Mental health reform challenges: Perspectives from Victoria

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1. Introduction

**OPA is an independent statutory authority with the following key functions:**

- guardian of last resort (31% of clients have mental ill health)
- investigates applications to Vic. Civil and Administrative Tribunal
- coordinates 4 volunteer programs
  - Community Visitors program
  - Independent Third Person program
  - Community Guardianship program
  - Corrections Independent Support Officers
- advocates (individual and systemic)
- provides an advice service
- delivers community education
Office of the Public Advocate

Safeguarding the rights and interests of people with disability

Disability Services
Mental Health
Residential Services
2. Human rights

*Charter of Human Rights and Responsibilities Act 2006 (Vic)*

*Convention on the Rights of Persons with Disabilities*

Three of the key themes in the Convention:

1. Minimise state-directed substitute decision making
2. Supported decision making to be preferred
3. Prevention of abuse
2. Human rights

*Convention on the Rights of Persons with Disabilities*

UN Committee on the Rights of Persons with Disabilities, General Comment (No. 1, 11 April 2014, Article 12, pars 28, 31):

‘State parties’ obligation to replace substitute decision-making regimes by supported decision-making requires both the abolition of substitute decision-making regimes and the development of supported decision-making alternatives. The development of supported decision-making systems in parallel with the maintenance of substitute decision-making regimes is not sufficient to comply with article 12 of the Convention.’

‘Recognition of legal capacity is inextricably linked to the enjoyment of many other human rights provided for in the [CRPD], including, but not limited to, the right to … be free from involuntary detention in a mental health facility and not to be forced to undergo mental health treatment (art. 14) …’
3. Towards supported decision making

Substitute decision making examples include:

- Guardians
- Attorneys and others appointed under activated enduring powers of attorney
- Statutory health decision makers (in Victoria known as ‘person responsible’ and, from 12 March 2018, ‘Medical Treatment Decision Maker’)
- Compulsory mental health treatment
- NDIS ‘plan nominees’
Problems with substitute decision making

- Consistency with human rights developments
- Can be a blunt response to service failure, neglect or harm (e.g. elder abuse)
- Legal complexity over:
  - NDIS interaction with state/territory laws
  - Knowledge of professionals (e.g. doctors)
  - When is it required (e.g. admission to residential aged care)?
- Assessing capacity
- Monitoring of substitute decision makers
3. Towards supported decision making

Supported decision making is an ever more common feature of legislative developments

The Australian Law Reform Commission in its final report on *Equality, Capacity and Disability in Commonwealth laws* (2014, Rec. 3-1) recommended:

- 'Reform of Commonwealth, state and territory laws and legal frameworks concerning individual decision-making should be guided by the National Decision-Making Principles and Guidelines ... to ensure that:

  » supported decision-making is encouraged;
  » representative decision-makers are appointed only as a last resort; and
  » the will, preferences and rights of persons direct decisions that affect their lives'.

On the topic of **mental health**, the ALRC (par. 10.72) recommended:

- ‘that state and territory governments review mental health legislation, with a view to reform that is consistent with the National Decision-Making Principles and the Commonwealth decision-making model. This might involve, for example, moving towards supported decision-making models …’
Increased patient involvement

‘persons receiving mental health services should be involved in all decisions about their assessment, treatment and recovery and be supported to make, or participate in, those decisions, and their views and preferences should be respected …’ (section 11(1)(c))

• Nominated person (can receive information)
• Advance statements (not binding, reasons for divergence must be recorded)
From 1 September 2015 this Act has enabled adult Victorians to make a supportive attorney appointment.

‘Supportive attorneys’ have power:

- to collect information,
- to ‘communicate’ information, and
- to ‘give effect to’ decisions (but not a ‘significant financial transaction’)

Guardianship and Administration Bill 2014 (which lapsed) proposed the new (complementary) entity of ‘supportive guardian’.
‘General principles guiding actions under this Act’ (section 4)

• ‘People with disability should be supported to participate in and contribute to social and economic life to the extent of their ability.’

• ‘People with disability should be supported to exercise choice, including in relation to taking reasonable risks, in the pursuit of their goals ...’

‘General principles guiding actions of people who may do acts or things on behalf of others’ (section 5)

• ‘people with disability should be involved in decision making processes that affect them, and where possible make decisions for themselves’
(1) ‘The role of a support person for the person making the appointment is—
(a) to support the person to make, communicate and give effect to the person's medical treatment decisions; and
(b) to represent the interests of the person in respect of the person's medical treatment, including when the person does not have decision-making capacity in relation to medical treatment decisions.

(2) A support person acting in the capacity of a support person does not have the power to make a person's medical treatment decisions’ (section 32).
1. OPA won a grant from the Victoria Law Foundation to run a pilot volunteer Supported Decision-Making program. The program (ended June 2015) connected 18 isolated people with cognitive impairments with volunteer supporters.

2. **Oval project**: OPA assisted advocacy agency Valid in this pilot project funded by the National Disability Insurance Agency. The project has run from 1 August 2015 and has seen 15 NDIS participants matched to 15 volunteer decision-making supporters. Now extended (in north and east of Melbourne) under the name **Choice Mentor Program**.
Supported Decision Making Project

Welcome to the Supported Decision Making (SDM) project, a project that aims to investigate and support the rights, agency and self-determination of people in the mental health system.

A key output of this project was the production of two internet resources based on research participants’ stories of living with severe mental health problems and carers’ experiences. Launched in June 2016, the resources can be found on the Healthtalk Australia website.

The two websites are:

Mental Health and Supported Decision Making: Lived Experience Perspectives

Mental Health and Supported Decision Making: Carers’ experiences

Lead: Associate Professor Renata Kokanovic (Monash University). Collaborators: researchers at University of Melbourne and Victorian Department of Health; non-governmental organisation representatives.

http://artsonline.monash.edu.au/supported-decision-making/
4. Substitute decision-making law reform in Victoria

Substitute decision-making laws seek to protect a person by enabling someone else to make decisions for that person. In doing this, substitute decision-making laws inhibit other freedoms.

The broad challenge in the law reform process: what is the right balance between autonomy and protection?

General trend towards seeking to:
- limit state-appointed substitute decision making
- encourage supported decision making, and
- improve protection mechanisms
4. Substitute decision-making law reform in Victoria

Mental Health
• Mental Health Act 2014

Enduring Powers of Attorney
• Powers of Attorney Act 2014

Medical Treatment
• Medical Treatment Planning and Decisions Act 2016

Guardianship
• Review by Victorian Law Reform Commission of Guardianship and Administration Act 1986
• Final report 2012 (610 pages, 440 recommendations)
5. Mental Health Act 2014

Scheme for compulsory treatment

Detention

- ‘Appearance’ of mental illness only permits detention for 72 hours (under an Assessment Order)
- Inpatient Treatment Orders (temporary up to 28 days), extensions of 6 months by Mental Health Tribunal
- Community Treatment Orders (temporary up to 28 days), extensions of 12 months by Mental Health Tribunal

Treatment

- Attempt to increase ability of people to consent to treatment while in detention – but if they refuse? OPA view: if people have capacity to consent to treatment they must be permitted to refuse treatment.
Compulsory treatment criteria

s. 5. ‘The treatment criteria for a person to be made subject to a Temporary Treatment Order or Treatment Order are —

a. the person has mental illness; and

b. because the person has mental illness, the person needs immediate treatment to prevent —
   (i) serious deterioration in the person's mental or physical health; or
   (ii) serious harm to the person or to another person; and

c. the immediate treatment will be provided to the person if the person is subject to a Temporary Treatment Order or Treatment Order; and

d. there is no less restrictive means reasonably available to enable the person to receive the immediate treatment.’
Patient can say ‘yes’ but not ‘no’. Possible therapeutic intent?

s. 71 (1) ‘This section applies if … a patient —

  i. does not have the capacity to give informed consent to the treatment proposed by the authorised psychiatrist; or

  ii. has the capacity to give informed consent, but does not give informed consent to treatment proposed by the authorised psychiatrist …

(3) The authorised psychiatrist may make a treatment decision for the patient …’
Increased patient involvement
• Nominated person
• Advance statements

New review mechanisms
• Mental Health Tribunal (replaced Mental Health Review Board)
• Mental Health Complaints Commissioner – investigates complaints
• Second Psychiatric Opinions
s. 19. ‘An **advance statement** is a document that sets out a person's preferences in relation to treatment in the event that the person becomes a patient.’

s. 73 (1). ‘An authorised psychiatrist may make a treatment decision … for a patient **that is not in accordance with that patient's advance statement** if the authorised psychiatrist is satisfied that the preferred treatment specified by the patient in the advance statement —

a. is not clinically appropriate; or

b. is not a treatment ordinarily provided by the designated mental health service.’
• Uncertainty around ability of substitute decision makers to make decisions for non-compulsory mental health patients who are unable to make their own decisions.
• Particularly problematic at the moment in relation to ECT.
• Current Mental Health Act (s. 93) specifies ECT can be performed on a patient if they have given informed consent or if the tribunal authorises it.
• But Act is silent about people without capacity to consent who are not ‘patients’. Can a substitute decision maker consent on behalf of a person who is not a patient?
• From 12 March 2018, new requirement in Victoria (following enactment of Medical Treatment Planning and Decisions Act 2016): All ECT treatments for adults who are unable to consent to it must receive Mental Health Tribunal authorisation (whether they are compulsory patients or not).
Electroconvulsive treatment

- Used more than 12,000 occasions in Victorian public mental health facilities per year
- Mental Health Tribunal: 588 orders authorising ECT in year to June 2017. Previous year 620 orders (similar rate to Queensland: 560).
- Evidence from NSW: where advocacy/representation is routine, there is a much higher rate of rejection by the tribunal of applications to use ECT.
- Victoria Legal Aid representative: ‘If you’re represented by a lawyer, there’s a 50 per cent chance the tribunal will grant the application and you’ll have to have ECT, whereas if you’re not represented the tribunal makes the order in 90 per cent of cases.’ Triple J ‘Hack’, 16 August 2017.
Interaction between *Mental Health Act* and general medical treatment laws

- Most mental health treatments = pharmaceuticals. These (in regular dosage levels) excluded from the definition of ‘medical treatment’ in the guardianship legislation (until 12 March 2018).
- New Victorian legislation (*Medical Treatment Planning and Decisions Act 2016*) introduces broader definition of ‘medical treatment’, including pharmaceuticals in this definition.
- This substantially broadens out the requirement for substitute consent for the provision of mental health treatment to people in the general community, where the person themselves cannot consent.
- OPA’s policy position here, when we are guardian: we’ll decide on a case-by-case basis, but we are unlikely to consent where the person is actively objecting to treatment.
6. Advocacy
### Long-stay patient project

<table>
<thead>
<tr>
<th>Type of unit</th>
<th>Period of stay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Unit</td>
<td>&gt; three months</td>
</tr>
<tr>
<td>Community Care Unit</td>
<td>&gt; two years</td>
</tr>
<tr>
<td>Secure Extended Care Unit</td>
<td>&gt; six months</td>
</tr>
<tr>
<td>Other units</td>
<td>&gt; six months</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Unit long-stay patient identified in</th>
<th>A. Not able to be discharged</th>
<th>B. No suitable accommodation available</th>
<th>C. Waiting on a vacancy</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>SECU</td>
<td>9</td>
<td>15</td>
<td>10</td>
<td>34</td>
</tr>
<tr>
<td>CCU</td>
<td>10</td>
<td>21</td>
<td>8</td>
<td>39</td>
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<tr>
<td>Acute unit</td>
<td>5</td>
<td>1</td>
<td>6</td>
<td>12</td>
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<tr>
<td>Forensicare</td>
<td>-</td>
<td>1</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Brain disorder unit</td>
<td>-</td>
<td>7</td>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td>Aged acute</td>
<td>-</td>
<td>2</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>24 (24%)</strong></td>
<td><strong>47 (47%)</strong></td>
<td><strong>28 (28%)</strong></td>
<td><strong>99</strong></td>
</tr>
</tbody>
</table>
7. Challenges and possible reform

Practice
- Overuse of Community Treatment Orders?
- Is Tribunal oversight of compulsory treatment timely and meaningful?
- How can people be better supported to make their own treatment decisions?
- Use of tracking devices?

Criminal justice system
- Consistency of ‘unfitness to plead’ and ‘mental impairment’ defence with human rights standards (Gooding et al research)
- Adequacy of mental health support services in prison
- Shortage of forensic psychiatric beds (meaning acutely unwell people are kept in prison)
Challenges and possible reform

**NDIS**

- Mental health recovery framework sits awkwardly with the NDIS
- Consumer eligibility
  - in the case of episodic mental ill health, what constitutes ‘substantially reduced functional capacity’?
  - what are ‘reasonable and necessary supports’?
- Service sector uncertainty
  - many new providers, pockets of ‘thin’ markets & ‘market failure’
  - workforce challenges
- Interaction with other service and support systems
  - health (including acute mental health)
  - criminal justice (NDIS-funded support in prisons and forensic detention)
  - homelessness
Challenges and possible reform

Law reform?

- Legislated right to advocacy?
- Incapacity a criterion for compulsory treatment?
- Steps toward ‘fusion’ of mental health and other substitute decision-making laws? E.g. Separate ‘risk to self’ from ‘risk to others’.
  - promotion and enablement of supported decision-making?
  - substituted judgement approach to substitute decision making?
  - enable personally-appointed substitute decision makers to make treatment decisions in compulsory settings where risk is to self (VLRC proposed this)?
  - binding advance statements where risk is to self?
Thank you