Queensland Health Mental Health Social Work Working Group and AASW(Qld) Clinical & Mental Health Practice Group submission on the review of the Mental Health Act 2000

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Acknowledgement

This paper was prepared jointly by members of the Queensland Health Mental Health Social Work Working Group and the Australian Association of Social Workers (Queensland Branch) Clinical and Mental Health Practice Group.
Introduction

The Australian Association of Social Workers is the key professional body representing more than 8000 social workers throughout Australia. Social work is founded on the principles of social justice, human rights and professional integrity. It aims to enhance the quality of life and support the development of the full potential of each individual, group and community in society through practice that is ethically accountable, professionally competent and transparent. The Clinical and Mental Health Practice Group is one of several practice groups established under the Queensland Branch of the AASW and is comprised of social workers who work in the context of clinical and mental health service delivery. As well as promoting the unique speciality of clinical and mental health social work, the practice group provides a platform for the discussion of contemporary clinical, mental health and professional social work practice.

The Social Work and Welfare Leadership Group is the peak body for Social Work in Queensland Health. This Group sponsors a range of working groups and the Mental Health Social Work Working Group (MHSWWG) is one of these. The MHSWWG membership comprises Social Workers who hold senior clinical and leadership positions in a range of Queensland Health mental health services. Mr Paul Hickey is the Chair of the Group and holds the position of Social Work Leader at Princess Alexandra Hospital Metro South Addictions and Mental Health Service.

Submission

We would like to begin by acknowledging the significant and positive proposed changes to the Mental Health Act 2000 (‘the Act’) detailed in the Review of the Mental Health Act 2000 Discussion Paper, May 2014. We submit the following further feedback and recommendations to strengthen and improve this Act.

This submission is based on the following principles which we suggest should underpin the review of the Act.

1. Upholding procedural fairness. There is strong research evidence which demonstrates that the negative impact of involuntary treatment is reduced through a perception of procedural fairness and the provision of information that addresses the consumer’s legal rights, status, the reason for their hospitalisation and alternative treatments available and when this information also available to family and carers.

2. Differentiating Mental Health and Criminal Justice Systems. Forensic provisions in the Mental Health Act are devised to divert consumers from the criminal justice system to the health system. Accordingly, mental health service consumers on forensic orders should not be treated as criminals nor forensic orders and involuntary treatment orders be used as pseudo sentencing tools. These instruments should be used in a manner that reflects the least restrictive options that address the individual’s right to be treated in a socially just manner and not be subjected to contraventions of their human rights.

3. No Financial Disadvantage. It is vital to ensure that the Mental Health Court proceedings do not cause financial disadvantage to any consumer who is required to attend. That is, the needs of those who cannot afford a legal representative but do not qualify for legal aid must be identified, acknowledged and addressed.
4. **Recovery Oriented Service.** Any provision of the Act must be based on Recovery oriented principles, which is inclusive of both biomedical and consumer definitions of recovery.

**General Recommendations**

1. **Repeal of Act**

   We note that the Act is to be ‘repealed and replaced to implement the extensive changes recommended [through the consultation process]’ (p6). We support this recommendation.

   **Recommendation**

   That before repealing the Act further consultation occurs in regards to the whole Act as the majority of consultation which has occurred to date has primarily related to the Forensic areas of the Act.

2. **Capacity**

   How the concept of ‘capacity’ is applied in terms of involuntary examinations and assessments (Recommendation 1.6) would benefit from further clarification. This issue of what defines or demonstrates “capacity” is acknowledged as complex and challenging. If or when a person has an alcohol or other drug dependency they may have limited capacity due to drug dependency and/or mental illness and in this case, limited capacity may be clearly evident. However, it is important that the term ‘capacity’ be addressed fully and is embodied in the new Act in a manner which balances both the potential need for treatment with an individual’s human right to refuse such treatment. This principle is best demonstrated by considering a situation in which a person may choose to terminate chemotherapy if the side effects outweigh the possible benefits in that patient’s opinion. If a person on specific psychotropic medications wishes to cease taking them because of weight gain and other negative side effects – the question of whether this demonstrates a lack of capacity must be fully assessed and considered rather than an automatic assumption of incapacity being made. Questions about assessments based on risk rather than capacity have been highlighted. Future risk behaviour is impossible to accurately predict and therefore capacity is a far more reliable foundation for assessment - and should be used within the decision making process when considering involuntary treatment. This approach would bring mental health legislation in line with other legislation that covers substitute decision-making within all health care settings.

   Currently, this Act and the **Guardianship and Administration Act QLD 2000** must be reconciled when considering the concept of capacity. It would be simpler practically, and in relation to legal congruence, if the same definitions of capacity were assumed. The **Guardianship and Administration Act** defines capacity as the ability to understand the nature and effect of decision-making; the ability to make decisions freely and voluntarily and the ability to communicate the decision in some way. A person may have capacity to make decisions for some matters but not for others. For example, a person may be able to make simple financial decisions but not complex ones or alternatively, may be able to make personal and health decisions but not manage complex finances. Consequently, in
accordance with the least restrictive principles of the Act (echoing the Human Rights Conventions), a person is assumed not to lose capacity globally but incrementally. The Guardianship and Administration Act includes consideration of matters of health as well as personal and financial aspects within its ambit. Most importantly, the person is presumed to have capacity until proved otherwise. This principle is essential and clearly locates the onus of proof to the person who seeks to find incapacity. It reminds us that the imposition of medical treatment without a proper and full assessment of capacity to determine whether a person can voluntarily give consent is technically an assault.

**Recommendations**

1. Assessment of capacity in mental health consumers should be applied consistently in line with other legislation.
2. Each MHRT review must consistently incorporate a recent assessment of capacity.
3. That the Act is amended to ensure ‘capacity’ is understood in more depth and that lack of capacity extends beyond the unreasonable refusal of treatment.
4. That the Act be amended to require a full assessment of capacity to be taken into account in addition to risk, and that sufficient time is allowed for this to occur.

**3. Utilisation of Advanced Mental Health Care Directives.**

These advance health care statements facilitate a collaborative treatment approach when a person is so unwell their preferences are unable to be communicated. The use of Advance Care planning in the treatment of a person with mental illness is to ensure that family and health professionals respect a person’s health care wishes. It also gives the opportunity for the person to develop a plan with their support network before he or she becomes well.

These advanced care statements support the autonomy of the consumer, are written expressions of the consumer’s treatment wishes and recovery goals. They must be considered by the treating psychiatrist and the MHRT when a person is subject to involuntary treatment.

The Australian Capital Territory (ACT) Mental Health Services already have these provisions which have occurred after comprehensive consultation with consumers, families and carers and service providers and were introduced in 2011.

**Recommendation**

The introduction of Advance Mental Health Directives be included in the Act to enable a person to make an advance Mental Health Care Directive to record their treatment preferences in the event that they become unwell and require involuntary treatment.
Recommendations specific to sections

1. Section 4. Orders and other actions following court findings.

There is a risk that an approach where Magistrates make determinations of unsoundness of mind could be misused. People may be placed on orders via the judicial system for behaviours that mental health services may have dealt with differently or which may be more appropriately dealt with by other agencies. Magistrates do not have the necessary training, understanding or experience of the complexities involved in assessment of mental health. Determinations about unsoundness of mind or a need for mental health treatment should be made by a clinician. Peoples with or suspected of having a mental illness are best served when determinations about their soundness of mind is made by qualified mental health practitioners.

Furthermore, following the abolition of the drug court, where there was capacity to respond to people with a mental health issue, there is a risk that people whose primary reason for contact with the judicial system is related to substance misuse may be inappropriately ordered to mental health units.

Recommendations

In relation to Items 4.24 to 4.29:

1. That Magistrates not have the ability make determinations about a person’s soundness of mind at the time of the alleged offence and fitness for trial.

2. That assessments about fitness for trial or unsoundness of mind are appropriately dealt with by clinicians rather than magistrates.

3. That a psychiatrist or clinician is readily available to magistrates to support their decision-making and to ensure that appropriate training and education about mental illness be provided to magistrates.

2. Section 5. Treatment and Care of Involuntary Patients.

We strongly support the changes which clearly articulate that when patients are moving to a community or limited community treatment order, the authorised doctor is required to provide consumers, their carers, support persons and families with better communication and information provision about treatment and care and the patients obligations under the order (5.10).

In our initial submission we noted the need for treatment plans to clearly link to the reason for the involuntary treatment and we note that this has been addressed to some degree in sections 5.2 to 5.6. Section 5.6 addresses the requirement for regular assessment of involuntary patients however there is no mandate of the time period in which a review or reassessment must occur.

Recommendation

That the maximum acceptable time between reassessments be specified, aligned to the...
current clinical practice of 91 day reviews, as specified in the National Standards for Mental Health Services 2010, Section 10.4.6.

3. **Section 6. Treatment in the Community - electronic monitoring devices**

We reiterate the concerns raised by the Office of the Public Advocate in relation to amendments to the Act identified in their submission to the Health and Community Services Committee in 2013. Specifically, we are concerned about the use of ‘electronic monitoring devices’, as a monitoring condition, for patients accessing Limited Community Treatment, particularly given the potentially stigmatising effect of these devices and the paucity of evidence regarding their use with a comparable cohort in other jurisdictions. The assumption is that monitoring devices assist the public safety while allowing graduated leave. This assumes that stigma and social exclusion does not relate to increasing risk factors rather than decreasing risk factors which is what the aim of the devices is surely about. Any amendment to the Act in relation to the use of electronic monitoring should be based on and informed by sound evidence about whether they work in relation to the intent of the Act.

There is no evidence to suggest this is either a necessary or effective measure for consumers on Forensic Orders or Involuntary Treatment Orders. We have significant reservations about the recommendation that monitoring conditions, which could include electronic monitoring devices, may be authorised by the Director of Mental Health for use on involuntary consumers in the community.

**Recommendations**

1. The Act maintains a legal intent to protect the rights of people with mental illness who were mentally unsound at the time of committing an offence.

2. The Act provides for the exclusion of electronic monitoring devices among monitoring conditions for all mental health consumers.

4. **Section 7. Support for Involuntary Patients**

We note the discontinuation of the ‘allied persons’ model and the introduction of the ‘Independent Patient Companion’ and support the inclusion of advocacy as a role within the MHRT. We note as per our previous submission, that this person should have the capacity to question the treating team’s findings and recommendations.

We support the development of this role but note that it is vital that there is capacity to balance the needs of both consumer and their family and carers. This may require separate advocates for the consumer and the family at times when both party’s needs are in conflict. We consider that there are limits to independence where the Independent Patient Companions are employed by mental health services.

It may also be worth reconsidering the name of the new role. The term ‘companion’ is in use for other positions in mental health services in which the person in the position has a lived experience of mental illness. This would not necessarily be the case for these positions.
We support increased recognition of the role of family, carers and other support persons and the principles in the Act emphasising the importance of recovery-oriented services and the reduction of stigma associated with mental illness. “The National Standards for Mental Health Services 2010”, Standard 7 clearly outlines the expectations that Mental Health services are to engage with carers of consumers with supporting a person recovering from a mental illness.

The Queensland Government is already committed to a legislative framework that promotes recovery oriented practice in the public mental health system as reflected in the following:

2. Sharing Responsibility for recovery: creating and sustaining recovery oriented systems of carer in mental health: Queensland Health 2005
3. Queensland Consumer, Carer and Family Participation Framework 2010
4. Queensland Carer Recognition Act 2008. (This Act, while it provides recognition of the role of carers, does not create rights for carers and is directory only to public authorities and “anyone else”).

While there are current guidelines for “Information sharing between mental health workers, consumers, carers family and significant others” (QLD Mental Health 2011), these are guidelines only and there is often confusion about whether to disclose information of any sort by practitioners to an identified primary carer who is often a relative and has a significant role in supporting a person in their recovery. The lack of relevant information disclosure where it has been demonstrated to be in the best interest of the person with the mental illness, has created substantial barriers for both the person receiving treatment and the families and carers providing support during a person’s recovery. This was clearly illustrated in the Mental Health Council of Australia, National “Mental Health Carers Report 2009 ‘Adversity to Advocacy’”, which provided the first quantifiable measure of the issues and concerns of Australian mental health carers; one of which included the barriers to being partners in treatment where relevant information was not disclosed to the support carers and families.

Prescription about disclosure of confidential information about clients of mental health services to guardians, family and primary carers would support the disclosure of information where it is required in connection with further treatment. This is provided that the information is reasonably required for the ongoing care of a client and the person who is receiving the information will be involved in providing care and supporting their recovery.

The Victorian Mental Health Act 1986 Section 120A (3) (ca) and s.120A (3) (e) already has these provisions which has strengthened the partnership that both carers and consumers have with the treatment team and well received in the community. Adopting similar provisions would strengthen the Qld legislation in terms of service delivery support.

**Recommendations**

1. That consideration of alternative funding options of these positions be considered, e.g. through Legal Aid.
2. The role of Independent Patient Companions needs to be clearly defined and inclusive of working in partnership with families and other carers.
3. We recommend that people appointed to these positions have or be supported to
gain the skills required to navigate the complexities of the mental health system, the Act and the judicial system.

4. That the nomenclature and description of the ‘Patient Companion’ role be revisited in order to emphasise its role as complimentary to other support offered to and by family and carers and distinguished from roles requiring the lived experience.

5. A definition of recovery-oriented services be included in the Act and that this definition is inclusive of both biomedical and consumer definitions of recovery.

6. The Queensland MHA recognise in legislation that support of carers and families is significant to a person’s recovery and these supportive relationships and partnerships need to be maintained during treatment and recovery.

7. That the Act prescribes circumstances where confidential information about clients of mental health services to be disclosed to guardians, family and primary carers without the consent of the client.

5. Section 8. Support for Victims

We recognise the significance of acknowledging victims in the principles of the Act and where possible affording greater support to victims. However we note that recommendation 8.8 Forensic Information Orders, significantly alters the threshold for reporting information to victims. In particular, the ‘provision of a summary of the risk assessment that led to a decision for a forensic patient to be granted access to the community or the revocation of a forensic order, divulges greater information about consumer treatment than has previously been made available. The maintenance of the existing limits to information strike a better balance between the rights of victims to information and of consumers to confidentiality. We are concerned that there is a significant risk of information released to victims being published in the media.

Recommendations

1. That existing limits to information provided to victims should be retained.

2. In line with principle number two (above) the right to privacy should not be diluted because a person is subject to a forensic order or has a mental illness.

6. Section 9. The Mental Health Review Tribunal

We support the recommendation for patients to have independent legal representation at tribunals without incurring a cost in the instances outlined. This is a particular priority where the State has representation by the Attorney General. This should be extended to across the board to all age groups and categories of patients going through the review process.

We also support the recommendation for individuals to provide evidence to the tribunal where this is requested by the patient or another party. This has the potential to broaden the information available to the MHRT in informing its decision.
**Recommendation**

That the community person role be reviewed to ensure preference be given to people with lived experience of mental health issues or those who have experience as a carer or family member.

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7. **Section 11. Forensic Disability**

The *Forensic Disability Bill 2011* was introduced in response to the Butler and Carter Reviews (2006) with a view to providing an appropriate alternative to involuntary detention in a mental health service for people with an intellectual disability. However, service responses to this cohort continue to require expansion and improvement.

**Recommendation.**

That in concert with the review of the Act, it would be timely to review the effectiveness of the interface between the *Forensic Disability Act* and Mental Health Acts to identify if any legislative amendments can improve the service response to this cohort.

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8. **Section 13. Restraint and Seclusion**

We wish to state our support for initiatives aimed at reducing seclusion and restraint. Mechanical restraint is a contentious issue, open to abuse, there should be sound evidence of its effectiveness before it is used; its use should be reviewed and based on sound rationale. We are concerned that approval for the use of mechanical restraints can be applied to any authorised mental health services (13.8) that could include medium or low secure facilities.

**Recommendations**

1. That the Act stipulates that a management plan developed under 13.2 and which allows the use of mechanical restraints must be reviewed more frequently than monthly to ensure that this practice does not become embedded and/or accepted as part of any individual’s treatment plan. Weekly reviews are recommended.

2. That such management plans be reviewed weekly as opposed to monthly as currently outlined in the discussion paper.

3. That the Act stipulates that the use of mechanical restraints applies solely (if used at all), to high secure mental health facilities.

4. That the Act stipulates that the use of mechanical restraints is not used on minors.
9. Section 18. Children and Adolescents

We support the term ‘minor’ being applied to children and young people under the age of 18 years.

In line with our commitment to the principles of social justice and human rights, and in line with the principle of ‘least restrictive practice’, we are opposed to minors being physically restrained to manage behaviours (Background Paper 18, May 2014, 18.2.3). Similarly, the use of seclusion or ‘locked time out’ for minors has the potential to be misused or abused if/when used to manage behaviours that are not related to a mental illness.

Recommendations

1. That locked time out for minors be treated as different to seclusion and restraint for adults e.g., as per Background Paper 18, May 2014, 18.2.2, the Act to provide for locked time out to be for shorter periods of time - five minute periods, four times per day.

2. Establish criteria that distinguish between behaviour management, as it relates to what is considered normal in terms of child and adolescent development and, that of behaviours considered to relate to a mental illness (similar to the reference to the ‘Gillick competence’ test used to determine circumstances where a minor may be found to have the capacity to consent to treatment).

3. It is recommended that a principle relating to minors being cared for and held separately from adults in in-patient facilities is inserted into the Act.

Conclusion

The AASW (Qld) Clinical and Mental Health Practice Group and the Queensland Health Mental Health Social Work Working Group, thank the Department of Health for the opportunity to contribute to this important legislative review. Both groups who have contributed to this submission are committed to working with the Queensland Government to ensure just and equitable legislation and service delivery, particularly for the most vulnerable members of our society.

References


6. Queensland Health, 2011 *Information sharing between mental health workers, consumers, carers, family and significant others.*

