

WITH US, NOT TO US

**A submission to the Review of the ACT Mental
Health (Treatment and Care) Act 1994**

(October 2006)

ACT MENTAL HEALTH CONSUMER NETWORK INC.

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SUBMISSION OVERVIEW

The review of the ACT Mental Health (Treatment and Care) Act 1994 seeks to ensure that the Act reflects best practice in mental health law as it has developed over the past ten years.

The ACT Mental Health Consumer Network Inc. (the Network) welcomes the review.

The review's discussion paper (July, 2006) called for submissions to be made by 30th October 2006. This submission is made in response to that call and forms one part of the Network's overall response to the review process.

This initial response is based on three critical observations:

Firstly, and unequivocally, the Act is a long way short of best practice in mental health law as it has developed over the past ten years.

Secondly, the Act is inconsistent with the human rights guarantee to ACT citizens provided by the ACT Human Rights Act 2004. The Act undermines the basic human rights of people who experience mental illness in the ACT.

Thirdly, and most importantly, review of the Act must not be limited to an examination of developments in legislative principle and practice promoted and/or adopted in other jurisdictions. It must be guided by principles that support a mentally healthy community in the ACT.

In chapter 1, this submission outlines our *Statement of Consumer Principles for a Mentally Healthy Community*. We propose that this Statement must underpin development of modern, effective and best practice legislation in the ACT.

In chapter 2, we provide a brief critique of the ACT Mental Health (Treatment and Care) Act 1994. This critique discusses the Act's purpose, its current and historical policy context, and several key questions identified in the discussion paper.

Chapter 3 identifies requirements for modern and effective mental health legislation in the ACT based on our *Statement of Consumer Principles for a Mentally Healthy Community*.

Specific recommendations for action are provided in chapter 4.

CHAPTER 1

STATEMENT OF CONSUMER PRINCIPLES FOR A MENTALLY HEALTHY COMMUNITY

Introduction

Many people will experience mental illness at some time in their life. For some people, it will be an isolated event. For others, it will be a recurring experience over their lifetime. In all cases, people have lives beyond their mental illness.

Our society's treatment of people with an experience of mental illness has often been, and often still is, shameful. Many people have been and still are, effectively excluded from the social and economic life of our community. Many people have been and still are, stigmatised and discriminated against on a daily basis. Many people with a mental illness are denied the basic rights and protections of citizenship. The law has often been a central tool in this oppression.

This submission will argue that, in the ACT, the ACT *Mental Health (Treatment and Care) Act 1994*, underpins a policy and service provision framework which relies heavily on the use of coercion and control, without due regard to safeguarding the human rights of people with mental illness, and without seeing the exercise of such powers as a last resort. Network members express a concern that Mental Health ACT services, particularly acute services, see the use of "negative powers", those associated with involuntary detention and treatment, the use of seclusion and physical and chemical restraint, as the normal way to do much of its business¹. Network members express a concern that heavy reliance on these negative powers for day-to-day business encourages Mental Health ACT services to be structured around crisis management, rather than prevention and recovery². Network members perceive this emphasis as explaining, for example, the "prisoner like" processing of persons admitted to the Psychiatric Services Unit, resulting in further and unnecessary trauma for people experiencing a psychotic episode.

The current review of the ACT *Mental Health (Treatment and Care) Act 1994* offers the ACT community an opportunity to change the law to reflect a new way of thinking and acting in relation to mental health. Of course, reforming the law is only the beginning of the changes that are needed. However, it is an important symbolic and practical step that can provide a better foundation for mental health

¹ Network members also note with dismay that such practices are not evidence based. That is, for example, the use of seclusion and restraint are reported in the literature as overwhelmingly harmful, non-best practice, interventions.

² Such an emphasis is inconsistent with the guiding principles for the National Standards for Mental Health Services (1996), p.2.

services in the ACT. Along with the implementation of the ACT *Human Rights Act 2004*, people with experience of mental illness see new legislation as an important starting point for real change.

As people with experience of mental illness, the ACT Mental Health Consumer Network (the Network) believes a new philosophy and approach is needed to turn the rhetoric of past decades into real achievements. We want a mentally healthy community which welcomes people with experience of mental illness as valued and participating members in the economic and social life of our society.

A positive approach to mental health in our community

The ACT Mental Health Consumer Network, as people with experience of mental illness, calls for a positive approach to mental health in our community. This must be reflected in the design of services to meet our needs and in any legislation that affects our lives.

To this end, we claim our rights to:

- participate in the social and economic life of our community, to the extent that we choose.
- access health, housing and other support services to improve and maintain our mental health.
- work in partnership with health care providers to develop treatment regimes and services which suit our needs and to participate in decision-making throughout any illness.
- help shape a better future for ourselves, according to our own individual needs and our shared experiences of mental illness.

New mental health legislation and the policies and services which support the achievement of its purpose and objectives must:

- Help to create a community where mental health is maximised;
- Ensure services and supports are available to reduce the incidence and duration of mental illness; and
- Protect the human rights and rights of citizenship of anyone with a mental illness.

Drawing on the best aims from earlier reform efforts and building on the deep understanding of our own experiences as consumers, the Network outlines its *Consumer Principles For A Mentally Healthy Community*.

We believe these principles will guide the creation of a better, more inclusive future for people with experience of mental illness and for those who may, one day, have such experience.

Implementation of this statement will require strong government and community commitment and action within a solid framework of legal rights and responsibilities to ensure real and sustainable change.

Statement of consumer principles for a mentally healthy community

People with experience of mental illness are respected citizens³ of our community and valued contributors to the economic, social, cultural and creative life of the ACT.

The mental health of all people is a shared community concern and priority.

The legislative and policy framework of our society must endorse and support the full participation and human rights of people with experience of mental illness, eliminate discrimination, and ensure their right to the broad range of services and natural supports needed to improve and maintain their mental health.

Services must:

- Promote and support independence and recovery
- Enhance and develop each person's power and capability to control and direct their own lives
- Acknowledge each person's right to access assistance when needed
- Be available early, when needed or asked for
- Care for and nurture each person as an individual, with unique history, relationships, needs and aspirations
- Maintain and enhance each person's family relationships and their connection to the community
- Promote educated acceptance and a positive view in the community of people who experience mental illness
- Seek to protect people who experience mental illness from stigmatization and discrimination within the community
- Be sensitive to and responsive to cultural difference
- Be provided in the least restrictive and invasive way possible
- Build the foundation for constructive therapeutic relationships based on trust
- Provide a safe environment for the treatment, care and support of people experiencing mental illness
- Eliminate additional fear and trauma created by service delivery practices
- Provide each person with the information they need to understand and make informed decisions about their mental health

³ When we use the word "citizen", it is not intended to exclude those who have yet to formally take up citizenship in our community or those who have arrived, for example as refugees. We believe the rights and protections of citizenship should apply to all people living in our community, whatever their legal status.

- Work collaboratively with each person to prevent and prepare in advance for any potential mental health crisis
- Reference and utilise evidence based practice

Conclusion:

The review process must be guided by the following *Statement of consumer principles for a mentally healthy community*:

People with experience of mental illness are respected citizens of our community and valued contributors to the economic, social, cultural and creative life of the ACT.

The mental health of all people is a shared community concern and priority.

The legislative and policy framework of our society must endorse and support the full participation and human rights of people with experience of mental illness, eliminate discrimination, and ensure their right to the broad range of services and natural supports needed to improve and maintain their mental health.

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- Reference and utilise evidence based practice

All future legislation, policy and practice changes should be consistent with these principles – they should shape any new Act, which in turn, should shape the service systems.

CHAPTER 2

CRITIQUE OF THE ACT MENTAL HEALTH (TREATMENT AND CARE) ACT 1994

This chapter is a brief critique of the ACT *Mental Health (Treatment and Care) Act 1994* (the Act). The Act's purpose is discussed, its current and historical policy context is analysed, and several key questions identified in the discussion paper are addressed.

Purpose of the current Act

Although Part 2 of the Act sets out a number of objectives under three subheadings, there is no overall statement of purpose. This purpose can only be surmised from an interpretation of the stated objectives, the overall content of the Act, and the way in which the Act has been applied.

So what then, is the purpose of the Act?

In summary, the stated *Objectives of the Act* identify, as the major objective, the provision of "treatment, care, rehabilitation and protection for mentally dysfunctional or mentally ill persons"⁴. This objective is subject to the clarifying objectives that this "provision" may occur:

- voluntarily and in some circumstances involuntarily,
- in a manner least restrictive of human rights,
- in a manner which protects individual dignity and self respect, and
- in a manner which is least restrictive and intrusive having regard to the individual's needs and the need to protect other people from physical and emotional harm.

An additional objective is to facilitate access to services. (Part 2, section 7)

The *Objectives of the Territory*, as stated in the Act, can be summarised as service development which is comprehensive, community focused, enabling of early intervention, culturally sensitive, and effective in reducing the incidence and adverse impact on the community of mental illness and mental dysfunction. This service development is intended to involve non-government as well as government services, promote a high standard of training for service providers, and be informed by consultation with consumers, carers and the community. An additional objective is to ensure that the restrictive provisions of the Act and the rights of mentally ill and mentally dysfunctional people under this Act are adequately explained to people affected by the Act. (Part 2, section 8)

⁴ Mental illness and mental dysfunction as defined in the Act.

A separately stated objective requires that people exercising power under the Act or under an order of the Tribunal established by the Act should endeavour to ensure that any restriction on someone's personal freedom and any derogation of that person's dignity and self-respect are kept to a minimum necessary for their proper care and protection and the protection of the public. (Part 2, section 9)

These stated objectives suggest that the overall purpose of the Act is to enable access to a full range of appropriate services by people with mental illness and mental dysfunction in a manner which offers protection to the individual and the community through the regulated provision of voluntary and involuntary services.

While many of these objects are ones that are supported by the Network, we consider that they are not reflected in the provisions of the Act. In effect, the Act provides for and supports a coercive, controlling and crisis focussed approach to mental health treatment and care. It fails to offer any significant provision or support for meeting the ongoing health and community living needs of citizens who experience mental illness.

Specifically:

The Act provides extensively for:

- Powers for the making of mental health orders (part 4);
- Powers to enable emergency detention and care (part 5);
- The regulation of certain services (mental health facilities, ECT and psychosurgery, care coordinators, chief psychiatrist and mental health officers, private psychiatric institutions: parts 6, 10, 11, 12);
- The establishment and operation of the mental health tribunal (parts 3 and 9);
- Regulation of referrals by Courts; and
- Interstate application of mental health laws.

On the other side, the Act fails to provide mechanisms to ensure:

- service development which is comprehensive, community focused, enabling of early intervention, culturally sensitive, and effective in reducing the incidence and adverse impact on the community of mental illness and mental dysfunction.
- service development which involves non-government as well as government services, promote a high standard of training for service providers, and is informed by consultation with consumers, carers and the community.

- availability of and access to voluntary services which protect individual dignity and self respect, and in a manner which is least restrictive and intrusive.

In short, the Act provides mechanisms to enable involuntary treatment, care, rehabilitation, and mechanisms for the protection of people with mental illness and dysfunction and other community members in certain circumstances. It also establishes a regulatory framework whereby certain services can be provided on both a voluntary and involuntary basis.

Network members have observed that the relative ease by which negative powers are granted and exercised under this legal framework has shaped a mental health system which is crisis driven, over-reliant on involuntary measures, restrictive of and destructive to the development of therapeutic relationships based on understanding and respect , and dismissive of human rights and citizenship.

The following conclusions arise:

The real but unstated purpose of the current Act is to licence the “negative powers” associated with involuntary detention and treatment, and the use of seclusion and physical and chemical restraint.

While Network members acknowledge that exercise of these “negative powers” may be necessary in a very small number of cases, either to protect people with mental illness or to protect other community members, they argue that the Act and the service system which it supports has established as a norm, practices which should be cited as “extraordinary”.

The frequent use of and reliance upon these “negative powers” has shaped a mental health system which is “crisis driven”, and which causes psychological and physical trauma to people when they are very vulnerable.

Thus, the unstated purpose of the current Act is primarily a social control purpose, or at best, a social control approach to a health care purpose. Neither interpretation is a best practice approach to mental health legislation. It is an approach which is substantially rejected in other areas of health care even when a potential or perceived risk to other members of the community is involved.

Even where the major provisions of the Act do not support their implementation, it could be argued that the statement of objectives in the Act provides a policy framework which is sufficient to enable or substantially facilitate their

achievement. The experience of mental health consumers in the ACT negates that view. The experience of mental health consumers in the ACT is of:

- an over-reliance on inpatient treatment and care;
- unequal (disempowered) relationships with service providers;
- poor community acceptance and inadequate community support; and
- too often, assistance only at the point of crisis, accompanied by compulsion, deprivation of choice and deprivation of liberty.

It is concluded that:

A new Act is required which provides:

- A clearly stated legislative purpose
- A consistent statement of objectives
- Consistent legislative content

The required purpose, objectives and content are outlined in Chapter 3.

The Act's current and historical policy context

Historical application of established legislative principle

Historically, there has been little public policy attention to or public scrutiny of the Act's compliance with basic mental health legislative principle.

As part of the first *National Mental Health Plan*, endorsed in May 1992, all Australian Health Ministers undertook to:

- develop legislation consistent with the United Nations *Principles For The Protection Of Persons With Mental Illness And For The Improvement Of Mental Health Care*, adopted by the United Nations General Assembly in December 1991.
- ensure that all Australian mental health legislation incorporates the principles set out in the *National Mental Health Statement of Rights and Responsibilities*.

Application of the United Nations *Principles* and the National Mental Health Strategy's *Mental Health Statement of Rights and Responsibilities* (1991) to

development of mental health legislation in the Australian context was independently examined in reports published by the Human Rights and Equal Opportunity Commission (HREOC) in 1992, and by the University of Newcastle, Centre for Health Law, Ethics and Policy in 1994.

The Human Rights and Equal Opportunity Commission (1992) report analysed mental health legislation in all Australian jurisdictions solely in relation to the United Nations *Principles*. This analysis predates the Australian Capital Territory's *Mental Health (Treatment and Care) Act 1994*.

The University of Newcastle, Centre for Health Law, Ethics and Policy (1994) *Model Mental Health Legislation* report to the Australian Health Minister's Advisory Council National Working Group on Mental Health Policy, was released with its analysis of compliance with United Nations *Principles* and other rights instruments withheld from publication.

Subsequently, the Australian Health Minister's Advisory Council (AHMAC) endorsed a revised rights analysis instrument based on the United Nations *Principles* and the Mental Health Statement of Rights and Responsibilities but did not release this publicly. This revised instrument provided for jurisdictions to self-assess their legislative compliance to these rights instruments. It has never been publicly released.

Application of Rights Analysis Instrument to Australian Mental Health Legislation, (AHMAC, 2000) reported on such self-assessment by seven of eight Australian jurisdictions including the ACT. Unfortunately, the publication, particularly in the absence of the rights analysis instrument itself, did not provide a detailed summary of compliance by any one of the participating jurisdictions.

In short, there has been no public and comprehensive analysis of compliance with these two fundamental – though dated - statements of mental health rights, even though Australian health ministers had formally agreed to both statements by 1992. There has been a clear government reluctance – in the ACT and elsewhere – to subject legislation to close, expert and open analysis of its compliance with basic (if imperfect) rights instruments.

It is beyond the capacity of this submission to undertake such an analysis. In any case, the rights instruments referred to are themselves now dated and incomplete.

Nonetheless, the following segments of this chapter do reveal some serious cause for concern in relation to these basic standards.

The Act in the context of the ACT Human Rights Act 2004

The ACT *Human Rights Act 2004* gives effect to internationally accepted human rights standards in territory law. It establishes a 'dialogue' model which requires

government, legislature and judiciary to take human rights into account. In effect it requires review of all relevant ACT legislation to ensure its' compatibility with this Act.

Rights protected include equality before the law; the right to life, to freedom of expression, to freedom of religion, thought and conscience; the right not to be arbitrarily detained and the right to a fair trial. Importantly, protection provided by the Human Right Act 2004 extends to the way in which territory laws are applied and interpreted. Section 30(1) of the Human Rights Act 2004 does provide that:

In working out the meaning of a territory law, an interpretation that is consistent with human rights is as far as possible to be preferred.

It does however, remain possible for the ACT Legislative Assembly to legislate inconsistently with human rights if it so intends.

In an ACT Mental Health Consumer Network workshop conducted in February 2006, mental health consumers considered the application of a human rights framework to the ACT *Mental Health (Treatment and Care) Act 1994*. (R.Daw, February 2006).

In this single consultation meeting several factors were identified which limit the application of human rights principles and potentially result in systematic human rights breaches. These factors include provisions in the Act, and omissions from it. The major charges identified included the following.

The Act was conceived from prejudice

That is, its primary purpose is community safety and the control of people determined to be mentally dysfunctional or mentally ill and a risk to themselves or others. This purpose, though differently stated is not dissimilar to the conclusion reached in chapter 1 of this submission. The Act and associated service arrangements are not premised on meeting the health and community living needs of people who experience mental illness but on an inherent assumption of them as social misfits who must be controlled. In consequence of the law, mental health needs are not addressed on an equal footing to other health needs.

This is potentially a breach of the right to equality before the law.

Procedures in the Act fail to safeguard against stigma and discrimination in the legal profession and amongst mental health practitioners

Examples of these are,

- Decisions about emergency detention are made by one medical practitioner acting alone, without the safeguard of multi-party assessment and agreement;

- Consumer judgements are discounted on the basis of an existing diagnosis of mental illness;
- Capacity to decide, for example about the appropriate treatment to be given, is not adequately assessed or respected.

The Act allows for arbitrary detention

A person detained as mentally dysfunctional and a danger to themselves or others could be argued to have been arbitrarily detained. This is because, mental dysfunction, although defined in the Act, is not a medically diagnosable condition – as required by Principle 4.1 of the United Nations' *Principles For The Protection Of Persons With Mental Illness And For The Improvement Of Mental Health Care* – and is subject to subjective, not authoritative, interpretation. This would be in breach of the right to liberty.

A similar argument applies to a person found by the Mental Health Tribunal to be mentally dysfunctional and a danger to themselves or others, and placed on a Community Care Order. This could entail a breach of the right to freedom of movement.

Failure to mandate critical early intervention services, collaborative relapse prevention strategies and advanced directives

A Failure to mandate critical early intervention services, collaborative relapse prevention strategies and advanced directives has resulted in an over-reliance on crisis intervention, inpatient services and involuntary admission as the critical point of access to services. Provision of services in this manner has potential, at minimum, for breach of the right to life, the right to protection from degrading treatment, and the right to protection of the family.

Our conclusions from this are that:

The (current) Act undermines the basic human rights of people who experience mental illness in the ACT:

- It was conceived from a prejudicial social control purpose;
- It allows for arbitrary detention;
- It fails to mandate early intervention services, collaborative relapse prevention strategies and advanced directives.

A new Act must seek to protect the rights of people who experience mental illness before contemplating the need to remove or compromise any of those rights.

A new Act must be openly, comprehensively and critically assessed for its compliance with human rights principles.

The application of a new Act must be progressively monitored and evaluated for its compliance with human rights principles.

Some critical Issues identified in the discussion paper

In this section several critical questions raised in the discussion paper are addressed. In doing so, the Network states the following caveats:

- Addressing individual components of the Act will not address the fundamental flaw in the Act's construction. This basic flaw begins with the Act's unstated purpose and its conception in prejudice (see above).
- Not all components of the Act or issues raised in the discussion paper have been addressed in this segment.

Provisions for voluntary treatment and care

It has been argued elsewhere that making special provision in legislation for voluntary access to services stigmatizes people with mental illness (Standing Committee on Social policy, 1994, p.8). However, it is the experience of mental health consumers in the ACT that the more significant issues are the stigma and discriminatory practice associated with refusal of services voluntarily sought.

Others have complained about the consequences when someone admits themselves voluntarily and then are treated as if they are an involuntary patient.

Network members report circumstances where someone has admitted themselves voluntarily, been treated inappropriately, expressed concern verbally about this and then been informed that they would be "made involuntary" because of their attitude. Too frequently this results in mental health deterioration and later invocation of involuntary treatment and care.

The failure to provide care when someone presents voluntarily reflects the crisis focus of the system and its lack of concern about reducing the chances of involuntary treatment. Given the difficulty often involved in an individual's effort to come forward at an early stage, refusal of service often leaves them recognising that a crisis is coming, but unable to do anything about it. It also reduces the likelihood of them presenting voluntarily in future, if it becomes necessary, and so the spiral of crises and potential involuntary orders continues.

Network members have argued for a statutory obligation on government to provide necessary services for people experiencing mental illness, so that the

later use of involuntary treatment is avoided. For Network members, the issue is not stigmatisation of those seeking voluntary services by the inclusion of this right in a Mental Health Act. The real issue is the need to ensure that services are provided early and voluntarily. Experience suggests that this is only likely to be satisfactorily achieved through creation of a statutory obligation.

It is concluded that:

A new Act must make provision for voluntary care, treatment and admission. Such provision must take its place as a cornerstone of a new Act and include:

- The right to seek service without formal written application
- The right to oral explanation and a prompt written explanation when requested, where service is refused
- The right to make formal written application for service
- A requirement to provide a formal written explanation where service is refused following a written application
- The comprehensive right of appeal, through the service provider, through an advocate of choice, and through a review tribunal.

Service providers must be required to provide information on these rights whenever a service is sought.

These rights must be equally applicable to people experiencing mental illness or mental disorder.⁵

The definition of mental illness

The discussion paper reports as follows:

The definition of mental illness contained in the ACT Act is to be used only when employing the criteria for involuntary treatment and care in hospital on the grounds of mental illness, for involuntary treatment in the community and for the admission and treatment of forensic patients and offenders. UN Principle 4.1 provides that:

'a determination that a person has a mental illness shall be made in accordance with internationally accepted medical standards.' A key task then, is for mental health legislation to give 'medical' meaning to the term 'mental illness'

⁵ For the purpose of voluntary treatment and care, mental illness and mental disorder are terms which are readily interpreted by reference to internationally accepted clinical standards and authoritative texts. For example, referenced to the American Psychiatric Association's Diagnostic and Statistical Manual (DSM-IV), these terms would encompass Axis I Clinical Diagnoses and Axis II Personality Disorders.

Any decision that a person has a 'mental illness' for the purposes of mental health legislation must be made in accordance with internationally accepted medical standards. This requirement minimises the risk of a non-clinical interpretation of mental illness, whilst not restricting access to treatment for those people who require it.

In the Dictionary of terms found within the Act, the ACT Act states that:

mental illness means a condition that seriously impairs (either temporarily or permanently) the mental functioning of a person and is characterised by the presence in the person of any of the following symptoms:

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

This definition is either the same or almost the same as the definition proposed by the Model Mental Health Legislation and definitions for mental illness used in the NSW, WA, NT, Victorian and Queensland Acts. Some Acts emphasise the medical nature of 'mental illness' with a view to also emphasising the Act's primarily therapeutic and health-based purposes. The Northern Territory Act adds the requirement that determination of a person having a mental illness is made in accordance with internationally accepted clinical standards and concordant with the current edition of the World Health Organisation, International Classification of Mental and Behavioural Disorders, Clinical Description and Diagnostic Guidelines or the American Psychiatric Diagnostic and Statistical Manual of Mental Disorders (s6(2)).

The definition in the Act refers to seriously impaired mental functioning. It is, therefore, a definition appropriate to provisions for involuntary admission, treatment and care. That is, it is too restrictive a definition to apply in determining any rights to access services on a voluntary basis.

The definition accords with United Nations Principle 4.1. Its' appropriate interpretation would be strengthened by direct reference to accepted clinical standards and current editions of authoritative diagnostic texts.

It is concluded that:

A new Act must contain a definition of mental illness for the purpose of involuntary admission, treatment and care which is appropriately based on internationally accepted medical standards (as per the current Act) and is referenced to accepted clinical standards and current editions of the World

Health Organisation, International Classification of Mental and Behavioural Disorders, Clinical Description and Diagnostic Guidelines or the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (s6(2)).

Exclusions and the needs of people with personality disorder and other mental disturbances

The discussion paper reports that:

Mental health statutes throughout the world seek to clarify the grounds as to when a person is not considered to have a mental illness by reason of that matter alone. These grounds or matters are referred to as 'exclusions'.

The current ACT Act provides no exclusionary clauses for people determined to have a 'mental illness' for the purposes of the Act, but provides exclusions for people determined to have a 'mental dysfunction'. People are not to be considered to have a 'mental dysfunction' by reason alone of factors including political belief, religious beliefs, sexual preference, involvement in criminal activity or in activities viewed as 'immoral', drug or alcohol taking or engagement in anti-social behaviour.

These exclusions are similar to those found in other Australian mental health Acts (eg NSW, NT, QLD). The exclusionary matters are drawn largely and directly from the UN Principles. Exclusions found elsewhere include involvement in family conflicts⁶ and having been previously treated for mental illness.⁷ Both the NSW and Victorian Acts add a clarification in relation to people who are drug or alcohol affected. For example, section 8(3) of the Victorian Mental Health Act 1986 states that the exclusion that the person takes drugs or alcohol does not prevent the serious temporary or permanent physiological, biochemical or psychological effects of drug or alcohol taking from being regarded as an indication that person is mentally ill. The QLD Act also seeks to clarify the Act's intention by giving examples –

A person may have a mental illness caused by taking drugs or alcohol.

A person may have a mental illness as well as an intellectual disability.

Providing an explanatory statement that a person with personality disorder may also have a mental illness might assist to clarify the situation for a group of people who are currently thought to be denied assessment and treatment because of their primary diagnosis.

It is important that legislated exclusory clauses do not result in people being denied services when they are mentally ill simply because they have a primary diagnosis or other characteristic noted in the exclusions.

⁶ 12(j) QLD *Mental Health Act 2000*

⁷ s12(k) QLD *Mental Health Act 2000*

In the ACT, the current Act does not include exclusionary clauses against the criteria of mental illness. Even so, people who are or appear to be mentally ill are being excluded from appropriate assessment, treatment or care.

However, defining mental illness against internationally accepted medical standards and clarifying these interpretations through the use of exclusions, provides an important safeguard against misuse of mental health legislation for political or other inappropriate social control purposes.

In the ACT, exclusionary clauses are required, including clarifying clauses similar to those contained in the Queensland *Mental Health Act 2000*, and noted in the discussion paper.

The discussion paper also reports on a concern held by the Network about access to services by people with a primary diagnosis of personality disorder.

In the ACT there is concern among consumers and carers that a primary diagnosis of personality disorder is currently preventing a person who is in crisis and deteriorating from being assessed and considered for treatment under the Act. The Review is seeking to explore options for ensuring that a person who is experiencing mental illness irrespective of their primary diagnosis has the same rights to assessment and treatment as other members of the community.

The Model Mental Health Legislation suggested that provision be made for a person with a personality disorder alone or with other mental disturbances to be involuntarily admitted for a brief period of up to 10 days to a mental health facility on the grounds of 'mental disorder'. Both the NSW & NT mental health acts have similar provisions for brief detention to those suggested by the Model Legislation. These provisions enable a person who does not fulfill the criteria for involuntary admission on the grounds of mental illness but whose behaviour is so irrational or disturbed as to lead to the conclusion that the person is experiencing a severe impairment of a nature requiring psychiatric assessment, treatment or therapeutic care to prevent further serious mental or physical deterioration.

The Network supports the approach outlined in model mental health legislation but also notes the following further concern outlined in the discussion paper. That is, a shared community concern about:

... people with mental health issues who exhibit disturbing behaviour that might ultimately lead to a minor offence, continuing to cycle through the criminal justice system. Some individuals are unwell and are engaging in low level offending behaviour, are not suitable for admission to the PSU, and yet the behaviour may warrant a discretion by police not to charge the person. The continuing behaviour may reach the point where the police decide to charge the person and the Courts then face the dilemma of dealing with an unwell person in the criminal justice system. The review seeks discussion of how this cycle of low level anti social behaviour and involvement with the police might be ameliorated or prevented.

The Network notes that an approach to mental health service provision based upon the legislated implementation of the *Statement of consumer principles for a*

mentally health society presented in chapter 1, will address much of this problem at source. This will be achieved through an emphasis on prevention and appropriate, early and ongoing community support. Where these strategies are unsuccessful, and mental health issues reach a crisis point where an individual's behaviour poses a danger to self or others, provisions for involuntary detention, treatment and care applied in relation to proposed definitions of mental illness and mental disorder (as above) will provide for an appropriate response.

It is concluded that:

A new Act must:

- Provide exclusionary clauses which clarify when a person is not considered to have a mental illness by reason of that matter alone.
- Provide further clarifying clauses such as:

A person may have a mental illness caused by taking drugs or alcohol.

A person may have a mental illness as well as an intellectual disability.

A person may have a mental illness as well as a personality disorder.

- Include provision for the short-term involuntary detention of persons with 'mental disorder' as outlined in Model Mental Health Legislation (1995).

The inclusion of “mental dysfunction”

The discussion paper reports that:

The ACT Act provides for involuntary admission, treatment and care of people with 'mental dysfunction' which is defined in the ACT' as:

mental dysfunction means a disturbance or defect, to a substantially disabling degree, of perceptual interpretation, comprehension, reasoning, learning, judgment, memory, motivation or emotion.

This definition is broad and encompasses non-medical conditions. Commentators have discussed the implications of involuntarily detaining people with non-medical

conditions through provisions in mental health legislation.⁸ If the ACT Legislative Assembly is of the view that given local circumstances and contingencies there is a need for people who could be considered to have 'mental dysfunction' to be provided with care and control against their will, the question becomes whether the Mental Health Act given general international agreement about the parameters of its purposes, is the right piece of legislation for this to occur under.

As noted in the previous section of this submission, the definition of mental dysfunction for the purpose of involuntary admission, treatment and care is inconsistent with Principle 4.1 of the United Nations *Principles* and is inconsistent with the Act Human Rights Act 2004.

It is concluded that:

The current Act's provisions relating to "mental dysfunction" for the purpose of involuntary admission, treatment and care are inconsistent with Principle 4.1 of the United Nations *Principles* and are inconsistent with rights protected under the ACT Human Rights Act 2004.

The purpose of these provisions and the appropriateness of their placement within mental health legislation require substantive review in the context of a new legislative framework.

Police and ambulance

The discussion paper reports that:

Under the current Act the Tribunal, a police officer and a doctor or mental health officer can initiate emergency assessment, detention and care. Before apprehending a person, a police officer has to believe on reasonable grounds that a person is mentally ill or mentally dysfunctional and has attempted or is likely to attempt to commit suicide or to inflict serious harm on himself or herself or another person (s37(1)). Except for the inclusion of mental dysfunction, this provision is consistent with the suggestions of the Model Mental Health Legislation and other Australian statutes. The grounds are prescribed to minimise undue police intervention.

....

... the current Act has detailed provisions concerning the powers and roles of doctors, mental health practitioners and police officers. Consumers and carers and the police themselves, have in recent years argued for reducing the role of police officers and for clarification of when and under what circumstances their services may or may not be required.

⁸ See for example, Watchirs, H, 'Human Rights audit of mental health legislation – results of an Australian pilot', *International Journal of Law and Psychiatry*, 2005: 28(2), pp 99-125.

The Model Mental Health Legislation suggests that police should only be used if there is no other alternative and if the threat posed by the person warrants police involvement. Queensland and the Northern Territory have recently introduced provisions empowering ambulance officers to intervene and transport a person for the purposes of assessment. NSW is currently considering introducing similar provisions whilst South Australia is considering introducing provisions which clarify the roles and powers of security staff at emergency departments.

The Network supports the call to reduce the role of police and to authorise ambulance officers to intervene and transport a person for the purpose of assessment. This change must be supported by a comprehensive education and training program.

It is concluded that:

A new Act must minimise the role of police and authorise ambulance officers to intervene and transport a persons for the purpose of emergency assessment, treatment and care when necessary.

This change must be supported by a comprehensive education and training program.

Children and Young people

The discussion paper asks whether special provisions are required in relation to children and young people under the age of 18. These special provisions might relate to a range of matters including a separate test of competence related to age; whether special provisions are required in relation to involuntary treatment and care, and review mechanisms for different age groups; and whether there should be express provision for the recognition, promotion and protection of the rights and needs of children and young people experiencing mental illness.

The Network answers unequivocally, yes, to each of these questions. The special needs of children and young people include the right to specialised treatment and care separate from adult treatment and care services.

In conclusion:

A new Act must make special provision relating to:

- the recognition, promotion and protection of the rights and needs of children and young people experiencing mental illness
- an age related test of competence and ability to provide informed

- consent to treatment;
- provision of specialised treatment and care services separate from adult services;
 - specific provisions addressing involuntary treatment and care for different age groups of children and young people; and
 - the right to an advocate of choice.

Forensic provisions

The discussion paper acknowledges that:

The Commonwealth, State and Territory jurisdictions have developed draft *National Statement of Principles for Forensic Mental Health*⁹ during the last three years. The first principle requires that people who come into contact with the criminal justice system have the same rights to availability, access and quality of mental health care as the general population. This principle is to apply equally and irrespective of the nature or extent of a person's involvement with the criminal justice system. The principle is to apply from the point of first contact where police are called to an incident involving a person exhibiting disturbed behaviour to the point where the dealings of the criminal justice system are completed with that particular legal matter.

The Network is in full agreement with this principle and strongly supports the right of people involved in the criminal justice system to benefit from any and all provisions which might be contained in a new Mental Health Act. To ensure that this happens, independent mental health advocates must be available to all people held in custody.

However, we have argued that the current Act was constructed principally for the purpose of social control. It is important to the Network that such a purpose does not become dominant in the construction of new legislation, through the linking of criminal justice purposes and mental health purposes in this Act.

It is concluded that:

A new Act must extend the benefits of its assessment, treatment and care provisions to people who are involved in the criminal justice system

Issues affecting the management and control of people involved in the criminal justice system and requiring mental health assessment for forensic

⁹ Mental Health Branch Commonwealth Department of Health and Aged Care, *National Statement of Principles for Forensic Mental Health, Draft for Consultation*, Canberra 2002 Reference

purposes, must be subject to provisions contained in an Act separate from a new Mental Health Act.

This other Act must also ensure that people with a mental illness who are involved in the criminal justice system are not denied rights ordinarily available to people in the criminal justice system who do not have a mental illness.

All people held in custody must be provided with access to an independent mental health advocate.

The Mental Health Tribunal

The discussion paper reports that:

The Mental Health Tribunal has only existed since the introduction and implementation of the Mental Health (Treatment & Care) Act. The Tribunal is a relatively new body and the Review provides a timely opportunity for discussion as to whether any fine tuning is required in relation to how the Tribunal operates including for example:

- *How evidence is gathered, heard and assessed*
- *Parties who are given leave to appear before the Tribunal*
- *The effects for a person who has matters before the Tribunal as well as the Magistrates Court etc.*

The Review also invites discussion as to whether any unforeseen implications have arisen from the Tribunal being under the organisational umbrella of the Magistrates Court, a body with a legal imperative. The Review invites comment as to whether any procedural issues are arising from the placement of a body having primarily a therapeutic focus within the Magistrates Court and whether jeopardy is in any way occurring when a Presiding Officer of the Tribunal is also hearing a matter in a different jurisdiction about the same person.

The Network is concerned about manifest conflicts of interest in the operation of the Mental Health Tribunal. These conflicts of interest arise from two factors.

Firstly, the Magistrates Court auspice mixes criminal and therapeutic matters, often involving the same personnel. As example, Network members have expressed concern about actual instances where prior knowledge of past matters occurring in the Magistrates Court have been raised by Tribunal members during hearings and considered in the formulation of decisions. This allows for potentially prejudicial and arguably, legally irrelevant material to be included in the Tribunal's deliberations and calls the independent administration of the Magistrates Court and the Mental Health Tribunal, into serious question. This conflict of interest is unacceptable.

Secondly, contrary to other Australian jurisdictions where Tribunals perform a review function, the ACT Mental Health Tribunal has responsibility to determine initial applications for involuntary treatment and care orders and carries out the review of such orders. Arguably, this could be overcome by a requirement that different panels hear applications and appeals. A more appropriate response would be to separate the functions entirely. In NSW, Magistrates make the initial judgement and the Tribunal holds the review function.

In Victoria, the separation is achieved by making initial judgements the prerogative of medical opinion. This is consistent with definitions in the Victorian Act which establish mental illness in accordance with internationally accepted medical standards (see section on definition of mental illness, above). This process would be strengthened if initial decisions regarding involuntary treatment and care had to be made by a multidisciplinary team, including a requirement for a second medical opinion.

The Network draws the following conclusions:

A new Act must ensure that:

- initial decision regarding involuntary treatment and care must be made by a multidisciplinary team which includes, at minimum, a psychiatrist and a social worker, and which must be supported by a second medical opinion;
- a Mental Health Tribunal is independent of any other body (judicial or otherwise) and that its responsibilities are limited to review;
- this Tribunal is subject to the same conflict of interest rules and rules of evidence which protect the parties in other Tribunals, and that appropriate procedural protections and protections of the rights of the citizen are in place.

Network members have also expressed concern about the availability of legal representation when appearing before the Tribunal. It appears that, currently, people have difficulty accessing legal aid assistance unless they are already subject to involuntary orders. This results in people, often vulnerable people in a state of mental ill-health, being forced to represent themselves.

It is concluded that:

A new Act must require that:

Independent legal representation, supported by legal aid assistance, is automatically available to all persons appearing before a Mental Health Tribunal.

All persons appearing before a Mental Health Tribunal are entitled to the support of a (non-legal) consumer advocate of choice.

Regulation of certain treatments and interventions

The discussion paper calls for comment on provisions related to ECT, psychiatric surgery, restraint and seclusion, non-psychiatric treatment and major medical procedures.

Network members have expressed concerns about the way in which provisions regarding the use of ECT are applied. In particular, Network members have:

- questioned the quality and completeness of information provided as a precursor to seeking “informed consent”.
- complained about a “lack of respect” within the therapeutic relationship for a person’s right to say no. This lack of respect was said to culminate in situations where the individual is told that “... there is nothing more we can do”.
- complained that they are pressured to agree to ECT treatment.

Network members have also expressed concern that the current efficacy of ECT as a treatment in certain circumstances is, at best, uncertain and unproven.

It is concluded that:

A new Act must ensure that:

- Where ECT is under consideration as a treatment, comprehensive information detailing possible temporary and permanent side effects must be provided with the assistance of an independent advocate prior to informed consent being sought.
- Where ECT is under consideration as a treatment, a second, independent medical opinion is provided.
- No-one who is capable of giving informed consent should be given ECT against their will.

CHAPTER 3

REQUIREMENTS FOR MODERN AND EFFECTIVE MENTAL HEALTH LEGISLATION IN THE ACT

The *National Mental Health Policy* published by Australian Health Ministers in 1992, outlined what it described as a “new approach to mental health” and signalled an ongoing period of mental health reform in Australian States and Territories.

The new approach identified mental health as a significant health issue. It highlighted a move to, and the appropriateness of, care in the community including the need for a mix of community and health services to address “whole of life” needs. The new approach acknowledged the potential for recovery of people experiencing mental health problems. Additionally, the rights of people with mental health problems were referenced to *United Nations Principles For The Protection Of People With A Mental Illness And For The Improvement Of Mental Health Care*.

The following period of national mental health reform has heralded a series of national policy initiatives, action plans, service reform agendas and a consequent series of inquiries and reviews.

Mental health consumers have, by and large, welcomed these developments but to date, remain unconvinced that governments, service providers and communities are fully engaged in understanding and responding to mental health problems as experienced by mental health consumers seeking to live fulfilling lives within the community.

In the *Not For Service* report (2005) the Australian Capital Territory (ACT), government was acknowledged for its stated commitments, outlined in the *ACT Mental Health Strategy and Action Plan 2003-2008*, and in the *ACT Mental Health Promotion, Prevention and Early Intervention Plan 2004 – 2008*, to:

- A human rights framework.
- Equity for all.
- Developing an innovative and fresh approach to mental health issues focused on maintaining good health.
- A whole of community approach encompassing a well-being model and incorporating strategies for enhancing community acceptance and reducing stigma, mental health promotion, early intervention, prevention and recovery.
- The continued allocation of additional resources to match the problem.

Despite this, *Not For Service* reported that mental health consumers in the ACT faced major difficulties in accessing services, an inadequate clinical and community services base, little attention to early intervention, and an over-reliance in service provision on police and emergency services interventions.

This chapter identifies requirements for modern and effective mental health legislation in the ACT based on the ACT Mental Health Consumer Network's *Statement of Consumer Principles for a Mentally Healthy Community*.

The requirements of each of the principles is examined below under the headings of:

- Citizenship
- Shared community concern and priority
- Legislative and policy framework
- Services and natural supports

Citizenship

The ACT Mental Health Consumer Network's *Statement of Consumer Principles for a Mentally Healthy Community* states that:

People with experience of mental illness are respected citizens of our community and valued contributors to the economic, social, cultural and creative life of the ACT.

As a consequence of:

- past and current policies of social exclusion,
- entrenched societal stigma and discrimination,
- the personal impact of mental illness; and
- past and current failures in society's response to the health and community living needs of people who experience mental illness;

there is a need for mental health legislation which enables, supports and guarantees the rightful place of people who experience mental illness as respected citizens in our community and valued contributors to the economic, social, cultural and creative life of the ACT.

It is concluded that:

A new Act must have a stated purpose as follows:

To enable, support and guarantee the rightful place of people who experience mental illness as respected citizens in our community and as valued

contributors to the economic, social, cultural and creative life of the ACT.

Shared community concern and priority

The ACT Mental Health Consumer Network's *Statement of Consumer Principles for a Mentally Healthy Community* states that:

The mental health of all people is a shared community concern and priority.

Opening comments in this submission noted that:

Our society's treatment of people with an experience of mental illness has often been, and often still is, shameful. Many people have been and still are, effectively excluded from the social and economic life of our community. Many people have been and still are, stigmatised and discriminated against on a daily basis. Many people with a mental illness are denied the basic rights and protections of citizenship. The law has often been a central tool in this oppression.

...

As people with experience of mental illness ... We want a mentally healthy community which welcomes people with experience of mental illness as valued and participating members in the economic and social life of our society.

For this to occur, the ACT needs laws, policies and services which:

- Promote a mentally healthy society;
- Reduce the incidence and duration of mental illness;
- Reduce reliance on the exercise of negative powers in mental health care and treatment; and
- Protect the human rights and rights to participatory citizenship of people affected by mental illness;

It is concluded that:

A new Act must state the following as a primary objective:

- To ensure that the mental health of all people in the ACT is a shared community concern and priority.

A new Act must seek to implement this objective through provisions which:

- Ensure a proactive and inclusive mental health promotion strategy;
- Ensure that services are developed to prevent mental illness, intervene early and prevent deterioration when mental illness occurs, and prevent the recurrence of mental illness;
- Ensure that the exercise of any negative powers are subject to effective limitations that protect the rights of the person with a mental illness and require accountability for services in avoiding their use except as a last resort; and
- Ensure that the attitudes, knowledge held, and future experiences of the ACT community are supportive of an integrated approach to mental health promotion and mental illness prevention.

The Network notes that other areas of health care can demonstrate models for primary reliance on and the highly successful use of preventive, early intervention and health promotion strategies.

The legislative, policy and service framework

The ACT Mental Health Consumer Network's *Statement of Consumer Principles for a Mentally Healthy Community* states that:

The legislative and policy framework of our society must endorse and support the full participation and human rights of people with experience of mental illness, eliminate discrimination, and ensure their right to the broad range of services and natural supports needed to improve and maintain their mental health.

Services must:

- ***Promote and support independence and recovery***
- ***Enhance and develop each person's power and capability to control and direct their own lives***
- ***Acknowledge each person's right to access assistance when needed***
- ***Be available early, when needed or asked for***
- ***Care for and nurture each person as an individual, with unique history, relationships, needs and aspirations***
- ***Maintain and enhance each person's family relationships and their connection to the community***
- ***Promote educated acceptance and a positive view in the community of people who experience mental illness***
- ***Seek to protect people who experience mental illness from stigmatization and discrimination within the community***
- ***Be sensitive to and responsive to cultural difference***
- ***Be provided in the least restrictive and invasive way possible***

- ***Build the foundation for constructive therapeutic relationships based on trust***
- ***Provide a safe environment for the treatment, care and support of people experiencing mental illness***
- ***Eliminate additional fear and trauma created by service delivery practices***
- ***Provide each person with the information they need to understand and make informed decisions about their mental health***
- ***Work collaboratively with each person to prevent and prepare in advance for any potential mental health crisis***
- ***Reference and utilise evidence based practice***

People with experience of mental illness have complained that mental health crises occur far too often in the ACT. Many crises could be avoided with appropriate community support and early assistance. Yet in the ACT, deepening crisis is too frequently the precursor needed to obtain effective assistance. It then also becomes the precursor to extensive use of involuntary detention and treatment orders and the exercise of other negative powers. Early intervention would allow the co-operative engagement of most people in their treatment and care, so that involuntary orders would be unnecessary. The creation of better therapeutic environments and relationships are likely, if there is a focus on earlier intervention and prevention of crises.

The regular use of those “negative powers” which are the main focus of the current Act, has serious consequences for individuals experiencing mental illness. One person noted that:

Being removed from the community and involuntarily detained is said to be a last resort. It is held, therefore to be reasonable. We need to understand that ... this is not a reasonable event. It is an extraordinary event. An extraordinary failure. Community mental health care should be allowed very few such failures.

Such failures result in unnecessary trauma, are counterproductive to the recovery process, enhance community and professional stigma, and reinforce the legitimacy of other traumatic practices.

Claimed examples of treatment and care practice that involve the use or threat of negative powers which have been highlighted by people with experience of mental illness, include the following:

- *When someone was threatening suicide following self-harm, the CAT team came out and rather than de-escalating the situation, behaved like a SWAT team. Others present feared for the person because of their heavy tactics, and, once the immediate physical treatment had been administered by the ambulance, suggested that they would take the*

person home and look after them closely, because they were “more frightened of those sent to help”.

- *A consumer who was a voluntary patient was quietly watching television, while waiting for their doctor to come. A nurse came and turned the tv off and told the person to go to bed. The person told the nurse that they were waiting for the doctor and that the tv was on quietly. The nurse then threatened the patient with being “made involuntary” if they didn’t comply, and being placed in seclusion if they objected any further.*
- *A consumer who lived at Brian Hennessey House was placed in the room used for involuntary seclusion after having a verbal exchange with one of the staff. When a complaint was made about it, the seclusion register was checked as part of the investigation and it had not been completed, so no medical authority had been sought or granted. When asked why these legal processes had not been done, the staff stated that the door had not been locked and so it wasn’t “proper” seclusion. It was not clear that the consumer knew the door was unlocked. In this case, it was clear that the seclusion technique was being used as punishment, rather than because of any real or perceived threat of harm to staff.*

In order to minimise the need for treatment and care in response to deepening crisis it is imperative that services work collaboratively with people who experience mental illness to address their needs for information and knowledge, to establish agreed treatment and care plans, and to avoid the threat of or need for involuntary treatment and care.

The collaborative and skilled use of Advanced Treatment Directives are one mechanism which would substantially and directly impact upon any requirement for involuntary detention, treatment and care. Another separate but important tool which is appropriate within the therapeutic relationship, is the collaborative development of holistic and practical treatment and care plans. The Network believes that neither of these arrangements is used as widely or effectively as they should be within the ACT. It is important however, to clearly distinguish between these two arrangements.

The discussion paper notes that:

Scotland gives legal recognition to advanced directives and details provision for their making, withdrawal and confirmation. The Report of the Review of Mental Health Legislation in South Australia recommended that advanced directives by consumers to cover the times when they are temporarily incapacitated should be given legal recognition.

The Network supports an approach which provides legal recognition to Advanced Treatment Directives.

In order that services are delivered in a way which eliminates deepening trauma it is imperative that services respond early, are respectful of and responsive to individual circumstance, and work intensively within the community.

A wide range of health, housing and other community services might be relevant to an individual's circumstances. And significantly, each individual person with experience of mental illness has available or could be assisted to develop and maintain and benefit from their own set of natural, family and community, supports.

In order that services are delivered in a way which eliminates deepening trauma it is also imperative that service providers are equipped with appropriate attitudes, skills and knowledge, that service delivery procedures are not traumatic, that service delivery facilities are appropriately designed, and that the mix of services is adequately balanced in favour of options which are supportive of community life and not restrictive of liberty.

If the use of the "negative powers" associated with involuntary detention and treatment, the use of seclusion and physical and chemical restraint is to truly become a last resort option, each and every such incidence must be actively reviewed and the causes of failure to avoid it identified. A plan to avoid the use of negative powers in the future must be developed in collaboration with the consumer concerned.

It is concluded that:

A new Act must state the following as primary objectives:

To ensure that people with experience of mental illness are able to fully participate in the life of their community and to enjoy their full human rights.

To provide people with experience of mental illness with the right to access and benefit from the broad range of services and natural supports needed to improve and maintain their mental health.

To ensure that services made available to people who experience mental illness:

- Promote and support independence and recovery
- Enhance and develop each person's power and capability to control and direct their own lives
- Acknowledge each person's right to access assistance when needed
- Be available early, when needed or asked for
- Care for and nurture each person as an individual, with unique history, relationships, needs and aspirations
- Maintain and enhance each person's family relationships and their

connection to the community

- Promote educated acceptance and a positive view in the community of people who experience mental illness
- Seek to protect people who experience mental illness from stigmatization and discrimination within the community
- Be sensitive to and responsive to cultural difference
- Be provided in the least restrictive and invasive way possible
- Build the foundation for constructive therapeutic relationships based on trust
- Provide a safe environment for the treatment, care and support of people experiencing mental illness
- Eliminate additional fear and trauma created by service delivery practices
- Provide each person with the information they need to understand and make informed decisions about their mental health
- Work collaboratively with each person to prevent and prepare in advance for any potential mental health crisis
- Reference and utilise evidence based practice

Specifically, provisions in new Act must:

- Ensure provision of information required for informed choice.
- Recognise and require the use of advanced directives, developed with an advocate of choice and with full recognition of its legal implications. Where a doctor or other health professional wants to override such a directive, they must be required to seek an order from a court giving reasons for this.
- Recognise and require the use of care and treatment plans which are developed collegially with the consumer and others who the consumer wants involved in their care and in their lives as supporters and helpers
- Require the ongoing training of service providers and the establishment of enforceable service delivery standards which ensure:
 - The application of attitudes, knowledge and skills required to implement the purpose and objectives of the Act;
 - Application of the philosophy and process of recovery centred practice;
 - The elimination of fear and trauma; and
 - The elimination of restraint and coercive methodology.
- Ensure the establishment and ongoing support of a comprehensive community services framework which enables a person experiencing mental illness to receive effective treatment, care, community living support, recovery assistance and, where required crisis support

services.

- Ensure that services are delivered in, or in close approximation to, the individual's natural community setting.
- Require that any resort to the use of restraint or involuntary treatment or care occurs only in accordance with provisions outlined in the Act, and only after comprehensive attempts have been made to ensure voluntary agreement.
- Require that any resort to the use of restraint or involuntary treatment or care is subject to an open and independent review process and that a plan is developed to avoid any recurrence.
- ***Require that any resort to the use of restraint or involuntary treatment or care is reported to and reviewed by the Legislative Assembly on a quarterly basis, including a report on any contributing systems failures or inadequacies.***

CHAPTER 4

CONCLUSIONS AND RECOMMENDATIONS

Conclusions regarding the ACT Mental Health (Treatment and Care) Act 1994

The real but unstated purpose of the current Act is to licence the “negative powers” associated with involuntary detention and treatment, and the use of seclusion and physical and chemical restraint.

While Network members acknowledge that exercise of these “negative powers” may be necessary in a very small number of cases to either to protect people with mental illness or to protect other community members, they argue that the Act and the service system which it supports has established as a norm, practices which should be cited as “extraordinary”.

The frequent use of and reliance upon these “negative powers” has shaped a mental health system which is “crisis driven”, and which causes psychological and physical trauma to people when they are very vulnerable.

Thus, the unstated purpose of the current Act is primarily a social control purpose, or at best, a social control approach to a health care purpose. Neither interpretation is a best practice approach to mental health legislation. It is an approach which is substantially rejected in other areas of health care even when a potential or perceived risk to other members of the community is involved.

The (current) Act undermines the basic human rights of people who experience mental illness in the ACT:

- It was conceived from a prejudicial social control purpose;
- It allows for arbitrary detention;
- It fails to mandate early intervention services, collaborative relapse prevention strategies and advanced directives.

Conclusions regarding a policy framework to guide the review process

The review process must be guided by the following *Statement of consumer principles for a mentally healthy community*:

People with experience of mental illness are respected citizens¹⁰ of our community and valued contributors to the economic, social, cultural and creative life of the ACT.

The mental health of all people is a shared community concern and priority.

The legislative and policy framework of our society must endorse and support the full participation and human rights of people with experience of mental illness, eliminate discrimination, and ensure their right to the broad range of services and natural supports needed to improve and maintain their mental health.

Services must:

- Promote and support independence and recovery
- Enhance and develop each person's power and capability to control and direct their own lives
- Acknowledge each person's right to access assistance when needed
- Be available early, when needed or asked for
- Care for and nurture each person as an individual, with unique history, relationships, needs and aspirations
- Maintain and enhance each person's family relationships and their connection to the community
- Promote educated acceptance and a positive view in the community of people who experience mental illness
- Seek to protect people who experience mental illness from stigmatization and discrimination within the community
- Be sensitive to and responsive to cultural difference
- Be provided in the least restrictive and invasive way possible
- Build the foundation for constructive therapeutic relationships based on trust
- Provide a safe environment for the treatment, care and support of people experiencing mental illness
- Eliminate additional fear and trauma created by service delivery practices
- Provide each person with the information they need to understand and make informed decisions about their mental health
- Work collaboratively with each person to prevent and prepare in advance for any potential mental health crisis
- Reference and utilise evidence based practice

¹⁰ When we use the word "citizen", it is not intended to exclude those who have yet to formally take up citizenship in our community or those who have arrived, for example as refugees. We believe the rights and protections of citizenship should apply to all people living in our community, whatever their legal status.

All future legislation, policy and practice changes should be consistent with these principles – they should shape any new Act, which in turn, should shape the service system.

Recommendations

The following recommendations are made:

A new Act

A new Act is required which provides:

- A clearly stated legislative purpose
- A consistent statement of objectives
- Consistent legislative content

A human rights guarantee

A new Act must seek to protect the rights of people who experience mental illness before contemplating the need to remove or compromise any of those rights.

A new Act must be openly and comprehensively and critically assessed for its compliance with human rights principles.

The application of a new act must be progressively monitored and evaluated for its compliance with human rights principles.

Purpose, Objectives and key Provisions of a new Act

A new Act must have a stated purpose as follows:

To enable, support and guarantee the rightful place of people who experience mental illness as respected members of our community and valued contributors to the economic, social, cultural and creative life of the ACT.

A new Act must state the following as a primary objective:

- To ensure that the mental health of all people in the ACT is a shared community concern and priority.

A new Act must seek to implement this objective through provisions which:

- Ensure a proactive and inclusive mental health promotion strategy;
- Ensure that services are developed to prevent mental illness, intervene early and prevent deterioration when mental illness occurs, and prevent the recurrence of mental illness;

- Ensure that the exercise of any negative powers¹¹ are subject to effective limitations that protect the rights of the person with a mental illness and require accountability for services in avoiding their use except as a last resort; and
- Ensure that the attitudes, knowledge held, and future experiences of the ACT community are supportive of an integrated approach to mental health promotion and mental illness prevention.

A new Act must state the following as primary objectives:

To ensure that people with experience of mental illness are able to fully participate in the life of their community and to enjoy their full human rights.

To provide people with experience of mental illness with the right to access and benefit from the broad range of services and natural supports needed to improve and maintain their mental health.

To ensure that services made available to people who experience mental illness:

- Promote and support independence and recovery
- Enhance and develop each person's power and capability to control and direct their own lives
- Acknowledge each person's right to access assistance when needed
- Be available early, when needed or asked for
- Care for and nurture each person as an individual, with unique history, relationships, needs and aspirations
- Maintain and enhance each person's family relationships and their connection to the community
- Promote educated acceptance and a positive view in the community of people who experience mental illness
- Seek to protect people who experience mental illness from stigmatization and discrimination within the community
- Be sensitive to and responsive to cultural difference
- Be provided in the least restrictive and invasive way possible
- Build the foundation for constructive therapeutic relationships based on trust
- Provide a safe environment for the treatment, care and support of people experiencing mental illness
- Eliminate additional fear and trauma created by service delivery practices
- Provide each person with the information they need to understand and make informed decisions about their mental health

¹¹ "negative powers" are those powers associated with involuntary detention and treatment, and the use of seclusion and physical and chemical restraint.

- Work collaboratively with each person to prevent and prepare in advance for any potential mental health crisis
- Reference and utilise evidence based practice

Specifically, provisions in new Act must:

- Ensure provision of information required for informed choice.
- Recognise and require the use of advanced directives, developed with an advocate of choice and with full recognition of its legal implications. Where a doctor or other health professional wants to override such a directive, they must be required to seek an order from a court giving reasons for this.
- Recognise and require the use of care and treatment plans which are developed collegially with the consumer and others who the consumer wants involved in their care and in their lives as supporters and helpers
- Require the ongoing training of service providers and the establishment of enforceable service delivery standards which ensure:
 - The application of attitudes, knowledge and skills required to implement the purpose and objectives of the Act;
 - Application of the philosophy and process of recovery centred practice;
 - The elimination of fear and trauma; and
 - The elimination of restraint and coercive methodology.
- Ensure the establishment and ongoing support of a comprehensive community services framework which enables a person experiencing mental illness to receive effective treatment, care, community living support, recovery assistance and, where required crisis support services.
- Ensure that services are delivered in, or in close approximation to, the individual's natural community setting.
- Require that any resort to the use of restraint or involuntary treatment or care is subject to an open and independent review process and that a plan is developed to avoid any recurrence.
- Require that any resort to the use of restraint or involuntary treatment or care occurs only in accordance with provisions outlined in the Act, and only after comprehensive attempts have been made to ensure voluntary agreement.
- ***Require that any resort to the use of restraint or involuntary treatment or care is reported to and reviewed by the Legislative***

Assembly on a quarterly basis, including a report on any contributing systems failures or inadequacies.

Voluntary care and treatment

A new Act must make provision for voluntary care, treatment and admission. Such provision must take its place as a cornerstone of a new Act and include:

- The right to seek service without formal written application
- The right to oral explanation and a prompt written explanation when requested, where service is refused
- The right to make formal written application for service
- A requirement to provide a formal written explanation where service is refused following a written application
- The comprehensive right of appeal, through the service provider, through an advocate of choice, and through a review tribunal.

Service providers must be required to provide information on these rights whenever a service is sought.

These rights must be equally applicable to people experiencing mental illness or mental disorder.¹²

Definitions, exclusionary and clarifying clauses

Mental Illness

A new Act must contain a definition of mental illness for the purpose of involuntary admission, treatment and care which is appropriately based on internationally accepted medical standards (as per the current Act) and is referenced to accepted clinical standards and current editions of the World Health Organisation, International Classification of Mental and Behavioural Disorders, Clinical Description and Diagnostic Guidelines or the American Psychiatric Diagnostic and Statistical Manual of Mental Disorders (s6(2)).

A new Act must:

- Provide exclusionary clauses which clarify when a person is not considered to have a mental illness by reason of that matter alone.
- Provide further clarifying clauses such as:

¹² For the purpose of voluntary treatment and care, mental illness and mental disorder are terms which are readily interpreted by reference to internationally accepted clinical standards and authoritative texts. For example, references to the American Psychiatric Association's Diagnostic and Statistical manual (DSM-IV), these terms would encompass Axis I Clinical diagnoses and Axis II personality disorders.

A person may have a mental illness caused by taking drugs or alcohol.

A person may have a mental illness as well as an intellectual disability.

A person may have a mental illness as well as a personality disorder.

Mental Disorder

Include provision for the short-term involuntary detention of persons with ‘mental disorder’ as outlined in Model Mental health Legislation (1995)

Mental Dysfunction

The current Act’s provisions relating to “mental dysfunction” for the purpose of involuntary admission, treatment and care are inconsistent with Principle 4.1 of the United Nations *Principles* and are inconsistent with rights protected under the ACT Human Rights Act 2004.

The purpose of these provisions and the appropriateness of their placement within mental health legislation require substantive review in the context of a new legislative framework.

Children and Young people

A new Act must make special provision relating to:

- the recognition, promotion and protection of the rights and needs of children and young people experiencing mental illness
- an age related test of competence and ability to provide informed consent to treatment;
- provision of specialised treatment and care services separate from adult services;
- specific provisions addressing involuntary treatment and care for different age groups of children and young people; and
- the right to an advocate of choice.

A Mental Health Tribunal

A new Act must ensure that:

- initial decision regarding involuntary treatment and care must be made by a multidisciplinary team which includes, at minimum, a psychiatrist and a social worker, and which must be supported by a second medical opinion;
- a Mental Health Tribunal is independent of any other body (judicial or otherwise) and that its responsibilities are limited to review;
- this Tribunal is subject to the same conflict of interest rules and rules of evidence which protect the parties in other Tribunals, and that appropriate procedural protections and protections of the rights of the citizen are in place.

A new Act must require that:

- Independent legal representation, supported by legal aid assistance, is automatically available to all persons appearing before a Mental Health Tribunal.
- All persons appearing before a Mental Health Tribunal are entitled to the support of a (non-legal) consumer advocate of choice.

Forensic Matters

A new Act must extend the benefits of its assessment, treatment and care provisions to people who are involved in the criminal justice system

Issues affecting the management and control of people involved in the criminal justice system and requiring mental health assessment for forensic purposes, must be subject to provisions contained in an Act separate from a new Mental Health Act.

This other Act must also ensure that people with a mental illness who are involved in the criminal justice system are not denied rights ordinarily available to people in the criminal justice system who do not have a mental illness.

All people held in custody must be provided with access to an independent mental health advocate.

Police and Ambulance

A new Act must minimise the role of police and authorise ambulance officers to intervene and transport a persons for the purpose of emergency assessment, treatment and care when necessary.

This change must be supported by a comprehensive education and training program.

Regulation of certain treatments and interventions

A new Act must ensure that:

- Where ECT is under consideration as a treatment, comprehensive information detailing possible temporary and permanent side effects must be provided with the assistance of an independent advocate prior to informed consent being sought.
- Where ECT is under consideration as a treatment, a second, independent medical opinion is provided.
- No-one who is capable of giving informed consent should be given ECT against their will.

BIBLIOGRAPHY

- ACT Government (July 2006). *Discussion Paper. The review of the ACT Mental Health (Treatment and Care) Act 1994*
- American Psychiatric Association (1994) Diagnostic and Statistical manual of Mental Disorders. Fourth Edition. Washington, DC.
- Australian Health Ministers (1992). *National Mental Health Policy*. AGPS, Canberra
- Australian Health Ministers (1996) *National Standards for Mental Health Services*. AGPS, Canberra
- Australian Health Ministers (2003). *National Mental Health Plan 2003-2008*. AGPS, Canberra
- Australian Health Minister's Advisory Council Mental Health Working Group (2000). *Application of Rights Analysis Instrument to Australian Mental Health Legislation*. Commonwealth of Australia, Canberra.
- Australian Health Minister's Advisory Council Mental Health Working Group (1995). *Model Mental Health Legislation*. Commonwealth of Australia, Canberra.
- Human Rights and Equal Opportunity Commission (1992). *Mental Health Legislation and Human Rights. An analysis of State and territory Mental Health Legislation in terms of the United nations principles for the protection of persons with mental illness*. Commonwealth of Australia, Canberra.
- Legislative Assembly of the ACT (2006). *Criminal Code (Mental Impairment) Amendment Bill 2006*
- Legislative Assembly of the ACT (2004). *Human Rights Act 2004*. ACT legislation register, Canberra.
- Legislative Assembly of the ACT (1994). *Mental Health (Treatment and Care) Act 1994*
- Legislative Assembly of the ACT (2003). *Mental Health (Treatment and Care) Regulation 2003*
- Australian Health Ministers Conference. *Mental Health Statement of Rights and Responsibilities*. AGPS, Canberra
- Standing Committee on Social Policy report No. 5. (April 1994) *Report on the Inquiry into the Mental Welfare and Crimes (Amendment) Exposure Draft Bills*. Legislative Assembly for the ACT
- Mental Health Council of Australia (2005) *Not for service. Experiences of injustice and despair in mental health care in Australia*.
- Mental Health (Care and Treatment) (Scotland) Act 2003
- Queensland Government . *Mental Health Act 2000*.