ANGLICARE
TASMANIA

Strengthening Safeguards and Support

Review of the Mental Health Act 1996

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1. Executive Summary and Recommendations

It is Anglicare's primary submission that Tasmania's Mental Health Act 1996 (the Act) should not be amended to further curtail the rights and freedoms of mental health consumers without both strengthening safeguards and doing more to ensure the proper care and support of those consumers.

Specifically, Anglicare recommends:

- That the current review consider how the legislation could be structured to encourage well integrated treatment and care of mental health consumers.

- That as a component of the review the Government consider how effectively current safeguards in the Act are implemented.

- That section 5AA of the Act be amended to require that a note be kept on the patient record of whether informed consent was given to a particular named treatment.

- That medical practitioners and authorised officers approved for the purposes of the Act pursuant to sections 12 & 13 receive training in the operation of the Mental Health Act.

- That section 45 of the Act be amended to provide that similar information to that provided to involuntary patients is also provided to voluntary patients.

- That the viability of extending the Official Visitor program to community facilities be considered if resources are available.

- That any necessary legislative change is made to provide the Official Visitors with access to all wards where a person may be detained pursuant to the Act, and access to incident reports.

- If the confidentiality provision in section 90 of the Act is likely to be interpreted conservatively, then the Act should be amended to clarify and codify families and carers access to information, particularly in relation to discharge planning.

- That 'authorised temporary admissions' that will cease at the end of June 2008 at the expiry of the sunset clause should not be continued.

- The development and implementation of treatment plans should be mandatory for consumers who are to be treated involuntarily. Section 19A of Victoria's Mental Health Act 1986 provides a useful precedent for how such a provision would look.

2. About Anglicare Tasmania

Anglicare Tasmania works for social justice in Tasmania through the provision of prevention and early, crisis, transitional and long term intervention services. Anglicare is the largest state-wide community service organisation in Tasmania. It has offices in Hobart, Glenorchy, Moonah, Launceston, St Helens, Devonport and Burnie and provides a range of services including emergency relief, accommodation, counselling, employment and mental health services, acquired injury support services, alcohol and other drug services, parenting support programs and outreach services to rural areas.

Anglicare's mental health services

Anglicare is funded to provide a range of mental health services throughout Tasmania:

- **Curraghmore** is a residential facility in the North West for clients who have psychiatric disabilities and are recovering from mental illness. It provides a recovery program and support to individual clients both at Curraghmore and in the wider community.
- **My Place**, operating in the North and North West, aims to provide an early intervention service to people accessing acute mental health services who are homeless or at risk, prior to their admission and/or discharge from hospital.
- **Club Haven** is a recreational, social and personal development program located in Devonport. It is managed by Club members who are all people with a mental illness.
- **Supported Packages of Care** offers support to people with mental health issues in the North and South to enhance individual recovery through an Individual Program Plan.
- **TAMOSCH - Towards a Model of Supported Community Housing** is a project in Devonport providing long-term supported accommodation for people with a mental illness. It is managed by Anglicare in partnership with a range of external service providers and local support groups.

3. Introduction

Two of the questions driving this review of Tasmania's mental health legislation are concerned with the important issues of involuntary detention and treatment of mental health consumers. The first question is whether we should continue the provisions enabling the involuntary detention of consumers on community treatment orders (the 'sunset clauses'). The second is whether we should amend provisions to make it 'easier' to compulsorily treat consumers who are already involuntarily detained.

In Anglicare's view we are not ready in Tasmania to further curtail the rights and freedoms of mental health consumers as we do not have sufficient safeguards in place nor do we have a system that ensures the care and support of all consumers.

Detention and involuntary treatment represents a severe infringement of basic human and common law rights including freedom of movement and the right to refuse medical treatment. Detention may be justified in relatively infrequent circumstances as necessary to prevent harm to human life. The ethical basis of forced treatment is, in Anglicare's view, far less solid. However, we acknowledge that a mental health system with well-functioning elements of prevention, early intervention, integrated community support and access to quality treatment would be required to support the ideal of no involuntary treatment. We may all be working towards such a system but we have not yet achieved it in Tasmania.

Pragmatically accepting then, for the purpose of this review, the reality of the widespread use of detention and involuntary treatment of mental health consumers, we submit that this approach incurs a concomitant responsibility of providing both support and safeguards.

The principle of reciprocity suggests that where governments curtail freedoms they incur a reciprocal responsibility to provide for the best interests of the person whose rights are curtailed. At a minimum, this would require:

- Access to quality care and support for the consumer both in hospitals and other facilities and in the community.
- A matrix of safeguards that protects consumers from abuses of the system.

4. Care and Support

The first stated object of the Mental Health Act is "to provide for the care and treatment of persons with mental illnesses in accordance with the best possible standards" (s 6(a)), however there is very little in the Act that ensures that consumers are provided with even basic care let alone the best possible care.

Where the Act covers care, it is skewed toward the clinical end of care with insufficient attention paid to community based care (whether provided by government or non-government agencies).

The legislation could provide far more direction as to how treatment, care and support are to be provided to consumers. For example there could be reference to the importance of community programs, bridging programs and support programs for those in transition between acute care mental health settings and the community. The approach taken in the UK and in Victoria has been to mandate the development and implementation of treatment plans. Treatment plans may have legislated components such as the proposed treatment, the name of the medical practitioner and case manager who will assist the consumer, and details of the psycho-social supports needed by the consumer. This kind of approach is worthy of consideration to see how it may be applied in Tasmania.

Recommendation:

- **That the current review consider how the legislation could be structured to encourage well integrated treatment and care of mental health consumers.**

5. Safeguards

Anglicare is concerned that the Act does not provide adequate safeguards to protect the rights of people with a mental illness.

Some of these issues may be addressed by amendments to the Act and others not, but all are relevant to this review, because the issue of expanding the ability to detain and treat involuntarily has been raised. When we consider curtailing basic human and common law rights then we must be sure that workable safeguards are firmly in place.

5.1. Sanctions

In general few provisions of the Act are backed with sanctions and this has lead to a perception that the legislation is a 'toothless tiger' at least in regard to enforcing safeguards. In consultations around this review we frequently heard that consumers were not advised of their rights, or even told that their informed consent should be obtained before treatment in hospital was commenced.

Currently there is a low level of consumer and community confidence that the Act is well or consistently implemented and it would be relevant and beneficial for the Government to consider how effectively the Act is implemented as an issue in this review.

Recommendation:

- **That as a component of the review the Government consider how effectively current safeguards in the Act are implemented.**

5.2. Advocacy and representation

Two other issues relating to safeguards should be mentioned here although they do not require legislative change. The first is the lack of access for consumers to mental health advocacy. Currently there is only one Mental Health Advocate for the whole State and in our submission that is inadequate. In many cases an advocate could provide valuable assistance to consumers who are attempting to enforce legislative safeguards.

The second important issue is the lack of legal representation for consumers appearing before the Mental Health Tribunal. We note that the Act provides a right of representation; however few consumers are legally represented. In Anglicare's view it is of great concern that the provision of representation is not funded via the Legal Aid Commission or community legal centres and we note that in other jurisdictions a duty lawyer covers Mental Health Tribunal (or the equivalent) hearings. While commending the work of the Mental Health Representation Scheme, we note that

representation by undergraduates cannot be equated with the work of qualified practitioners and conclude that there remains a serious gap in the matrix of safeguards surrounding the legislation. Another alternative would be to increase funding for the Mental Health Representation Scheme to enable more professional support for the volunteers representing clients as part of the scheme.

Anglicare acknowledges that these arrangements cannot be addressed as part of the review of the Act. However we have raised them because we consider that they are very relevant to the operating environment of the legislation and deserve and require attention at a senior level to ensure that a high standard of care is available for all mental health consumers.

5.3. Documenting consent

Relevant section of the Issues Paper: question 7

Staying with the broad issue of strengthening safeguards, we now turn to four issues that were all raised in the Review of the Mental Health Act 1996 Issues Paper (Issues Paper). These are:

1. Documenting consent;
2. Training;
3. Access to information; and
4. Official Visitors.

An important safeguard would be to require practitioners to document a patient's consent to medical treatment. Section 5AA of the Act is clear about the requirements of informed consent, but currently it may be difficult to check if informed consent to a particular treatment had been given. It would be beneficial for a supervising practitioner or Official Visitor, for example, to be able to easily check the provision of consent. The legislation should simply require that a note be made on the patient record whether or not informed consent was given. It would not be necessary to require particular detail (for example, notes on all the provisions of s 5AA) as we would expect the appropriate level of detail would be settled as a question of good clinical practice.

Recommendation

- **That section 5AA of the Act be amended to require that a note be kept on the patient record of whether informed consent was given to a particular named treatment.**

5.4. Training

Relevant section of the Issues Paper: question 14

In Anglicare's view it is important that relevant personnel be trained in the operation of the Mental Health Act and related legislation. This would include medical practitioners and authorised officers approved for the purposes of the Act pursuant to sections 12 & 13.

Such training would be an important safeguard as the Act contains a number of relevant protections of the rights and interests of mental health consumers and their carers and families. If mental health personnel are not fully aware of these protections there is an unacceptable risk that they will not be fully implemented.

We are not close enough to Departmental operations in this area to know if including training as a criteria for approval of personnel in sections 12 and 13 is the best way to ensure this outcome. In the context of personnel shortages the Department may wish to retain flexibility via the rolling availability of targeted training rather than making this a prerequisite to appointment. It is the outcome that is important: mental health personnel being trained in the operation of the legislation in a timely way.

If it were decided that legislative change was the most effective way to achieve this outcome, then we note that in relation to the appointment of authorised officers there is already provision for conditions to be placed on the appointment (s13(2)(b)) and this may be a mechanism through which appointment can be made conditional on completing training in mental health legislation.

Recommendation:

- **That medical practitioners and authorised officers approved for the purposes of the Act pursuant to sections 12 & 13 receive training in the operation of the Mental Health Act.**

5.5. Access to Information

Timely access to information is another aspect of appropriate safeguards for consumers. Section 45 of the Act provides for specified information to be provided to involuntary patients such as information about diagnosis and treatment, and the patients' rights. In Anglicare's view it would also be beneficial to provide similar information to voluntary patients and this should be contained in the legislation. Obviously the information to be provided to voluntary patients would be different in some respects, for example information relating to review of involuntary detention orders would not need to be included.

Recommendation

- **That section 45 of the Act be amended to provide that similar information to that provided to involuntary patients is also provided to voluntary patients.**

5.6. Official Visitors

Relevant section of the Issues Paper: questions 49-52

The Official Visitors are an important part of the framework of safeguards that are intended to protect the rights and interests of people with mental illness. We agree that the legislation should be clearer on the question of whether the Official Visitor (OV) provisions are intended to apply to community settings as well as to approved hospitals and secure mental health units. In principle we are not opposed to extending the current OV provisions to apply to services funded by the government but provided by the non-government sector (such as Anglicare's mental health services). This is in keeping with our view of the importance of strengthening safeguards in the mental health sector, and an acknowledgement that abuses may occur in community settings. However, the OV program should not be given an extended role without a commensurate increase in resources. There would be no benefit if the attention of the OVs was spread too thinly across the State, particularly if this meant less time for what must be their priority of watching out for the most vulnerable consumers: those who are involuntarily detained, treated, restrained and/or secluded.

We note that if it was decided to amend the Act and make clear that that the OVs could visit and investigate community facilities then it would be necessary to reconsider the location of the OV program. It may no longer be tenable for the program to be co-located with the community sector peak body The Mental Health Council of Tasmania. We suggest it may be appropriate for the OV program to be located in the office of the Health Complaints Commissioner. In Anglicare's view it may usefully strengthen the independent function of the OV program to be located and associated with the Health Complaints Commissioner or another independent statutory authority.

As stated we consider that the OVs play a vital role in relation to the most vulnerable consumers who are involuntarily detained, treated, restrained and/or secluded. It follows that constraints on their ability to review the care of these consumers should be removed where possible. The OVs should have access to medical wards such as surgical or paediatric wards or indeed any place where a person is detained pursuant to the provisions of the Mental Health Act. Furthermore the OVs should have access to incident reports including those written in relation to entries in the Seclusion/Restraint Registers so they may properly investigate complaints.

Recommendations:

- **That the viability of extending the Official Visitor program to community facilities be considered if resources are available.**
- **That any necessary legislative change is made to provide the Official Visitors with access to all wards where a person may be detained pursuant to the Act, and access to incident reports.**

6. Privacy

Relevant section of the Issues Paper: questions 41, 42 & 53

The basic right to have medical information kept confidential should only be abrogated in limited and well defined circumstances. Yet undeniably this is an area where balancing the mental health consumers right to privacy with their right to the best possible treatment can be difficult. Put another way, this may be seen as the difficulty of judging what is in the consumer's overall best interest.

The question put here is: in what, if any, circumstances should information about a consumer be shared with carers and persons responsible against the wishes of the consumer?[1] In our view the context for this debate is the concern noted in the national report *Not for Service* about the "inappropriate use of 'privacy' and 'confidentiality' considerations to exclude families and carers from treatment planning."[2]

The first thing to note is that the confidentiality provisions of the Act (s 90) allow information to be shared with carers and persons responsible at any time with the permission ("authorisation") of the mental health consumer. The situation is less clear when the consumer objects to information

[1] Department of Health & Human Services, 2007, *Review of the Mental Health Act 1996 Issues Paper*, Q 42, p 36
[2] Mental Health Council of Australia, 2005, p 46.

being shared. However, we do not fully agree with the interpretation of s 90 of the Act put forward in the Issues Paper where it says:

> One of the effects of section 90 is to prevent information about a person's ongoing treatment and illness being provided to family members where the person doesn't consent or lacks the capacity to consent to the disclosure of the information[3].

Pursuant to s 90 (2)(b) information about a consumer may be disclosed where 'the disclosure is reasonably required for the care or treatment of the (consumer)'. In our view this section authorises disclosure to family and/or carers where they are involved in the care of the consumer[4]. Perhaps the most obvious scenario is when planning for the patient's care as they exit inpatient services, but no doubt other situations would arise.

Sometimes a braver or more robust interpretation of privacy provisions is needed to further the best interests of the consumer. In this regard we note the very useful discussion of the issues in the Mental Health Privacy Kit and quote the guiding principle of the Mental Health Coalition as expressed in the Kit, that a "sensible application of privacy law is likely to enhance, and not hinder the provision of quality heath care"[5].

However if difficulties of interpretation remain it would be preferable to spell out in the Act the approach to be taken. This is so particularly in the important area of discharge or exit planning where it is essential that mental health practitioners work closely with carers as well as community service providers to ensure the best outcomes for the consumer. An example of this approach is section 89 of the Northern Territory Mental Health and Related Services Act 2005[6].

Recommendation:

- **If the confidentiality provision in section 90 of the Act is likely to be interpreted conservatively, then the Act should be amended to clarify and codify families and carers access to information, particularly in relation to discharge planning.**

7. The sunset clauses: enforceability of community treatment orders

Relevant section of the Issues Paper: questions 38-40

It is Anglicare's submission that the sunset clauses[7] that relate to the enforceability of community treatment orders place an inappropriate emphasis on controlling mental health consumers rather than providing them with care. It is an indictment of the system if considerable numbers of

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[3] Department of Health & Human Services, 2007, *Review of the Mental Health Act 1996 Issues Paper*, p 39

[4] See the approach taken by the Mental Health Privacy Coalition, 2004, p 8.

[5] Mental Health Privacy Coalition, 2004, p 5.

[6] Mental Health and Related Services Act (NT) 2005 s 89, retrieved 23 May 2007 from http://www.austlii.edu.au/au/legis/nt/consol_act/mharsa294/s89.html

[7] The amendments in the Mental Health Amendment Act 2005.

consumers receiving care in the community need to be threatened with hospitalisation to comply with their community treatment orders.

It is unacceptable that under the 'authorised temporary admissions' provisions a consumer with a community treatment order may be admitted involuntarily to hospital under quite different provisions then those that would usually apply. They may be admitted if "the health of the patient has deteriorated" or there is a significant risk of deterioration occurring (s 44A(1)(c)). The bar has been set very low here. Contrast this to the involuntary admission of any other mental health patient where it must be established that there is a significant risk of harm and detention is necessary to protect the patient or others from harm.

In our view involuntary detention should be used infrequently for the small number of cases where there is real and imminent risk of harm being caused to the consumer themselves or another person. There should be one set of criteria, one process and one process of review that applies to all involuntary admissions.

Considering overall the provisions for the involuntary admission of consumers on community treatment orders, it is difficult to escape the conclusion that 'authorised temporary admissions' are intended as a punishment, or to be used as a threat of punishment for 'non-compliant' consumers. In our submission, the therapeutic value of such an approach is questionable, is contrary to the intention of the Mental Health Act and is a breach of human rights.

It seems untenable at this time when inpatient places are so scarce that we would admit community treatment patients involuntarily without (necessarily) any strong clinical justification. The efficient use of scarce inpatient resources would surely necessitate assessment of inpatients and prioritising the need for inpatient care on the basis of strict clinical criteria. In our own consultations we heard repeatedly of the unavailability of voluntary admission to inpatient care as all places are taken up with involuntary admissions. Clearly this renders s 18 of the Act very hollow: "(a)dmission to an approved hospital with the patient's consent is to be preferred to involuntary admission".

In Anglicare's view a very different approach to care in the community should be developed. The development of treatment plans should be central to this approach, with packages of care including appropriate case management and psycho-social supports as well as medical treatment developed for each consumer[8].

Certainly in our view if a consumer is to be treated involuntarily in the community this should only be done pursuant to a treatment plan that clearly establishes the care and support as well as treatment they will receive. The implementation of treatment plans developed in consultation with the consumer and (where appropriate) their carers and family would greatly reduce the need to rely on the threat of detention to enforce treatment. In any case, the extreme step of involuntary detention should be kept for those relatively infrequent situations where safety is at risk.

Recommendation

- **That 'authorised temporary admissions' that will cease at the end of June 2008 at the expiry of the sunset clause should not be continued.**

[8] This approach is discussed further in the section entitled 'Care and Support'.

- **The development and implementation of treatment plans should be mandatory for consumers who are to be treated involuntarily. Section 19A of Victoria's Mental Health Act 1986 provides a useful precedent for how such a provision would look.**

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