge the legitimate concerns underlying the Commission’s considerations and would agree, in the context of mental illness, that the Commission’s ultimate recommendation that substitute decision makers must be able to retain a degree of flexibility when determining how they fulfil their responsibilities in exercising substituted judgment. In particular, we think it is reasonable that although a person’s known will and preferences must be the paramount consideration it should be exercised with the “*the overarching goal ... to ‘promote the personal and social wellbeing’ of the represented person.*”⁸⁵

In this respect we also agree with the Commission’s further suggestion that detailed guidelines and codes of practice would need to be developed to assist substituted decision makers to understand what substituted judgement and the “personal and social wellbeing” of a person might mean in practice.

We note that the current MHA stipulates as a general restriction on the detention of person’s that “*no other care of a less restrictive kind, that is consistent with safe and*

⁸⁴ Ibid, [17.118].

⁸⁵ Ibid, [17.122].

effective care, is appropriate and reasonably available to the person".⁸⁶ This could also be retained as an element in the issues that the substituted decision maker must consider. In any case, operationalising the requirement to give effect to a person's known will and preferences, and the content of any overarching requirement to act in the interests of a person's wellbeing would need to be significantly expanded in practice guidelines were the recommended reforms to be made.

Finally, and again consistent with the wording of the CRPD, new provisions would be needed to ensure that any substituted decisions made "*apply for the shortest time possible and are subject to regular review by a competent, independent and impartial authority or judicial body*".⁸⁷ In New South Wales this would require regular and timely review by the Mental Health Review Tribunal – see section below.⁸⁸

Recommendation 1: *Current provisions that centre coercive treatment decisions for people with mental illness on the basis of protection from serious harm should be removed from a revised Act.*

Recommendation 2: *The MHA incorporate a series of new provisions that include:*

a) a formalisation of the presumption of capacity;

b) a requirement that all persons be provided with appropriate support in making their own treatment decisions;

c) a requirement that substituted decision-making (including compulsory treatment orders) can only occur where a person can be shown to

⁸⁶ *Mental Health Act 2007 (NSW)*, s 12(b).

⁸⁷ *Convention on the Rights of Persons with Disabilities*, opened for signature 30 March 2007, Art 12.4 (entered into force 3 May 2008).

⁸⁸ Christopher James Ryan, Sascha Callaghan & Matthew Large, 'Long Time, No See. Australians with Mental Illnesses Wait Too Long before Independent Review of Detention' (2010) 35 *Alternative Law Journal* 137.

*lack decision-making capacity and where supported decision-making has failed;
and*

d) the introduction of guidelines for substituted decisions (including compulsory treatment orders) that require that the will and preferences of the person must be respected and be given effect to, to the greatest extent possible, and that in any case, must be shown to be manifestly necessary to promote the person's wellbeing, broadly conceived.

5.4 Additional “serious harm” criteria should not form an additional barrier to treatment

The drafters of the Mental Health Bill 2010 (Vic), which requires that a person lack decision-making capacity before coercive psychiatric treatment can be given, have retained an additional “serious harm” criterion, that must *also* be met before an incompetent person with a mental illness can access treatment. By way of example, clause 70(d) provides that before an incompetent person with a mental illness can receive treatment under an “Inpatient Treatment Order” it must be the case that:

“if the person is not detained and treated in an approved mental health service there is—

- (i) an imminent and significant risk that the person may cause serious harm to himself or herself or to another person; or
- (ii) a significant risk that the person will suffer serious physical or mental deterioration”.

In our view, if a person is not able to make their own decisions because they lack decision-making capacity, there is no additional benefit in adding a further “serious harm” criterion as a threshold for treatment. Considerations of potential harm are relevant of course, but only in so far as they might become part of a sophisticated attempt to make a substituted decision that respects the person’s will and preferences and is made to promote the

person's wellbeing. To add an additional test, to be considered outside this broader context, especially one that required "imminent and significant risk" of serious harm, is to impose an unreasonable barrier to unconsented treatment, that would apply to mentally ill persons alone.

In legislative schemes that do *not* base the imposition of coercive treatment on a determination of patient capacity, including the current Victorian and New South Wales mental health acts, the requirement that such treatment must be necessary to protect the patient from harming themselves or others is used in an attempt to provide the necessary justification for overriding a patient's autonomy.⁸⁹ Typically the only other situations where a person is compelled to accept treatment despite a competent refusal, are those rare situations where refusal raises the possibility of serious harm to others.⁹⁰ Rarely used quarantine and public health laws to combat infectious disease provide examples.⁹¹

By contrast, modern mental health legislation, of the type we are advocating, require that coercive psychiatric treatment may only be delivered when person lacks decision-making capacity and where decision-making support has failed. In those circumstances, a substituted decision about treatment can and should be made with the aim of promoting the person's wellbeing, where the persons known wishes, beliefs and values are the paramount consideration.

Provisions in mental health legislation that require a mentally ill person to be deemed at risk of serious harm to self or others, or at risk of serious deterioration, in addition to any wellbeing considerations, are know as obligatory harm criteria. Obligatory harm criteria have

⁸⁹ The criteria for involuntary treatment of a person under the current *Mental Health Act 1986* (Vic) include that "*because of the person's mental illness, involuntary treatment of the person is necessary for his or her health or safety (whether to prevent a deterioration in the person's physical or mental condition or otherwise) or for the protection of members of the public*" (s 8(1)). Note that this is a much broader harm criterion that that proposed by the draft legislation.

⁹⁰ It may also be the case that a person who has attempted suicide may be required to be treated at common law or to avoid prosecution for aiding and abetting a suicide, though Australian law is not clear on this at the present time. See: Sascha Callaghan & Christopher James Ryan, 'Refusing Medical Treatment after Attempted Suicide: Rethinking Capacity and Coercive Treatment in Light of the Kerrie Woollorton Case' (2011) 18 *Journal of Law and Medicine* 811.

⁹¹ *National Health Security Act 2007* (Cth) s 6(c); *Quarantine Act 1908* (Cth) ss 4(2), 18(1); *Public Health Act 2010* (NSW) s 8.

been shown to be associated with a near doubling to the delay before young people suffering their first episode of a psychotic illnesses access effective treatment.⁹² It is well established that the longer a psychotic young person goes without effective treatment, the worse the lifetime prognosis of their illness.⁹³

Obligatory harm criteria form an unacceptable barrier to people with mental illness who refuse treatment in circumstances where their decision-making capacity is seriously impaired and who are suffering significant harm as a consequence of a mental illness. This is because such people will not be able to access treatment unless they are *also* deemed likely to come to serious harm themselves or to seriously harm another person, or to deteriorate. And this will be so even if they had clearly expressed a preference for treatment prior to an acute and incapacitating episode of illness.

When a patient lacks decision-making capacity, the proper place for considerations as to any sort of current or reasonably anticipated harm is as part of a general consideration of what the wellbeing of a person requires, given that the person's will and preferences regarding treatment are paramount.⁹⁴

⁹² Large, Neilssen, Ryan & Hayes, 'Mental Health Acts That Require Dangerousness', above n 11.

⁹³ Max Marshall, Shon Lewis, Austin Lockwood, Richard Drake, Peter Jones & Tim Croudace, 'Association between Duration of Untreated Psychosis and Outcome in Cohorts of First-Episode Patients. A Systematic Review' (2005) 62 *Archives of General Psychiatry* 975; Diana O. Perkins, Hongbin Gu, Kalina Boteva & Jeffrey A. Lieberman, 'Relationship between Duration of Untreated Psychosis and Outcome in First-Episode Schizophrenia: A Critical Review and Meta-Analysis' (2005) 162 *American Journal of Psychiatry* 1785.

⁹⁴ It is possible to argue that the "serious harm" criterion as it appears in section 14 of the *Mental Health Act 2007* (NSW) should be interpreted so broadly as to provide a *de facto* best interests test, rather than an obligatory harm criterion. "Serious harm" is not defined in the Act, but there is anecdotal evidence to suggest that many psychiatrists and other doctors still consider the provision through the lens of the original wording of the 1990 Act. Section 9 of that Act, as made, defined a mentally ill person as one for which there was "reasonable grounds for believing that care, treatment or control of the person is necessary", either "for the person's own protection from serious physical harm" or "for the protection of others from serious physical harm". In addition, a person could also be considered a mentally ill person if the person were suffering from mental illness "characterised by the presence ... of a severe disturbance of mood ... and, owing to that illness, ... care, treatment or control of the person [was] necessary for the person's own protection from serious financial harm or serious damage to the person's reputation". Many psychiatrists appear to regard the current serious harm provisions as simply adding reputational and financial harm to serious physical harm as a warrant for coercive treatment for all persons with a mental illness. However, *obiter* in a recent New South Wales Supreme Court decision suggests that "serious harm" should include any serious harm occasioned by the symptoms of the mental illness itself (*Re J (No. 2)* [2011] NSWSC 1224). It is by no

We recommend, therefore, that where a patient lacks decision-making capacity, and supported decision-making has failed or is not appropriate because incapacitation is severe, a substituted decision about treatment can and should be made to promote the person's wellbeing, where the persons known wishes, beliefs and values are the paramount consideration. In such a scheme, concerns about the person's safety, including the possibility that they may harm themselves, the likely trajectory of their illness and the potential *benefits* of treatment,⁹⁵ would be relevant. A person's wellbeing will also be impacted by the potential for future harm to others. The serious possibility that a person who, lacking the capacity to decide on their need for medical treatment, would, as a result of not having such treatment, go on to seriously harm another, will always constitute a profound deficit in any wellbeing calculation.

Thus, while likelihood of harm would be relevant in the context of considering what is necessary to promote the person's wellbeing, in our view, it would be inappropriate for a requirement that person must be at likelihood of "serious harm" to provide a barrier to treatment where the person was clearly unable to consent to treatment and where all things considered, treatment was manifestly necessary to promote the person's wellbeing, provided the provision of treatment was also consistent with the persons known will and preferences.⁹⁶

means certain though that a similarly worded "serious harm" criterion in any future mental health act would or should be interpreted that broadly. Certainly clause 70(d) of the new Victorian Mental Health Bill, could not be interpreted this way. Moreover, even if the additional harm criteria could be interpreted as a *de facto* best interests test, this sort of test leaves no room for the proper consideration of the affected persons will and preferences is inconsistent with the demands of article 12 of the CRPD.

⁹⁵ Another criticism of a "risk of harm" requirement for admission to treatment is that it does not adequately take into account the potential benefits of treatment.

⁹⁶ It is also worth noting that the sort of "risk of harm" assessment anticipated by the draft Victorian legislation are also of no practical utility. As noted above the draft Victorian bill asks clinicians to make some specific judgements about the likelihood of future events. Specifically clinicians are expected to determine if without detention and treatment the person would present "an imminent and significant risk" of causing "serious harm to himself or herself or to another person" or "a significant risk" of suffering "serious physical or mental deterioration" (see for example cl 70(d)). Risk categorisation, of the type the draft Victorian legislation demands, involves using either clinical judgement or a variety of actuarial tools to try to sort patients into those that are likely to cause serious harm to themselves or others and those that are not. The problem with attempting this task is that the number of people who actually cause serious harm to themselves or others is so tiny

In any case, compulsory treatment must aim to restore the person's decision-making capacity as quickly as possible so as to facilitate participation in decision-making and to ensure that personal consent is provided for ongoing treatment wherever possible.

6 Community Treatment Orders

One of the major reforms of the 1990 *Mental Health Act* was the introduction of Community Treatment Orders (CTOs). In his second reading speech introducing that Act the then Health Minister, Peter Collins, noted:

“The community treatment order is designed for a person who could be found by a magisterial inquiry in a mental hospital to be a mentally ill person and eligible to be made a temporary patient. It is designed also to allow a temporary or continued treatment patient in a mental hospital to be conditionally released. ... It is intended that a community treatment order will not be made unless the person the subject of it is otherwise likely to be detained or is detained in a hospital.”⁹⁷

It was clear, therefore, that Parliament's intention was that CTOs would only apply to people who were currently mental ill persons and for whom coercive community treatment represented a welcome less restrictive alternative.

CTOs have, however, come to be applied far more broadly than that original intention. A 1994 New South Wales Court of Appeal decision found that people could be made subject to

compared to the large number of people that are assessed, that the task is analogous to feeling gloved and blind-folded for a few needles in a haystack. No matter what criteria you use for judging something you pick up to be a needle, you'll inevitably miss many needles and you'll end up with a vast number of suspected needles that are actually only hay.

The low base rate of suicide, serious deliberate self-harm and serious harm to others among people living with mental illness, means that it is impossible to *usefully* categorise people with mental illness who present in crisis into those who are at significant risk for causing serious harm to themselves or others and those who are not. (It follows logically that to usefully categorise patients according to an *imminent* risk of serious harm, as the draft Bill requires, is even more fanciful).

For thoroughly worked examples of this issue as it applies to risk assessment in psychiatry see: Large, Ryan, Paton, Nielssen & Singh, 'The Predictive Value of Risk Categorization in Schizophrenia' above n 11; Large, Smith, Sharma, Nielssen & Singh, 'Systematic Review and Meta-Analysis of the Clinical Factors Associated with the Suicide of Psychiatric Inpatients' above n 70; Ryan, Nielssen, Paton & Large, 'Clinical Decisions in Psychiatry Should Not Be Based on Risk Assessment' above n 11.

⁹⁷ Peter Collins, 'Second Reading Speech for the Mental Health Bill 1990 (NSW)' (1990) *Hansard of the New South Wales Legislative Assembly* 884, 888.

CTOs regardless of whether or not they were a “mentally ill person”, as defined. As a result, the original intention of legislators, that CTOs offer a tightly controlled alternative to coercive inpatient treatment was lost.⁹⁸

New South Wales currently has one of the highest per capita rates of coercive community treatment rates in the world – at 46.4 per 100 000,⁹⁹ and this without any apparent trade off in the rate of coercive inpatient treatment. However, there is no clear evidence that the use of CTOs provides any form of benefit in the delivery of mental health care, when compared to care delivered on a purely voluntary basis.¹⁰⁰

We recommend that legislative reform be made that returns the purpose of CTOs to that originally envisaged by the New South Wales Parliament, and they become solely a less restrictive alternative to coercive inpatient treatment. In line with the recommendations above in relation to inpatient treatment orders, we also recommend that CTOs should only apply in circumstances where a person lacks decision-making capacity in relation to treatment decisions and where those community delivered treatments are determined to be

⁹⁸ *Harry v the Mental Health Review Tribunal* [1994] 33 NSWLR 315; Robert Wheeler, *Mental Health Act Hearings: Community Treatment Orders and Community Counselling Orders* (2001) available from <http://mhcc.org.au/documents/RobertWheeler.pdf> .

⁹⁹ Edwina M. Light, Ian H. Kerridge, Christopher J. Ryan & Michael Robertson, 'Community Treatment Orders: Rates and Patterns of Use' (2012) *Australasian Psychiatry* (published online 6 November).

¹⁰⁰ See for example: Rachel Churchill, Gareth Owen, Swaran Singh & Matthew Hotopf, *International Experiences of Using Community Treatment Orders* (2007); S. Kisely, L. A. Campbell & N. Preston, 'Compulsory Community and Involuntary Outpatient Treatment for People with Severe Mental Disorders (Review)' (2005) *Cochrane Database of Systematic Reviews* CD004101; Andrew Molodynski, Jorun Rugkåsa & Tom Burns, 'Coercion and Compulsion in Community Mental Health Care' (2010) 95 *Br Med Bull* 105.

Even a recent Western Australian study that unexpectedly demonstrated a decrease in all-cause mortality in patients subject to CTOs, also found that this association disappeared when adjustments were made for increased outpatient and community contacts with psychiatric services. The authors of the study note that this means that the decreased mortality may have been a result that of increased contact with mental health clinicians which might have provided opportunities for identifying and managing comorbid physical illnesses, or for monitoring the presence of adverse effects of psychotropic medications that are known to increase the risk of chronic disease. While CTOs *do* increase the number of community and outpatient contacts it is not clear to what extent this increase is due to the coercion of patients, or to the “coercion” of mental health services which, feel compelled to offer improved services when a patient is under an involuntary order.: Steve Kisely, Neil Preston, Jianguo Xiao, David Lawrence, Sandra Louise & Elizabeth Crowe, 'Reducing All-Cause Mortality among Patients with Psychiatric Disorders: A Population-Based Study' (2012) *Canadian Medical Association Journal* (published online 12 November).

necessary to promote the person’s wellbeing (in which the known will and preferences of the person is a paramount consideration). They should also apply for the shortest period of time necessary and must aim to restore the person’s ability participate in decision-making, and to personally consent to ongoing treatment (or otherwise) as quickly as possible.

Compulsory treatment in the community must also receive timely and regular oversight by an independent tribunal that is at least equivalent to the review procedure for inpatient coercive treatment.

Recommendation 3: *Community Treatment Orders should only be made in the circumstances applying to inpatient treatment orders (consistent with Recommendation 2 above), as a less restrictive alternative to an inpatient order.*

Recommendation 4: *Community Treatment Orders should also apply for the shortest period of time necessary and must aim to restore the person’s ability participate in decision-making, and to personally consent to ongoing treatment (or otherwise) as quickly as possible.*

Recommendation 5: *Community Treatment Orders must receive timely and regular oversight by an independent tribunal that is equivalent to the review procedure for inpatient compulsory treatment.*

7 Mentally disordered provisions¹⁰¹

Another reform of the 1990 Act was the introduction of the mentally disordered provisions. In introducing this reform to the Parliament the then Health Minister explained this provision in these terms:

“Certain persons who could be classified as temporarily irrational would be excluded from the definition of mental illness. A common example would be persons who

¹⁰¹ Mental Health and Drug & Alcohol Office, above n 2, 20.

*suffer because of a traumatic crisis or a close personal relationship and who, overwhelmed by emotional turmoil, become unable to control their actions and emotions; they may become suicidal, or otherwise seriously out of control for a brief period. To deny such people protection and treatment is an abrogation of our duty of care. These people are covered by the term mentally disordered person, and may be involuntarily admitted to a mental hospital for a period of 24 hours. At the end of that period the person must be examined by the medical superintendent or a medical officer nominated by the superintendent, who may, if the person is still mentally disordered, continue the detention for a further period of 24 hours. Such detention can occur continuously only for a maximum of three working days, and a person cannot be detained as a mentally disordered person on more than three occasions in any one month.*¹⁰²

The provisions of the 1990 Act have survived unchanged into the 2007 Act and mentally disordered person is described in section 15 as:¹⁰³

A person (whether or not the person is suffering from mental illness) is a mentally disordered person if the person's behaviour for the time being is so irrational as to justify a conclusion on reasonable grounds that temporary care, treatment or control of the person is necessary:

(a) for the person's own protection from serious physical harm, or

(b) for the protection of others from serious physical harm.

New South Wales is the only Australian jurisdiction, and to our knowledge, the only jurisdiction in the world, to carefully separate provisions that apply to people with mental illness and people (whether they suffer mental illness or not) who “*overwhelmed by emotional turmoil, become unable to control their actions and emotions*” and who “*may become suicidal, or otherwise seriously out of control for a brief period*”.

¹⁰² Collins, above n 97, 889-890.

¹⁰³ *Mental Health Act 2007 (NSW)*, s 15; *Mental Health Act 1990 (NSW)*, s 10.

The mentally disordered provisions do not apply to people living with mental illness any more than they apply to the rest of the community, and if “so irrational” is taken to imply that the person’s capacity is impaired, as seems to have been the intention of Parliament, then the provisions anticipate many of the capacity-related arguments set out above.

Since the mentally disordered provisions do not apply specifically to people living with mental illness they do not necessarily trigger the same concerns about discrimination as the provisions relating to mentally ill persons.

The mentally disordered provisions appear to respond to community concerns that people who are extremely upset should not be permitted to recklessly endanger their own or other’s physical safety. To that end, they provide a special power for doctors, on behalf of the community, to temporarily detain persons whose behaviour is “so irrational” as to cause a doctor to believe that detention is necessary for their own physical safety or the physical safety of others, in a facility where such harm is probably less likely to occur. This kind of detention is short term only – currently a maximum of three (working) days.

There is a great deal of room for debate as to the appropriate boundaries of the role of the community in preventing harm to people – particularly people who may be able to make their own decisions about the risks they are willing to take. And perhaps the most concerning aspect of the mentally disordered provisions is that there is very little information available to inform public discussion. The New South Wales Mental Health Review Tribunal’s Annual Report for 2011/12 suggests that in that financial year people were admitted to Declared Mental Health Facilities in New South Wales on 3711 occasions.¹⁰⁴ This figure has remained fairly constant since 2003.¹⁰⁵ Unfortunately though the figure is almost certainly a significant underestimate since it does not include patients detained in emergency departments or the medical and surgical wards of general hospitals, who were not subsequently admitted to a psychiatric ward.¹⁰⁶ Additionally, nothing is known

¹⁰⁴ New South Wales Mental Health Review Tribunal, *Annual Report 2011/12* (2012).

¹⁰⁵ The figures for years 2010/11, 2009/10, 2008/09, 2007/08, 2006, 2005, 2004 and 2003 are 3633, 3696, 3956, 3710, 3401, 4026, 3619 and 3525 respectively.

¹⁰⁶ The figures are collated from information sent to the Tribunal under clause 48 of the Mental Health Act Regulation 2007 (NSW), however Emergency Departments acting as Declared Mental Health Facilities (DMHFs - emergency mental health assessment class) have not been asked to comply

beyond this figure. There are no figures on repeated use, for example, and there is almost no peer reviewed, or even grey literature, research on the issue.¹⁰⁷

In any case, there may be a prevailing view in the community that a general power is required to protect very upset people or those *in extremis* from perceived threats to their physical safety or the safety of others, at least for long enough to allow the person to calm down or 'sober-up'.¹⁰⁸ Police powers to take persons into protective custody exist for a similar purpose.¹⁰⁹ If this is the community view, further questions still need to be considered including the circumstances in which the state should be permitted to intervene and for how long detention may last?

There is no clear answer to these questions, though presumably: the person's decision-making capacity must, at least, be seriously impaired; the adverse consequences of the state not intervening must be very significant; and the time limit on intervention must be short.

In addition, it may be that such general protective powers should be contained in separate legislation, and should not be included in legislation regulating treatment for mental illness.

with these regulations and patients detained as mentally disordered on general medical wards would not be captured by them.

¹⁰⁷ The one exception to this is a very small study from Orange, New South Wales that found that use of the mentally disordered provisions grew remarkably between 1991 and 2005 and that, in the authors opinion anyway, a detailed review of a small sample (N=22) of these found that over time the degree of disturbance required to meet the "so irrational" criterion had significantly dropped: Martyn Patfield, 'The 'Mentally Disordered' Provisions of the New South Wales Mental Health Act 1990: Their Ethical Standing and Effect on Services' (2006) 14 *Australasian Psychiatry* 263.

¹⁰⁸ Interestingly, Mill, himself, allowed such an exclusion from this general rule:

'If either a public officer or anyone else saw a person attempting to cross a bridge which had been ascertained to be unsafe, and there was no time to warn him of his danger, they might seize him and turn him back, without any real infringement of his liberty; for liberty consists of doing what one desires, and he does not desire to fall into the river. Nevertheless, when there is not a certainty, but only a danger of mischief, no one but the person himself can judge of the sufficiency of the motive which may prompt him to incur the risk; in this case, therefore, (unless he is a child, or delirious or in some state of excitement or absorption incompatible with the full use of the reflecting faculty), he ought, I conceive, to be only warned of the danger; not forcibly prevented from exposing himself to it.': John Stuart Mill, *On Liberty* (1859) (emphasis added).

¹⁰⁹ Police powers for protective custody (eg *Law Enforcement (Powers and Responsibilities) Act 2002* (NSW), s 206).

7.1 How long should a person be detained under the mentally disordered provisions?

Currently a mentally disordered person “must not be detained in a mental health facility for a continuous period of more than 3 days (not including weekends and public holidays)”¹¹⁰ and “must not be admitted to and detained in a mental health facility ... on more than 3 occasions in any 1 calendar month”.¹¹¹ Such a person must be examined by an authorised medical officer at least once every 24 hours and “must not be further detained in the mental health facility if, on any such examination, the authorised medical officer is of the opinion that the person is not a mentally disordered person or a mentally ill person or that other care of a less restrictive kind, that is consistent with safe and effective care, is appropriate and reasonably available to the person”.¹¹²

Over the Christmas and Easter period in particular, the exclusion of the weekends and public holidays from the period of continuous detention could see a person detained as a mentally disordered person for upwards of a week. Given that the mentally disordered person must be examined by an authorised medical officer at least every 24 hours (regardless of whether or not it is a weekend or public holiday) it seems very difficult to justify the continued exclusion of weekend and public holidays, even on manpower or resourcing grounds.¹¹³ We would recommend that this element of the provision be deleted.

Recommendation 6: *The NSW Government should commission research into the current use of the mentally disordered provisions so as to better inform the review process. Particular consideration should be given to the criteria for detention and the length of detention.*

¹¹⁰ *Mental Health Act 2007* (NSW) sub-s 31(1).

¹¹¹ *Mental Health Act 2007* (NSW) sub-s 31(5).

¹¹² *Mental Health Act 2007* (NSW) sub-ss 31(3), (4).

¹¹³ Manpower and resourcing issues could arise if the MHA were interpreted as requiring a the opinion of second or even third psychiatrist to discharge a person from compulsory detention. This issue will be addressed in Part 2 of this document.

8 Timely independent review of orders

Section 27 of the MHA requires that if an assessable person has been found to be a mentally ill person or a mentally disordered person after three examinations he or she must be “be brought before the Tribunal *as soon as practicable* after admission”.¹¹⁴ This form of wording dates back to the introduction of the 1958 *Mental Health Act*, which required that a person in a similar situation “be brought *as soon as conveniently* ... before a stipendiary magistrate”.¹¹⁵ From that time, until June 2010, these italicized phrases were interpreted so as to ensure that independent review generally occurred with two to ten days.¹¹⁶

In June 2010, when reform of the MHA enabled the Mental Health Review Tribunal to take over the role of independent review,¹¹⁷ the then President of the Tribunal decided that the phrase “as soon as practicable” in section 27 of the MHA could be interpreted as “in the third or fourth week of detention”.¹¹⁸ The longer wait times were defended on the basis that

¹¹⁴ *Mental Health Act 2007* (NSW), sub-s 27(d) (emphasis added).

¹¹⁵ *Mental Health Act 1958* (NSW), sub-s 12(6) (emphasis added). See also *Mental Health Act 1990* (NSW), sub-s 38(1).

¹¹⁶ Most psychiatric units in this period were visited by a magistrate once a week on a specified day. Any person detained involuntarily prior to the afternoon of the working day before the magistrate’s visit would see the magistrate on that day. Patients admitted involuntarily on the afternoon before, or on the day of, the magistrate’s visit would not be presented to the magistrate until his or her next visit, to allow time to gather information for that presentation. As a consequence of this regime, the delay between involuntary admission and independent review was rarely more than ten days. Delays beyond ten days were occasionally experienced when the usual day of the magistrate’s visit fell on a public holiday.

Review of the second reading speech and parliamentary debate surrounding the introduction of the 1958 Mental Health Bill makes it apparent that Parliament intended that independent review by a magistrate should occur within a matter of days. A great deal of the Minister’s speech (and the subsequent debate) demonstrates that the Parliament was very concerned about providing “additional safeguards ... against what might be alleged as wrongful detention” (at 2152), and that these safeguards be timely. An interjection asks if there is time limit on “as soon as practicable” in relation to review by the second medical practitioner, noting “complaints have been made about the delays in view of that provision” (at 2156). Another interjection even names the alleged victim of what seems to have been an infamous case of wrongful detention. It is also clear that independence of review is highly prized, though admittedly this is only stressed in terms of the reviewing doctors being independent of each other, as again it seems the Minister had heard of case where “there was collusion in the matter” (at 2156).: William Sheahan, ‘Second Reading Speech for the Mental Health Bill’ (1958) 26 *Hansard of the New South Wales Legislative Assembly* 2150.

¹¹⁷ *Courts and Crimes Legislation Further Amendment Act 2008* (NSW).

¹¹⁸ Greg James, Letter to NSW Mental Health Service Directors (2010).

a high percentage of adjournments made at the more timely magistrate's hearings constituted evidence that the current New South Wales system was dysfunctional.¹¹⁹ This interpretation was difficult to understand and roundly criticized.¹²⁰

After considerable public and professional concern that the increased delay would compromise the rights and standard of care of people with mental illness,¹²¹ the current government commissioned an independent report that was critical of the increased delay,¹²² and committed "an additional \$400 000 a year to the Mental Health Review Tribunal to enable the tribunal to conduct patient reviews in a timely manner".¹²³ From 1 July 2012, the Mental Health Review Tribunal intended that automatic mental health inquiries would held "between seven and 21 days [after] detention".¹²⁴

While much improved on third or fourth week of detention, seven to 21 days remains significantly longer than the two to ten day delay that applied for fifty years prior to June 2010. The delay before independent review remains an area of significant concern.

Article 12 of the CRPD requires that:

"States 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 ... apply for the shortest time

¹¹⁹ Greg James, *Mental Health Changes Will Respect Patients' Needs* (Letter to the Editor), Sydney Morning Herald 17 March 2010, 12.

¹²⁰ Ryan, Callaghan & Large, 'Long Time, No See' above n 88.

¹²¹ Joel Gibson, *Mentally Ill Forced to Wait a Month to Appeal*, Sydney Morning Herald 13 March 2010, 5. Deborah Snow, *Mentally Ill to Held Longer without Review*, Sydney Morning Herald June 4. 2010; Louise Hall & Amy Corderoy, *Doctors Protest Delays for Mentally Ill Inmates*, Sydney Morning Herald 7 December. 2010.

¹²² Communio, *Evaluation of Efficacy and Cost of the Mental Health Inquiry System* (2012).

¹²³ Kevin Humphries, 'Business of the House - Mental Health' (2012) *Hansard of the New South Wales Legislative Assembly* 9759, 9760; Amy Corderoy, *New Report Cuts Review Wait Time for Mentally Ill*, Sydney Morning Herald 15 March. 2012.

¹²⁴ New South Wales Mental Health Review Tribunal, *Annual Report 2011/12* (2012), 1.

possible and are subject to regular review by a competent, independent and impartial authority or judicial body”.¹²⁵

An automatic review process that only operates between seven and 21 days after coercive admission, and that previously operated successfully between two and ten days after such admission, cannot be said to comply with provisions that seek to ensure that measures relating to the exercise of legal capacity apply for the *shortest possible time*. If anything, legislative changes that allow mental health enquiries to be conducted by the legal member of the Tribunal sitting alone, and the use of audio-visual link, should mean that the enquiries should be available in a more timely fashion than was previously possible.

We recommend that the MHA be amended to ensure that assessable persons are afforded prompt, automatic, independent review by the Mental Health Review Tribunal either by a face to face or video hearing. The lead time will need to take into account of the time needed to gather information with the imperative that review should take place at the earliest possible opportunity.

We acknowledge that on occasion a person may be so unwell that they may not be able to fully participate in a hearing, but this should not, by itself, provide a reason to delay an independent review of the terms of his or her detention.

In any case it is difficult to see why the wait time should exceed the two to ten delays that were achievable between 1958 and 2010.

In addition, the MHA currently provides that “*the Tribunal when holding a mental health inquiry is to determine whether or not, on the balance of probabilities, the assessable person is a mentally ill person*”.¹²⁶ There is no further power to independently consider recommendations about treatment or any objections the patient may have to treatment being ordered. We suggest that the details of proposed treatment should also be able to be considered by the Tribunal in order to ensure that patient preferences have been properly

¹²⁵ *Convention on the Rights of Persons with Disabilities*, opened for signature 30 March 2007, art 12(4) (entered into force 3 May 2008).

¹²⁶ *Mental Health Act 2007* (NSW), s 35(1)

taken into account and to verify that the treatment plan will promote the person's wellbeing.

Recommendation 7: *Assessable persons must be afforded prompt, automatic, independent review by the Mental Health Review Tribunal that should occur no more than 7 days after a compulsory treatment order is made.*

Recommendation 8: *The Tribunal should be empowered to review treatment plans to ensure that patient concerns and preferences about treatment have been properly taken into account and to verify that the treatment plan will promote the person's wellbeing.*

9 Non-admission and discharge of persons brought involuntarily to a declared mental health facility¹²⁷

The Discussion Paper notes that concerns have been raised that “on occasion, there are poor outcomes for persons who are taken to DMHFs and not involuntarily admitted, or who are discharged into the community too early”.¹²⁸ It suggests that a “mechanism for reviewing clinical decisions may give consumers, their families, and the community greater reassurance that consumers who are at serious and immediate risk of harm to themselves and others are receiving appropriate and timely treatment”.¹²⁹

Under the current system, without the reforms envisaged above, there is no possibility of any rational or workable system to review these clinical decisions. This is because, as the Discussion Paper suggests, the major sources of dispute over clinical decisions will involve families and carers believing that a mentally ill person is “at serious and immediate risk of harm” to themselves or others, when the assessing clinician disagrees. Since it is impossible

¹²⁷ Mental Health and Drug & Alcohol Office, above n 2, 45.

¹²⁸ Ibid, 46.

¹²⁹ Ibid, 47.

to verify the likelihood of serious self harm or violent behaviour in either direction, no amount of additional information, and no amount of further training in this task will provide a rational and consistent way to settle this dispute.

The risk is that, failing any valid way of settling this dispute, those called upon to adjudicate such matters will, fearing the consequences of a wrong decision that ends in suicide or violence, tend to be biased toward detaining patients whose cases are appealed. If that were to occur, clinicians may also become more conservative in making admission decisions, anticipating a likely successful appeal.

A lowering of the bar for involuntary admission would have serious implications for the right to autonomy and self-determination of persons with mental illness. It could also be expected to have significant resource implications.¹³⁰

Adoption of the reforms envisaged above, opens up the possibility of a rational review system, without the risk of adverse unintended consequence. In contrast to estimates of a mentally ill person's future risk of serious harm, it is quite possible to make valid estimates of a mentally ill person's current decision-making capacity.¹³¹ Moreover, it is also possible to improve the validity of judgments about decision-making capacity with improved training; and possible to rationally resolve disputes about a person's decision-making capacity and what might be necessary to promote his or her wellbeing through the collection of extra data from carers and families.

¹³⁰ Figures drawn from the 2010/11 MHRT Report cited in the document imply that the last financial year around 20% of people taken involuntarily to a Declared Mental Health Facility (DMHF) were not admitted into hospital. (In that financial year 16,449 persons taken to a DMHF involuntarily. Of these 11,915 (72.4%) were admitted involuntarily to a DMHF and 1,112 (6.8%) were admitted as voluntary patients: New South Wales Mental Health Review Tribunal, *Annual Report 2010/11* (2011)). If a goodly percentage of those 20% were to be admitted on, or before, appeal, the resultant increase in admissions would represent a significant impact on inpatient psychiatric services, with an associated increase in actual and opportunity costs, without any clear benefit.

¹³¹ Laura B. Dunn, Milap A. Nowrangi, Barton W. Palmer, Dilip V. Jeste & Elyn R. Saks, 'Assessing Decisional Capacity for Clinical Research or Treatment: A Review of Instruments' (2006) 163 *American Journal of Psychiatry* 1323.

Any sort of review process, based on the presence or absence of decision-making capacity, or on dispute over what is in the patient's will-and-preference-mediated wellbeing should be designed so as to minimise any extension of the period of detention that a person who is ultimately found to have decision-making capacity is exposed to. As it is unlikely that independent reviewers are likely to be rapidly available, it would seem most sensible that appeals should be made, in the first instance at least, to the medical superintendent. Under this scheme we would envisage the medical superintendents would be afforded special training in the determination of capacity and in the determining how to promote the person's wellbeing whilst respecting their will and preferences.

***Recommendation 9:** If, and only if, the MHA is amended as suggested in Recommendation 2, a further amendment be made to allow rapid review by the medical superintendent of any decision to discharge a patient in circumstances where family or carers believe that the original decision has not taken proper account of the person's decision-making capacity or promotion of wellbeing properly understood.*

10 Advance care planning

The Discussion Paper raises some broad questions in relation to advance care planning in the section headed "Consumer engagement in the development of treatment plans".¹³²

In New South Wales, the law in relation to future medical care planning is based on the common law of advance directives. Any advance directive purported to be made in relation to psychiatric treatment would be overruled by provisions in legislation, including the MHA, which permitted orders to be made contrary to the advance directive.

Currently the MHA provides no alternative means of future care planning for people with mental illness, which would allow them to anticipate periods of impaired decision-making

¹³² Mental Health and Drug & Alcohol Office, above n 2, 45.

ability in the future and to indicate their preferences for treatment or make an enforceable directive about future care.

We suggest that the opportunity for advance care planning is an important aspect of facilitating supported decision-making and giving effect to the will and preferences of people with psychosocial disability. Mental illness can be a chronic condition with recurrent periods of acute illness. In these circumstances, many people will be able to anticipate a recurrence of severe illness and indicate treatment preferences based on their past experience with particular medications and treatment regimes.

The opportunity now exists to develop a scheme that encompasses a facility for future care planning for people with mental illness.

Future care planning might include formal processes by which general goals, values and preferences can be indicated that can guide substituted decision-making when decision-making capacity is lost.

There would also be the opportunity to consider whether specific, legally binding directions about future care should also be permitted. Such directions, like advance care directives at common law, might be binding consents, or refusals of treatment effective in circumstances where a person later loses decision-making capacity.

A common law advance care directive is enforceable where it is executed by a competent person; is clear and unambiguous; and applies to the situation at hand.¹³³ Enforceable advance directives are not unproblematic however, particularly where they apparently extend to situations not previously experienced by the person; or where the person is expressing strong contrary current wishes even if they lack capacity; or where the advance directives appears to be contrary to the purpose of promoting the person's wellbeing in the circumstances. However as a starting point, given that the right to make advance care directives is afforded to all persons at common law, it is difficult to justify denying such a right to people purely because they have a mental illness, and may even constitute unlawful

¹³³ *Hunter and New England Area Health Service v A* [2009] NSWSC 761, 40.

discrimination. For this reason, careful consideration will need to be given to the justification for any differential treatment for people living with mental illness.

***Recommendation 10:** That a revised MHA include formal processes for future care planning for people with mental illness. This may include formalising processes for people to describe goals for treatment as well as general values, wishes and preferences regarding treatment. Further consideration should also be given to whether binding advance care directives should also be included in future care planning and the circumstances, if any, in which these should be able to be overridden, bearing in mind that a right to make binding advance care directives is generally available to all persons at common law.*

11 Voluntary patients and role of the Mental Health Review Tribunal¹³⁴

In addition to recommendations the recommendations above, we suggest that Tribunal's role in reviewing treatment and care plans for voluntary patients should be extended.

Currently the MHA provides detailed review mechanisms and protections for involuntary patients, while very little oversight is afforded to patients who are admitted voluntarily. While the Tribunal is required to review voluntary patients under section 9, this need only occur if the patient has been receiving care in a mental health facility for a continuous period of more than 12 months.

It is likely that many voluntary patients in mental health facilities do not have capacity to consent to admission and treatment. While some patients may be "voluntary" in the sense that they have assented to treatment, or are not objecting to it, they may not have given valid consent to the treatment they are receiving.

¹³⁴ Mental Health and Drug & Alcohol Office, above n 2, 54.

Some such patients - described as 'compliant incapacitated' patients – have been the subject of special regulations in the UK to address the so called “Bournewood Gap” where they could be effectively deprived of liberty because of institutional controls and procedures, without adequate independent oversight.¹³⁵

We recommend that, with respect to voluntary patients, a level of external oversight, by the Tribunal would be appropriate to ensure that the process provided for supported ongoing decision making is sufficient and is properly applied.

In addition, where another person (for example an Official Visitor, clinician, family member or carer) has concerns about the adequacy of the consent process in respect of a voluntary patient, the MHA should provide a mechanism by which that person could refer the matter to the Tribunal for review.

Concerns have also been expressed by consumer groups that some voluntary patients, even those who have decision-making capacity, may not be truly voluntary in the sense that consent to admission or treatment has been given under threat of detention. Clearly voluntary patients should give consent freely and without undue influence, which a threat of detention may be perceived to be. Guidelines relating to voluntary admission may therefore be required to ensure that consent is properly obtained.

Recommendation 11: *The Tribunal should be empowered to oversee the process provided for supported decision-making in voluntary patients to ensure that it is sufficient, and is properly applied.*

Recommendation 12: *Where another person has concerns about the adequacy of the consent process in respect of a voluntary patient, the MHA*

¹³⁵ Neil Allen, 'Commentary. The Bournewood Gap (as Amended?). GJ v Foundation Trust, Primary Care Trust, Secretary of State for Health [2009] EWHC 2972 (Fam)' (2010) 18 *Medical Law Review* 78

should provide a mechanism by which that person could refer the matter to the Tribunal for review.

Recommendation 13: *Guidelines relating to voluntary admission may be required to ensure that consent is properly obtained and is free from coercion or undue influence, including, for example, the threat of detention if voluntary admission is not agreed to.*

12 The economic impact of the proposed changes

Though not specifically addressed in the Discussion Paper the potential economic impact of legislative changes will undoubtedly be relevant to the outcome of policy discussions.

The authors do not believe that changes proposed in this document are likely to have a significant impact on current resourcing for inpatient treatment *per se*. Although the criteria for involuntary admission are quite different, we do not feel this will translate into either a significant increase or decrease in the absolute numbers of people admitted. While there is little empirical data to support claims about admission patterns in either direction, we note that numerous studies undertaken in 1970s and 1980s when US mental health acts changed from requiring only clinical need to requiring evidence of “risk harm”, found very little change in the numbers of people compulsorily admitted.¹³⁶

As we discussed above, we believe, and have some evidence to support the belief,¹³⁷ that it is likely that the reforms will see people suffering first episode psychosis admitted significantly sooner in the course of their illness, but this is unlikely to translate into more

¹³⁶ N. C. Beck, L. R. Houge, C. Fraps, C. Perry & L. Fenstemaker, 'Patient Diagnostic, Behavioural and Demographic Variables Associated with Changes in Civil Commitment Procedures' (1984) 40 *Journal of Clinical Psychology* 364.

¹³⁷ Large, Neilssen, Ryan & Hayes, 'Mental Health Acts That Require Dangerousness for Involuntary Admission May Delay the Initial Treatment of Schizophrenia' above n 11.

admissions. Indeed since there is good evidence that the sooner a person is treated in their first episode of psychosis the better the subsequent course of their illness,¹³⁸ it is likely this will translate into fewer admissions over all.

It is likely that the number of people currently subject to Community Treatment Orders (CTOs) will decrease significantly under the proposed reforms. There are no good figures on the numbers of people subject to CTOs who also have decision-making capacity, but a recent New Zealand study examining a cohort of forensic patients found that “67.6% had treatment-related decision-making capacity”. If these figures were mirrored in a New South Wales civil cohort it would translate into a significant decrease in the numbers of NSW citizens subject to CTOs. While this would involve some cost saving, in terms of fewer Mental Health Review Tribunal hearings, the savings are unlikely to large, and would be offset by the more timely reviews of compulsorily treated inpatients under the proposed reforms. It is important to note that there is no evidence that a decrease in the number of CTOs is likely to increase the number of inpatient admissions, or lead to any other increased health cost.

The MHA currently requires clinicians to estimate the likelihood of a person coming to future harm. When, people do go onto harm themselves, it is often difficult to defend civil claims in negligence that attest that clinicians should have been aware of the potential for harm and should have used this to the detain the person concerned. As we have argued extensively above, it is impossible for clinicians to usefully categorise mentally ill people in crisis into those at high and low risk of future serious harm, but a legislative scheme that demands this, creates a medicolegal environment where such actions are difficult to defend. It is possible that the reforms envisaged will be associated with significant cost savings if there is a decrease in the numbers of this sort of claim.

¹³⁸ Max Marshall, Shon Lewis, Austin Lockwood, Richard Drake, Peter Jones & Tim Croudace, 'Association between Duration of Untreated Psychosis and Outcome in Cohorts of First-Episode Patients. A Systematic Review' (2005) 62 *Archives of General Psychiatry* 975; Diana O. Perkins, Hongbin Gu, Kalina Boteva & Jeffrey A. Lieberman, 'Relationship between Duration of Untreated Psychosis and Outcome in First-Episode Schizophrenia: A Critical Review and Meta-Analysis' (2005) 162 *American Journal of Psychiatry* 1785.

Overall therefore, we believe that the economic impact of the proposed changes is likely to nil or very minimal. The only direct increases in costs demanded – that small cost associated with more timely Mental Health Review Tribunal Review – will be offset by savings in terms of fewer Tribunal reviews of CTOs and savings associated with a likely decrease in negligence claims against NSW Health.