CURRENT TRENDS IN MENTAL HEALTH LEGISLATION

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Introduction

In order to ascertain the position of Western Australia’s mental health laws in the global setting, it is necessary to consider existing laws in other common law countries in order to identify the current trends in mental health law reform. This paper concentrates primarily on mental health law in Scotland, as well as that in England, Canada, New Zealand and Australia.

In 2007, the Victorian Law Reform Commission Chairperson, Professor Neil Rees, set out some of the key areas for civil commitment reform. These can be grouped under three main headings – guiding principles and values; laws for involuntary detention and treatment; and accountability processes. Professor Bernadette McSherry has outlined the necessary considerations under these three key areas:

Guiding principles and values
Consideration needs to be given to human rights issues and to cultural, indigenous, gender and age issues in analysing the conceptual underpinnings of mental health laws. Legislators need to look at balancing protection and care in order to establish some of the guiding principles and values that should be taken into account in developing a legal framework. Article 25 of the United Nations Convention on the Rights of Persons with Disabilities requires State Parties to provide health care to persons with disabilities on an equal basis with others. The effect of this Convention on mental health laws requires careful consideration.

Laws for involuntary detention and treatment
Consideration needs to be given to the criteria for involuntary detention and treatment, as well as the use of advance directives in the mental health setting, the use of community treatment orders, and the role of carers and independent mental health advocates. The Mental Health (Care and Treatment) (Scotland) Act 2003 is one of the newer mental health acts that has a specific Part dealing with rights, safeguards and duties, and notably also has provisions concerning those in the criminal justice system.

Accountability processes
It is important that there be processes for independent external review, including mental health review tribunals and mental health commissions.

Convention on the Rights of Persons with Disabilities


The Convention provides that ‘persons with disabilities’ includes “those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.”

1 N Rees, Learning from the Past, Looking to the Future: Is Victorian Mental Health Law Ripe for Reform, Mental Health Review Board of Victoria’s 20th Anniversary, Melbourne, 6 December 2007
2 Professor Bernadette McSherry is an Australian Research Council Federation Fellow and Professor of Law at Monash University. She has published extensively in the fields of criminal law and mental health laws and has been a consultant to various governments on law reform issues
3 B McSherry, Rethinking Mental Health Laws: Developing Model Frameworks, Criminal Justice Research Consortium Seminar, Melbourne, 19 February 2008, at 6-8
4 Article 1
The purpose of the Convention is to “promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities (including mental illness), and to promote respect for their inherent dignity”\(^5\). A number of the Convention’s provisions are relevant to mental health law reform. These include rights to:

- equality and non-discrimination\(^6\)
- consider the best interests of the child as primary in all actions concerning children\(^7\)
- equal recognition as persons before the law\(^8\)
- safeguards relating to the exercise of legal capacity to prevent abuse including measures that respect a person’s rights, will and preferences\(^9\)
- effective access to justice on an equal basis with others\(^10\)
- liberty and security of person on an equal basis with others and freedom from unlawful or arbitrary deprivation of liberty\(^11\)
- freedom from torture or cruel, inhuman or degrading treatment or punishment\(^12\)
- respect for physical and mental integrity on an equal basis with others\(^13\)
- live independently in the community\(^14\)
- respect for privacy\(^15\)
- equal access to health services including on the basis of free and informed consent\(^16\)

Countries that have ratified the Convention are required to adopt strategies to pursue these general obligations, and ensure the full realisation of all human rights for all people with disabilities. Commentators argue that the Convention has ushered in a ‘new era’ in human rights and that its detailed provisions require “reshaping of societies in a way required by no other human rights treaty”\(^17\).

It has been argued that Article 12 of the Convention, which deals with the legal capacity of persons with disabilities and starts with the presumption that people with disabilities, including mental illnesses, are capable of making their own decisions and that any other form of decision-making must be seen as a measure of last resort, shifts the focus from substituted decision-making to supported decision-making\(^18\). Professor McSherry is of the view that Article 12 provides added impetus for the movement to include provisions for advance directives or statements into mental health laws.

**Mental Health (Care and Treatment) (Scotland) Act 2003**

Professor McSherry has commented that the *Mental Health (Care and Treatment) (Scotland) Act 2003* (Scottish Act) provides a good stating point for an analysis of what should be included in civil mental health laws\(^19\).

The Scottish Act was passed by the Scottish Parliament in March 2003, and came into effect in April 2005.

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\(^5\) United Nations Convention on the Rights of Persons with Disabilities, Article 1
\(^6\) Article 5
\(^7\) Article 7
\(^8\) Article 12
\(^9\) Article 12(4)
\(^10\) Article 13
\(^11\) Article 14
\(^12\) Article 15
\(^13\) Article 17
\(^14\) Article 19
\(^15\) Article 22
\(^16\) Article 25
The Act applies to people with ‘mental disorder’, which covers mental health problems, personality disorders and learning disabilities. The Act covers a wide range of issues, which broadly can be arranged under 4 main headings:

(i) Principles
(ii) Compulsory powers
(iii) People with mental disorder within the criminal justice system (this issue is not dealt with in this paper)
(iv) Rights and safeguards

The Act allows for “named persons” to be given information to support the patient, as well as for “advance statements”. Many of the provisions were included on the advice of the Mental Health Alliance, which consists of members of user groups, psychiatrists, social workers, nurses, psychologists, lawyers, religious groups and carers’ associations.

Principles

The Scottish Act is based on a set of guiding principles, which help to set the tone of the Act and guide its interpretation. As a general rule, anyone who takes any action under the Act has to take account of the principles, of which there are ten:

1. Non-discrimination – people with mental disorder should, wherever possible, retain the same rights and entitlements as those with other health needs.

2. Equality – all powers under the Act should be exercised without any direct or indirect discrimination on the grounds of physical disability, age, gender, sexual orientation, language, religion or national or ethnic or social origin.

3. Respect for diversity – service users should receive care, treatment and support in a manner that accords respect for their individual qualities, abilities and diverse backgrounds and properly takes into account their age, gender, sexual orientation, ethnic group and social, cultural and religious background.

4. Reciprocity – where society imposes an obligation on an individual to comply with a program of treatment and care, it should impose a parallel obligation on the health and social care authorities to provide safe and appropriate services, including ongoing care following discharge from compulsion.

5. Informal care – wherever possible, care, treatment and support should be provided to people with mental disorder without the use of compulsory powers.

6. Participation – service users should be fully involved, so far as they are able to be, in all aspect of their assessment, care, treatment and support. Their past and present wishes should be taken into account. They should be provided with all the information and support necessary to enable them to participate fully. Information should be provided in a way which makes it most likely to be understood.

7. Respect for carers – those who provide care to service users on an informal basis should receive respect for their role and experience, receive appropriate information and advice, and have their views and needs taken into account.

8. Least restrictive alternative – service users should be provided with any necessary care, treatment and support both in the least invasive manner and in the least restrictive manner and environment compatible with the delivery of sake and effective care, taking into account where appropriate the safety of others.

9. Benefit – any intervention under the Act should be likely to produce for the service user a benefit that cannot reasonably be achieved other than by the intervention.
10. Child welfare – the welfare of a child with mental disorder should be paramount in any interventions imposed on the child under the Act.

Compulsory Powers

The Scottish Act allows for people to be placed on different kinds of compulsory order according to their particular circumstances. There are three main kinds of compulsory powers:

(i) Emergency detention – this allows someone, on the recommendation of a doctor, to be detained in hospital for up to 72 hours where hospital admission is required urgently to allow the person’s condition to be assessed. Where possible, the agreement of a mental health officer (a social worker specially trained in mental health) should also be obtained.

(ii) Short-term detention – this allows someone to be detained in hospital for up to 28 days. It will only take place where it is recommended by a specially trained doctor (a psychiatrist) and is agreed to by a mental health officer.

(iii) Compulsory Treatment Order – this has to be approved by a Tribunal upon the application of a mental health officer. The application has to include two medical recommendations and a plan of care detailing the care and treatment proposed for the patient. The patient, the patient’s named person and the patient’s primary carer is entitled to have any objections they have heard by the Tribunal. The patient and the named person are entitled to free legal representation for the hearing.

A Compulsory Treatment Order can be based in the hospital or in the community. If it is based in the community, it can include various requirements, e.g. that the patient live at a certain address, attend certain services at particular times, or attend a particular place for treatment.

It has been proposed that the “most controversial reform in the (Scottish) Act is the introduction of a new compulsory treatment order … which will allow care and treatment to be tailored to the personal needs of each patient, whether in hospital or in the community”20.

Safeguards and rights of review and appeal under the Scottish Act

The Act provides additional rights for people accessing mental health services, as well as increased safeguards:

1. Patients, carers and named persons have the right to request an assessment of needs from the local authority or Health Board.

2. Local authorities and Health Boards have a duty to undertake an assessment of needs where certain conditions are met.

3. All people with mental disorder have the right of access to independent advocacy services, and Health Boards and local authorities have a duty to ensure the availability and accessibility of advocacy services.

4. Patients have the right to nominate a named person, who has the right to be kept informed of the patient’s status in certain circumstances set out in the Act and may act on behalf of the patient, including making applications and appeals to the Tribunal.

5. Patients have the right to make an advance statement regarding how they would wish to be treated or not treated.

6. Patients (and others on their behalf) have the right of appeal against detention in conditions of excessive security.

7. Informal patients have the right to apply to the Tribunal for an order requiring hospital managers to release a patient held unlawfully.

8. The Act gives the Mental Welfare Commission new powers to: monitor how the Act is working; encourage best practice; publish information and guidance; carry out visits to patients, investigations, interviews and medical examinations; inspect patient records.

9. Local authorities have duties to provide ‘care and support services’ and ‘services designed to promote well-being and social development’ for people who have, or have had, a mental disorder.

10. Health Boards have to provide services for children and young people that are appropriate for their particular needs.

11. Health Boards have to ensure the provision of mother and baby units to allow a mother admitted to hospital for the treatment of post-natal depression to care for her child in hospital.

Supported decision-making

Certain aspects of the Scottish Act highlight a trend towards statutory provisions for supported, rather than substitute decision-making. They are:

- **Recognition of the importance of carers**
  The Scottish Act includes a process for consumers to nominate a “named person”, such as a relative or friend, with rights to be involved in any legal hearings of the Mental Health Tribunal. The named person has the same rights as the individual concerned to be notified of, appear, and be represented at hearings. The named person has the right to initiate appeals against the renewal of compulsory treatment measures and the right to appeal decisions of the Tribunal. Families of individuals with mental illness also have rights to trigger assessments when needed.

- **Guidelines**
  The Scottish Executive has issued a comprehensive Code of Practice in three volumes, together with specific training manuals for staff and information for patients and families, to assist in the implementation and interpretation of the Act. The Code of Practice sets out processes for ensuring that carers are given appropriate information in relation to measures taken under the Act.

- **Access to independent advocacy**
  The Scottish Act provides that individuals with mental illnesses have a right of access to independent advocacy and the onus is placed on each local authority and each Health Board to secure the availability of independent advocacy services and to ensure the individual concerned has access to them.

**Mental Health Act 2009 (South Australia)**

The Mental Health Act 2009 (South Australia) (South Australian Act), which was proclaimed on 1 July 2010, provides a contemporary framework for the treatment, care and rehabilitation of persons with mental illness. It recognises the concept of “recovery”\(^\text{21}\) and introduces a definition of “relative” that accommodates the kinship rules of Aboriginal and Torres Strait Islander people. It also includes provision to work collaboratively with traditional healers (Ngangkarri)\(^\text{22}\).

\(^{21}\) Mental Health Act 2009 (SA), ss 6, 7, 39, 40, 41
\(^{22}\) Mental Health Act 2009 (SA), s 7
The key features of the South Australian Act are:

- Principle of the least restrictive approach to treatment;
- Recognition of the role of family/carers;
- Sharing of information;
- Treatment and care plans.

The key reforms are:

- Early access to expert assessment;
- Rights of consumers and carers;
- Greater monitoring and accountability;
- Transport arrangements;
- Equity of services for people in country South Australia.

New provisions include:

- Changes to Community Treatment Orders - level 1 no longer than 28 days; level 2 no longer than 12 months (adult), 6 months (child) and made only by the Guardianship Board.

- Changes to Detention and Treatment Orders - level 1 no longer than 7 days; level 2 no longer than 42 days; level 3 no longer than 12 months (adult), 6 months (child) and made only by the Guardianship Board.

- Authorised Officers – mental health clinicians, ambulance officers, RFDS medical officers and flight nurses; and officers prescribed by regulation. These officers can take a person into care and control, transport or arrange transport for the person, restrain the person using reasonable force, restrain by administering a drug (if authorised under the Controlled Substance Act 1984), enter and remain in a place where the person is suspected to be, search the person’s clothing or possessions and seize anything that may cause harm.

- Authorised Health Professionals – able to make a Community Treatment Order (level 1) and a Detention and Treatment Order (level 1). Also able to issue a transport request to transport a person to treatment centre, and arrange an examination of a person by a psychiatrist or authorised medical practitioner.

- Limited Treatment Centres – provide acute care for involuntary patients for up to 7 days when admitted for assessment and treatment.

- Chief Psychiatrist – replaces the Chief Advisor in Psychiatry. The Chief Psychiatrist will have increased powers to safeguard the rights of people accessing mental health services in South Australia, including the power to monitor and review standards of care, and will be responsible for education, training and information strategies.

- Community Visitors Scheme (similar to the Council of Official Visitors in WA) – will provide inspection of premises and consultation with consumers and staff to ensure appropriate treatment and care. Expected to be operational by June 2011.
Legislative Issues

1. Mental Health Commissions

In many international jurisdictions, particularly those with human rights charters, the Chief Psychiatrist and community visitor functions are performed by independent commissions with multidisciplinary expertise, or by lawyers employed for this purpose.

These bodies routinely attend public mental health services to ensure that involuntary patients are being treated appropriately and within the law, and to provide them with rights advice and other support. They are:

- Mental Health Commission, New Zealand - established in 1998 to act as an advocate for individuals with mental illnesses and to monitor the national mental health strategy.
- Mental Health Commission, Ireland - established in 2002 to “promote, encourage and foster the establishment and maintenance of high standards in the delivery of mental health services and to take all reasonable steps to protect the interests of persons detained in approved centres under the Mental Health Act 2001”. It resembles the WA Office of the Chief Psychiatrist in that it publishes codes of practice on issues such as ECT, restraint, admission, transfer and discharge of patients, notifications of death, and incident reporting. It also authorises approved facilities.
- Mental Welfare Commission, Scotland - recently been given new powers under the Scottish Act to:
  - Monitor the operation of the Act and to promote best practice;
  - Carry out visits to patients and to inspect records; and
  - Publish information and guidelines.
- Mental Health Commission, Canada - established in March 2007 and has a strong educative and policy-making agenda.
- Care Quality Commission, England and Wales – on 1 April 2009, the Mental Health Act Commission, which was established in 1983 to advise on policy matters and to review the operation of the Mental Health Act 1983, was subsumed by the Care Quality Commission. The Care Quality Commission is an independent body which is exclusively responsible for the inspection, monitoring and regulation of health and social care in England and Wales.

In New Zealand, the Mental Health Commission employs district inspectors, who are lawyers appointed by New Zealand’s Minister of Health. They have specific statutory functions to advise involuntary patients of their rights, support them in exercising their rights, and receive and investigate complaints of breaches of their rights. Similar to district inspectors in New Zealand, the Care Quality Commission, England and Wales, and the Mental Welfare Commission, Scotland, perform complaints and advocacy functions. They both employ staff from a variety of disciplines, including clinical experts.

The Care Quality Commission also provides an additional safeguard through a death review service. The Commission reviews the deaths of involuntary patients to establish whether good practice, as defined in a code of practice, has been followed and whether improvements can be made to practice or policy.

A fundamental feature of these specialist mental health monitoring bodies is their mandate to proactively visit mental health services on a frequent and unannounced basis to meet with patients. Such visits are focused on informing and assisting patients to exercise their rights.

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23 Mental Health (Compulsory Assessment and Treatment) Act 1992 (NZ), ss 75, 94
24 Other disciplines include social work, nursing, psychologists, lawyers, patients and carers
25 Mental Health Act 1983 (England and Wales), s 121(2)
and on assisting service and system improvement rather than on inspector-type regulatory functions. Specialist mental health monitoring bodies also have powers to conduct investigations and they report publicly on the results of their findings.

The focus of visits is to meet with individual patients in private to hear about their experiences. Medical records and registers of the use of restrictive practices are scrutinised and relevant factors, including environmental, organisational and human rights issues, are assessed to ensure treatment and care complies with legislative requirements. The aim of these visits is to improve the experience for individual patients and to check for patterns that may indicate the need for service improvement or systemic change. A wide range of powers are used to help resolve issues at a local level, investigate unresolved complaints, ensure compliance with legislation and investigate breaches of patients’ rights.

In order to achieve service and systemic improvement, specialist bodies in these jurisdictions publish their findings and recommendations following investigations and visits. In England and Wales, annual reports are produced based on information collated from individual service visits made throughout the year. The reports are service-specific. The purpose of these reports is to provide feedback to mental health services and other interested parties on the key issues that have arisen during visits and whether they have been addressed. Typically, such reports also contain a list of actions required. Publishing service-specific annual reports is one of the many advantages to a commission, as is the ability to perform a range of coordinated functions designed to improve patients’ rights and wellbeing.

2. Role of the Chief Psychiatrist

In New South Wales, the role of the Chief Psychiatrist at the Mental Health and Drug & Alcohol Office is to provide:

- High level advice to the Director of Mental Health and Drug & Alcohol Programs on the mental health needs of the NSW population;
- Professional leadership to NSW mental health clinicians across all areas; and
- Clinical input to policy development and implementation to improve the mental health status of target groups.

To achieve this, the Chief Psychiatrist is involved in:

- The review and analysis of service standards for monitoring outcomes and events and performance of mental health areas;
- Certain statutory responsibilities under the mental health legislative framework; and
- Clinical, teaching and research functions.

In Victoria, the Chief Psychiatrist has responsibility under the *Mental Health Act 1986* for the medical care and welfare of persons receiving treatment or care for a mental illness. The Chief Psychiatrist’s responsibilities include monitoring the clinical standards of psychiatric practice and treatment provided by public mental health services and responding to complaints from consumers, carers and others. The key functions of the Chief Psychiatrist include:

- Receive and review statutory reports relating to seclusion, mechanical restraint, electroconvulsive therapy, annual examinations and reportable deaths;
- Investigations concerning treatment-related issues where the Chief Psychiatrist determines such an investigation is warranted;
- Statewide clinical review of approved mental health services to examine the standard, quality and consistency of clinical practice provided;
- Investigation of complaints from consumers and carers;
- Development of clinical guidelines and circulars concerning application of the Act and establishment and maintenance of practice standards;
- Provisions of high level advice and consultation.

In South Australia, the Chief Psychiatrist has the following functions:
• to promote continuous improvement in the organisation and delivery of mental health services in South Australia;
• to monitor the treatment of voluntary patients and patients to whom detention and treatment orders apply, and the use of mechanical body restraints and seclusion in relation to such patients;
• to monitor the administration of the Act and the standard of psychiatric care provided in South Australia;
• to advise the Minister on issues relating to psychiatry and to report to the Minister any matters of concern relating to the care or treatment of patients;
• any other functions assigned to the Chief Psychiatrist by the Act or any other Act or by the Minister;
• with the approval of the Minister, to issue standards that are to be observed in the care or treatment of patients.

3. Involuntary orders – stages and decision makers

In Western Australia, a psychiatrist makes all the primary decisions regarding involuntary status and treatment of a patient.

Some jurisdictions achieve oversight of involuntary orders by separating the involuntary treatment process into stages. These typically include:

(i) an assessment or initial order – usually made by a clinician;
(ii) a second stage order – usually made by an external body; and
(iii) a third stage order – also usually made by an external body.

There are a range of approaches to the manner in which second and third stage orders are reviewed and made, both in terms of the clinician or body that makes and reviews the orders and whether or not a hearing is required. An external body making a second stage order can ensure that external review occurs as soon as practicable after an assessment or initial order.

The World Health Organisation has suggested that involuntary orders should be automatically externally reviewed within 3 days after they are made and every 6 months thereafter.\(^\text{26}\)

In New South Wales, the second stage involves an external review by a magistrate that must occur as soon as practicable after a person has been examined for involuntary treatment purposes.\(^\text{27}\) The magistrate attends at mental health services to conduct hearings. The third stage in New South Wales involves an inpatient order made by a tribunal that is externally reviewed by the tribunal at least every 3 months for the first 12 months of the order, and six monthly thereafter.\(^\text{28}\) An involuntary order requiring a person’s treatment in the community is reviewed externally every 12 months.\(^\text{29}\)

In South Australia, the second stage order is made by a psychiatrist or authorised medical practitioner.\(^\text{30}\) This must occur not more than 7 days after a person has been assessed as requiring involuntary treatment.\(^\text{31}\) The third stage involves an application to the Guardianship Board not later than 42 days after the second stage order is made.\(^\text{32}\) A third stage order expires, in the case of a child, not later than 6 months after the order is made and, in any other case, not later than 12 months after it is made.\(^\text{33}\)

Victoria and Queensland require periodic reviews within 12 months.

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\(^{26}\) World Health Organisation 1996, Mental health care law: ten basic principles, WHO, Geneva
\(^{27}\) Mental Health Act 2007 (NSW) s 27
\(^{28}\) Mental Health Act 2007 (NSW) ss 37(1)(b)-(c), 38(4)
\(^{29}\) Mental Health Act 2007 (NSW) s 53
\(^{30}\) Mental Health Act 2009 (SA), s 25(1)
\(^{31}\) Mental Health Act 2009 (SA), s 21(1), s 25(1)
\(^{32}\) Mental Health Act 2009 (SA), s 25(6), s 29(1)
\(^{33}\) Mental Health Act 2009 (SA), s 29(5)
The remaining States conduct more frequent periodic reviews. In the Australian Capital Territory, Tasmania and Western Australia, periodic reviews are conducted every 6 months. In the Northern Territory, periodic reviews are conducted every 3 months for involuntary inpatients and every 6 months for involuntary patients in the community.

In Scotland, a clinician makes a 28-day second stage order that can be extended. Third stage orders are generally made by a tribunal for a duration of 6 months in the first year, and 12 months thereafter. Consistent with the duration of the orders, external reviews in Scotland occur every 6 months in the first year and every 12 months thereafter.

In New Zealand, district inspectors may assist involuntary patients to apply for an external review. A district inspector first visits an involuntary patient at the end of a five-day assessment and treatment stage. District inspectors have a statutory duty to talk to involuntary patients to ascertain whether or not an application should be made for an external review.

4. Extended powers of authorised mental health practitioners

In some jurisdictions, authorised mental health practitioners have extended assessment and decision-making powers.

In South Australia, an “authorised health professional” can make a “level 1 community treatment order” and a “level 1 detention and treatment order”.

In Queensland, an “authorised mental health practitioner” can examine, and make a recommendation for assessment, of a person, and, upon a magistrate or justice of the peace making a “justices examination order”, can carry out an examination of a person to decide whether a recommendation for assessment for the person should be made.

In England and Wales, the role of authorised mental health professionals is primarily one of advocacy in the absence of a nearest relative.

5. Consent to treatment and safeguards

Actively involving patients in decisions about their treatment and care recognises the importance of autonomy and independence, including the freedom to make one’s own choices.

In Scotland, unless treatment is urgently required, an involuntary patient is given an opportunity to consent to a wide range of treatments while remaining on an involuntary order. If a clinician considers an involuntary patient is unable or refusing to consent, the clinician must consider the following before providing treatment: the person’s reason for not consenting; the views of the involuntary patient and a nominated person together with any advance statement; and the efficacy of the treatment. Treatment can only be provided if it is in the person’s best interests, and the clinician must record the reasons in writing.

6. Second psychiatric opinion

In Scotland, there are additional safeguards if treatment is to continue beyond 2 months. An involuntary patient who is unable or refusing to consent can only receive medication after 2 months if an independent psychiatrist provides a second opinion that the person is unable to consent, or is refusing consent, and the proposed treatment is in the person’s best interests. The reason for refusal must also be taken into account.

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34 Mental Health Act 2009 (SA), s 10
35 Mental Health Act 2009 (SA), s 21
36 Mental Health Act 2000 (QLD), s 19
37 Mental Health Act 2000 (QLD), s 28
38 Mental Health (Care and Treatment) (Scotland) Act 2003, ss 242(3), 243
39 Mental Health (Care and Treatment) (Scotland) Act 2003, s 242(5)
40 Mental Health (Care and Treatment) (Scotland) Act 2003, s 240(4)
Second psychiatric opinion schemes also exist in New Zealand, and England and Wales. In New Zealand, every patient who is subject to a compulsory treatment order must, during the first month of the currency of the order, accept the treatment prescribed by the responsible clinician. After the first month, the patient is not required to accept any treatment, unless the patient consents in writing to the treatment, or the treatment is considered to be in the interests of the patient by a psychiatrist (not being the responsible clinician) who has been appointed for this purpose by the Review Tribunal.

In England and Wales, certain treatments can only be given if the patient consents or an independent doctor appointed by the Care Quality Commission/Healthcare Inspectorate Wales confirms that treatment should be given.

7. Carers

Recent reviews of mental health laws have identified a lack of participation by and respect for carers as a matter for concern. The Scottish Act requires the views of carers to be taken into account when discharging functions under the Act, unless it is unreasonable and impractical to do so. Under the Scottish scheme, carers also have specific rights to be consulted before an involuntary treatment order is made and when determining a care plan.

In a review of the operation of the Scottish legislation, carers have reported that their needs and rights to be consulted and informed are now being considered far more than under the previous system.

In Western Australia, the Holman Review made a number of recommendations regarding the role of carers, most of which were accepted by the Labor Government and are part of the draft Bill.

8. “Named person” under the Scottish Act

The role and rights of carers in Scotland have been significantly advanced by the “named person” provisions introduced in the Scottish Act. Individuals with mental illnesses can nominate a family member or friend as a named person but, where no appointment has been made, the Act automatically deems the primary carer to be the named person. The role of the named person is particularly important in relation to involuntary treatment orders. Named persons have rights of notification, access to information, consultation, attendance and representation at tribunal hearings and rights of appeal. While named persons must act in the best interests of the individual concerned, they provide an independent and separate voice. They can exercise their powers even if their views differ from that of the patient. Carers, who were named persons, felt this emphasis on independence encouraged them to disclose difficult issues like physical abuse where it was in the patient’s best interest.

9. Access to information and confidentiality

Various approaches to improving carers’ access to information have been adopted by legislatures and can be broadly separated into three categories:

• allowing disclosure;
• mandating disclosure of certain information to carers; and
• highlighting the carer’s right to access information in the guiding principles of the legislation.

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41 Mental Health Act 1983 (England and Wales), s 58; Mental Health (Compulsory Assessment and Treatment) Act 1992 (NZ), s 59(2)(b)
43 Mental Health (Care and Treatment) (Scotland) Act 2003, s 1(3)(b)
44 Mental Health (Care and Treatment) (Scotland) Act 2003, ss 61, 62
45 Mental Health (Care and Treatment) (Scotland) Act 2003, s 251(1)
Allowing disclosure
In certain jurisdictions such as South Australia and Victoria, disclosure of information to carers is allowed where it is required for the patient’s ongoing care. The South Australian legislation requires that the information be provided in an easily understood format, acknowledging that information about involuntary treatment is generally provided in circumstances quite stressful to the carer.

Mandating disclosure
In Scotland, the Mental Health Tribunal and health professionals are required to notify the named person and (less routinely) the primary carer when certain events occur, such as the making of an involuntary treatment order, changes to treatment and tribunal hearings.

Access to information as a general principle
The legislation in Scotland and South Australia also contains guiding principles concerning the provision of information to carers.

The Holman Review made a number of recommendations regarding the provision of information to carers which are included in the draft Bill.

10. Nominated person
Many jurisdictions require a statement of rights to be provided to a member of the patient’s family or carer at certain times. In New South Wales, a patient may decide who receives information, except in specifically defined circumstances. A nomination by a patient must be respected, unless there is a reasonable belief that this may put the person or others at risk of harm, or that the person was incapable of making the nomination. A nominated person could assist an involuntary person to exercise his or her rights to appeal their involuntary order and appear at external review hearings.

11. Advance statements
The Scottish Act provides for the making and withdrawal of an “advance statement”. In making any decision in respect of a patient, the Mental Health Tribunal must have regard to the wishes expressed in the patient’s advance statement. Also, a person giving medical treatment to a patient who has an advance statement must have regard to the statement.

In England, the Mental Capacity Act 2005, allows for anyone who has reached 18 years of age to make an advance decision to refuse specified treatment at a time when he or she lacks capacity to consent to the carrying out or continuation of that treatment.

In Western Australia, the Acts Amendment (Consent to Medical Treatment) Act 2008 amends the Guardianship and Administration Act 1990 to provide for Advance Health Directives, including for people with a mental illness.

12. Refusal or inability to consent
In Victoria, one of the five grounds that must be met before a person can be placed on an involuntary order is that the person “has refused or is unable to consent to necessary treatment for the mental illness.”

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46 See, for example: Mental Health and Related Services Act 1998 (NT), s 87; Mental Health (Care and Treatment) (Scotland) Act 2003, s 260(2)(a)
47 There is a prescribed list of persons that must be given the information: Mental Health Act 2007 (NSW), s 71(1)
48 Mental Health Act 2007 (NSW), s 72
49 Mental Health (Care and Treatment) (Scotland) Act 2003, s 275
50 Mental Health (Care and Treatment) (Scotland) Act 2003, s 276
51 Mental Capacity Act 2005 (UK), s 24
In the Northern Territory and Queensland, a person with capacity can be placed on an involuntary order if they have "unreasonably refused" proposed treatment. Some commentators question whether it is ever appropriate to involuntarily treat a person who has capacity to consent and has refused treatment.

Deciding whether a person has capacity to consent can be difficult, due to a lack of guidance for clinicians as to the basis on which this decision may be made.

In Scotland, the grounds include that a person’s ability to make decisions about treatment is "significantly impaired" by their mental illness. The underlying basis for this ground is that a person with a mental illness may have capacity, yet their ability to make decisions may, at times, be significantly impaired. The other grounds in Scotland are: that the person has a mental disorder; treatment is available and will benefit the person; if treatment is not provided there will be a significant risk to the person or others; and the order is necessary.

Deciding whether a person’s ability to make decisions about treatment is ‘significantly impaired’ may be a clearer test to apply than deciding whether a person has ‘capacity’, because it is less legalistic.

13. Risk to the person or others

In Victoria, for example, another ground for treatment is that "because of the person’s mental illness, involuntary treatment of the person is necessary for his or her health or safety … or for the protection of members of the public”.

In other jurisdictions there are a range of approaches to the seriousness and immediacy of risk required. Some jurisdictions require a likelihood of "serious" or "imminent" or "significant" risk to the person or others. For example, in the Australian Capital Territory, there must be a likelihood of "serious harm" to self or others or "serious" mental or physical deterioration. In the Northern Territory, there must be a likelihood of "imminent harm" to the person or others, or "serious mental or physical deterioration".

In Scotland, the grounds include that there must be a "significant risk" to the person’s health, safety or welfare or to the safety of any other person. There is also a separate ground that requires that treatment is ‘available’ for the person which would be likely to prevent the mental disorder worsening or alleviate any of the symptoms, or effects, of the disorder.

The issue of possible deterioration in health is included as a criterion for a Community Treatment Order under the draft Bill.

14. Clinical guidelines or codes of practice

The World Health Organisation emphasises the importance of clinical guidelines in minimising intrusive treatments such as restraint and seclusion for both involuntary and voluntary patients.

In the United Kingdom, guidance to clinicians on how to interpret and apply the legislation is provided in codes of practice issued by Parliament. Those performing functions under the legislation are required to have regard to the codes. In addition, the Mental Health Act...
Commission, England and Wales (now Care Quality Commission), and the Mental Welfare Commission, Scotland each issued guidelines on clinical practice areas. The Mental Welfare Commission has a specific statutory responsibility to publish guidelines.\(^{62}\)

Detailed guidelines or a code of practice can provide guidance to clinicians, particularly regarding respecting patients' rights.

The Chief Psychiatrists in Victoria and Western Australia provide a suite of guides on a number of issues such as ECT, mental health legislation and alcohol and drug policy.

15. Transport of persons to and from mental health facilities

In New South Wales, ambulance officers, members of staff of the NSW Health Service, police officers and other persons prescribed by regulation are entitled to transport patients to and from mental health facilities.\(^{63}\) These people may use reasonable force in exercising this function and may restrain the person in any way that is reasonably necessary in the circumstances. They may also sedate the person, as well as search the person and seize any object that is dangerous or could assist the person to escape.

The Labor Government accepted a proposal that persons other than police officers should be authorised to restrain, detain and transport people with a mental illness, particularly between hospitals, and this is included in the draft Bill.

\(^{61}\) Mental Health Act 1983 (England and Wales), s 118(2D); Mental Health (Care and Treatment) (Scotland) Act 2003, s 274

\(^{62}\) Mental Health (Care and Treatment) (Scotland) Act 2003, s 10

\(^{63}\) Mental Health Act 2007 (NSW), s 81