Submission No 109

INQUIRY INTO EQUITY, ACCESSIBILITY AND APPROPRIATE DELIVERY OF OUTPATIENT AND COMMUNITY MENTAL HEALTH CARE IN NEW SOUTH WALES

Organisation: Mental Health Review Tribunal

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MENTAL HEALTH REVIEW TRIBUNAL

Legislative Council Portfolio Committee No. 2 – Health

Inquiry into the equity, accessibility and appropriate delivery of outpatient and community mental health care in New South Wales

Mental Health Review Tribunal Submission

Introduction

1. The NSW Mental Health Review Tribunal (the Tribunal) provides this submission to the Legislative Council's Standing Committee - Portfolio Committee No. 2 – Health inquiry into and report on the equity, accessibility and appropriate delivery of outpatient and community mental health care in New South Wales.

The Tribunal's Role

2. The Tribunal is an independent specialist Tribunal constituted under the *Mental Health Act 2007* (MHA). The Tribunal conducts hearings and makes various orders under the MHA and the *Mental Health and Cognitive Impairment Forensic Provisions Act 2020* (MHCIFPA) including for involuntary treatment orders as an inpatient and in the community. The Tribunal is not a service provider. Insights into the workings of the mental health system, including the quality and availability of care and treatment in the community, are gained from the Tribunal's role.

3. The Civil Division of the Tribunal decides whether there is a need for a consumer to be subject to orders for involuntary care and treatment, and decides whether to make Community Treatment Orders (CTOs), in both inpatient and community settings. Last year the Tribunal conducted around 17,500 civil hearings throughout NSW.

4. The Forensic Division of the Tribunal makes decisions about forensic patients and correctional patients – including people who have committed serious criminal offences whilst mentally unwell/unfit to stand trial, as well as correctional patients serving custodial sentences who are unwell. Forensic patients include people who are found 'act proven but not criminally responsible', owing to mental or cognitive impairment. A forensic patient may be detained in a prison, hospital or other place (e.g. locked aged care facility) with or without leave conditions, and may be released to live in the community under conditions set out in a forensic order, or unconditionally. In 2022-2023 the Tribunal conducted 1, 548 forensic reviews.

5. Forensic Community Treatment Orders (FCTOs) enable involuntary mental health care and treatment to be given to persons in custody without transfer to a mental health facility, or are made in anticipation of a correctional patient's release from custody, to transition to ongoing treatment in the community.

6. Tribunal hearings are generally conducted by a three member panel constituted by a lawyer, who chairs the panel, a psychiatrist, and 'another suitably qualified person'. The latter group comprises persons with a range of experience in the mental health sector, allied health staff and/or consumers. Mental health inquiries (the first review by the Civil Division after involuntary detention as an inpatient) may be chaired by a lawyer, sitting alone. Forensic hearings must be chaired by the President or a Deputy President.

7. This submission focuses particularly on Term of Reference (f): the use of Community Treatment Orders (CTOs) under the *Mental Health Act 2007.* While reference is made to Tribunal statistics and other research, the submission draws on Tribunal experiences gained during the many hearings conducted, as well as from frequent interactions with consumer and carer groups, NGOs and service providers.

8. It is important that this submission acknowledge that while the Tribunal engages with consumers who are presented for treatment orders – there are many consumers in the community who will access treatment without the backdrop of a legal treatment order.

Underlying Social/Health Contributors to Treatment Orders

9. The Tribunal emphasises that the following observations are not intended to define or describe a consumer, but are stated to highlight that some consumers suffer disadvantages which should be considered in any review of access to services, and effective delivery of services, including through a CTO. The Tribunal observes that some consumers before the Tribunal are experiencing unstable housing or homelessness, and many consumers will be diagnosed with a major mental illness, such as schizophrenia, schizoaffective disorder, bipolar disorder, personality disorder and major depression. Consumers with a major mental illness may have experienced childhood trauma or other trauma, or a background of significant social disadvantage. Trauma informed practice by service providers is fundamental to improved health outcomes.[1]

Community Treatment, CTOs and Substance Use

10. A significant proportion of consumers presented to the Tribunal for involuntary treatment orders, including CTOs, have substance use dependence. Rehabilitative therapy is crucially important for those with this dual diagnosis to reduce the risk of relapse and rehospitalisation. Indeed, substance misuse will frequently be implicated in involuntary admissions to a mental health facility. This aspect of care may be included in treatment plans, if there is evidence that such treatment is crucial to preventing deterioration. Drug screening conditions such as submitting to urinalysis are sometimes included in treatment plans, however it is less common to have engagement with drug rehabilitation counselling as a condition of a CTO treatment plan. This may be due to a view that such rehabilitation interventions will only be effective if they are consented to and/or engaged with by the consumer.

[1] MHCC *Supporting Implementation of Trauma-Informed Care in Mental Health Services Across NSW, Project Report* June 2022, Executive Summary page 11.

11. Sometimes substance use rehabilitation services and/or drug and alcohol counselling may be undertaken by an agency other than the community mental health care provider, such as a co-located drug and alcohol service, other government service or an NGO. It is accepted that relevant expertise can reside in these other agencies. However, the management of substance abuse disorder which impacts on mental health and/or exacerbation of a serious mental illness is crucial to maintaining wellness and is a mental health treatment need. The Tribunal is strongly of the view that there is a need to develop a co-ordinated approach to treatment of mental health and drug and alcohol-related conditions.

Social Supports Contributing to Successful Community Treatment

12. The Tribunal observes that the benefits of social interaction and community connection cannot be overstated in terms of a consumer's wellbeing and recovery. Consumers who have safe and stable accommodation, and who can access work or study, and who are supported to enjoy activities of interest to them, will often present in Tribunal hearings as having greater resilience, a sense of purpose and optimism for their future and improved satisfaction with their life circumstances.

13. Many consumers are well supported by families and carers, however some consumers present as socially isolated. Access to psychosocial services under the National Disability Insurance Scheme (NDIS) has meant that some consumers are able to enjoy greater community participation. Access to NDIS supports can be reliant on social workers or other clinicians/allied health workers being proactive in assisting consumers to obtain NDIS funding.

14. The Tribunal has observed that success in obtaining NDIS funding packages can occur during an inpatient hospital admission, which may point to a disparity between community resources and those available in hospitals. However, inpatient facilities also report a lack of social workers and other staff. A new service initiated by the Legal Aid Commission's specialist mental health advocacy services, discussed below, seeks to improve advocacy and access to the NDIS.

15. The program 'Pathway to Community', initiated by the Legal Aid NDIS Specialist and the Mental Health Advocacy Service, aims to assist consumers who face barriers to release into the community, or barriers to being able to maintain living in the community due to a lack of NDIS funding. In many cases the NDIS has been key to improving the psychosocial circumstances of consumers. However, navigating the NDIS successfully is challenging, and this program seeks to meet this need.

Relevance of Housing Support to Community Treatment and CTOs

16. It has also been the Tribunal's experience that the Housing and Support Initiative and Community Living Supports (HASI/CLS) has been instrumental in delivering services and accommodation that wraps around the whole person and places them at the centre of decisions regarding their plans and goals. We note that the program has demonstrated clear human and financial benefits. A comprehensive evaluation of the HASI/CLS program in 2022 by the UNSW Social Policy Research Centre (SPRC) found that

consumers receiving HASI /CLS /support were successfully supported to: improve their mental health and wellbeing; think about their physical health; and achieve a greater sense of inclusion within the community. The evaluation also concluded that there was:

- decreased consumer contact with community mental health services by 10% in the first year and 63.7% less if the person remained in the programs for more than one year, and

- reduced mental health hospital admissions by 74% and clinically meaningful improvement in mental health by 74.8% over two years.[2]

The CTT Program – a CTO Innovation in the Transition from Correctional/Forensic Status to Community Treatment

17. A recent model of care developed by the Justice Health and Forensic Mental Health Network (JHFMHN) known as the Community Transitions Team (CTT) has sought to improve outcomes for inmates being released into the community on FCTOs. As noted at paragraph 5 above, FCTOs are made for correctional patients and some forensic patients (detained in prison) who require mental health treatment but who cannot access care in the prison hospital and who do not meet the criteria for an involuntary hospital admission. FCTOs are administered by the JHFMHN. FCTOs are also made in anticipation of a person being released from custody, for example, on bail, parole, or at the end of their sentence. Following release, the FCTO is varied so that it is administered by a community mental health team where the inmate resides, with variations made to the treatment plan to reflect the way in which treatment and services will be provided by the community team.

18. The CTT comprises a multidisciplinary team made up of clinicians, and may include a social worker, a clinical nurse specialist, a clinical lead and an occupational therapist. This team support inmates in the weeks prior to their leaving custody and for four weeks post-release. The CTT coordinates health and social supports, including accommodation and wraparound supports, and regular engagement with community services, such as the NDIS and Housing, as well as advocacy and mental health support.

19. The Tribunal submits that this model of care highlights the benefits of multidisciplinary support of consumers in transition from non-community settings, to community care, and that consideration should be given to whether a transition service should be available to civil patients leaving an inpatient hospital admission on a CTO, as it may lead to better outcomes.

[2] Evaluation of NSW Community-based Mental Health Programs: Community Living Supports and Housing and Accommodation Support Initiative CLS-HASI evaluation report, 2022, Christiane Purcal, Peri O'Shea, Gianfranco Giuntoli, Fredrick Zmudzki, Karen R Fisher at page 5

Use of Community Treatment Orders – What are they and what does the Mental Health Act require?

20. CTOs were conceived as an alternative to involuntary hospital treatment and as a way of reducing 'revolving door' hospital admissions. In NSW they were introduced in the early 1990s and coincided with the period of deinstitutionalisation in NSW and in other Australian jurisdictions.[3]

21. A CTO is an order that obliges a consumer to accept care and treatment set out in a treatment plan. The obligations include: acceptance of 'medication, therapy, counselling, management, rehabilitation, and other services' (ss 54, 56 MHA). The maximum length of an order is 12 months, although an application for a further order may be made. The length of any order is determined by the period of time it takes for the person's condition to stabilise, and/ or to establish or re-establish a therapeutic relationship with the case manager (s 53(7) MHA). These criteria suggest that a purpose of CTOs is to transition consumers to voluntary care.

22. CTOs may be made for civil or forensic/correctional patients, although the majority are made for civil consumers.

23. In most situations the legal criteria for making CTOs requires evidence of: a history of treatment refusal and relapse for a person with a previous diagnosis of mental illness; a likely relapse into an active phase of mental illness or continuing mental illness if no order is made; the care and treatment to be the least restrictive alternative consistent with safe and effective care; a treatment plan capable of implementation.

24. The Supreme Court of NSW has recently stated, per Justice Lindsay, in *T v South Western Sydney Local Health District [2022] NSWSC 1173*, what a CTO is and how it should be conceived. Justice Lindsay stated:

> **WHAT IS A COMMUNITY TREATMENT ORDER?**
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> 5. A community treatment order is defined by section 4(1) of the Mental Health Act 2007 as "a community treatment order under Part 3 of Chapter 3" of the Act. In that Part, by virtue of section 50, a person for whom a community treatment order has been applied for or made is described as an "affected person".
> 6. Chapter 3 of the Act is headed "Involuntary Admission and Treatment In and Outside Facilities". Part 3 of Chapter 3 (comprising sections 50-67) is headed "Involuntary Treatment in the Community".
> 7. Section 51 of the Act provides (with emphasis added) that "[a] community treatment order *authorising the compulsory treatment in the community of a person* may be made by the Tribunal" on the application of specified classes of person, essentially medically qualified.

[3] John Dawson 'Community Treatment Orders and Human Rights' (2008) 26(2) *Law in Context* 148-159.

8. The provisions of the Act governing the making and implementation of a community treatment order must be read against the background of the common law's entrenched concern for the protection of civil liberties, especially in relation to medical treatment. The norm is that a prerequisite to the medical treatment of an individual is a need for the individual's consent to that treatment: *Rogers v Whitake*r (1992) 175 CLR 479 at 489.
9. Forced medical treatment is exceptional; but, subject to procedural safeguards, permissible when justified by necessities recognised by the law: *Harry v Mental Health Review Tribunal* (1994) 33 NSWLR 315 at 323E, 332G-333F and 334B-335D.
10. It is because of the intrusive effect of a community treatment order on the civil liberties of an affected person that Parliament has laid down conditions for the making of such an order: *Z v Mental Health Review Tribunal* [2015] NSWCA 373 at [35].

25. CTOs are enforceable treatment orders which may result in the consumer facing breach actions/proceedings for failing to adhere to the conditions where there is also a risk of significant deterioration in their physical or mental health. A consumer may be taken to a mental health facility and given treatment in accordance with the treatment plan.

26. In addition to the legal criteria for CTOs, the MHA 'Objects of Act' (s 3, MHA) and 'The Principles for Care and Treatment' (s 68, MHA) are relevant considerations in Tribunal decisions as to whether to make a CTO as well as in the development of treatment plans. They apply to all who have functions under the Act, including all service providers, as well as the Tribunal.

27. The Objects of the Act (s 3) are set out in full in the MHA and include facilitation of the care and treatment through community care facilities; and the provision of hospital care on a voluntary basis where appropriate and, in a limited number of situations, on an involuntary basis. The Objects refer to protection of the civil rights, and an opportunity to have access to appropriate care and treatment. It is important to observe that the Objects of the Act state that the involvement of those persons, and persons caring for them, in decisions involving appropriate care and treatment is to be facilitated.

28. The Principles for Care and Treatment (the s 68 Principles) are detailed and should be referred to carefully (there are a number of Principles set out in s68(a) – (j) MHA). The Principles are relevant to any consideration, or review, of the provision of mental health care/treatment/service delivery. The Principles should also be followed in delivery of services or treatment under a CTO. In general terms, the s 68 Principles promote recovery, and the engagement of service providers with consumers and carers. All the Principles in s68(a) to (j) are of importance and include:

- people with a mental illness or mental disorder should:
  - receive the best possible care and treatment in the least restrictive

environment enabling the care and treatment to be effectively given;
- should be provided with timely and high quality treatment and care in accordance with professionally accepted standards.

- care and treatment are to be designed to assist subject persons to live, work and participate in the community,

- medications are to be prescribed to meet a patient's therapeutic and diagnostic needs only and not for convenience or punishment,

- people with a mental illness/disorder are to be given appropriate information about treatment, alternative treatments and the effects of treatment,

- there be recognition of the religious, cultural, linguistic, age, gender and other special needs,

- the cultural and spiritual beliefs and practices of people with a mental illness or mental disorder who are Aboriginal persons or Torres Strait Islanders should be recognised; and

- every effort that is reasonably practicable should be made:
  - to involve persons with a mental illness or mental disorder in the development of treatment plans and recovery plans and to consider their views and expressed wishes in that development; and
  - to obtain the consent of people with a mental illness or mental disorder when developing treatment plans and recovery plans for their care, (and/or to monitor their capacity to consent and to support people who lack that capacity to understand treatment plans and recovery plans).

Use of CTOs and Community Treatment – General Observations

29. The Tribunal submits that treatment in the community should aim to be a collaboration between the service provider and the consumer. It should encompass the consumer's views and be delivered voluntarily wherever possible, consistently with the Objects of the MHA and s 68 Principles referred to above.

30. The Tribunal is, because of its legal decision making function, necessarily involved with involuntary treatment of consumers in hospitals and the community. We also see successful transitions to voluntary community based care. The availability of resources generally, and community based services, are ongoing issues impacting on the availability and continuity of community based care. How this may intersect with the use of CTOs in delivery of community based care is an area requiring research.

31. The number of CTO applications to the Tribunal has continued to increase since 1990. The increase over time is likely multifactorial. It is not an uncommon statement in Tribunal hearings by clinicians, consumers or carers, that CTOs help to guarantee services in an

environment where service availability varies. In addition, the relationship between availability of inpatient beds and the use of CTOs in not known. The Tribunal is aware that the Mental Health Commission is currently exploring issues relating to CTOs and perhaps further information will come from the Commission's work.

32. An area of concern to consumers is the use of CTOs in determining the mode of medication administration and this is discussed below.

Use of CTOs in Medication Administration

33. Many consumers object in Tribunal hearings to the condition in a treatment plan that medication be administered by depot medication rather than orally. Medication by depot injection is a guarantee that medication is delivered, and is often a condition to address concerns for non-compliance with oral medication and risk of deterioration/relapse. Many consumers report that they experience the administration of the depot injection as distressing and interfering with their autonomy and independence. However other consumers report a preference for depot injections, which can be administered less frequently, as those consumers find this a more convenient form of medication. It is the Tribunal's submission that the way a consumer prefers to receive medication should be respected and engaged with.

34. We note that the MHA, in the s 68 Principles, provides that medication should not be for the convenience of the service. We note the recent decision of the Supreme Court, referred to above, is relevant on this point: *T v Southwestern Sydney Local Health District* [2022] NSWSC 1173.

35. The case involved an objection to depot medication and a preference for oral medication. The facts of the individual case were determinative, and the Court decided for various reasons that the legislative basis for the CTO was not met on the evidence. However, the Supreme Court noted:

> 166. In my opinion, in the particular circumstances of the present case, a regime of oral medication for the plaintiff is appropriate and reasonably available to her, consistent with safe and effective care, and of a kind less restrictive than a regime of depot injections.
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> 167. In so far as the defendant lacks the ability, or will, to administer the current treatment plan in a way that accommodates the plaintiff's reasonable desire to engage in employment, it is not, in my opinion, an appropriate plan. It might, from the perspective of the defendant, be administratively convenient and a means of minimising risks of aberrant behaviour on the part of the plaintiff, but care needs to be taken not to elevate the defendant's administrative convenience beyond the reasonable; and a risk of relapse must be managed, not used as justification for coercive control of the plaintiff.
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> 168. In making these observations I should not be taken to be unmindful of the

important work undertaken by the defendant or the difficulties inherent in treating a mentally ill person and facilitating management of his or her affairs. On the contrary, the defendant is to be commended for the work it has done in treatment of the plaintiff, and in assisting her to come to a better understanding of her mental health and of a constant need for vigilance in dealing with mental illness. My impression is that the plaintiff has benefitted, particularly, from engagement with, and the encouragement of, the defendant's caseworkers who have maintained home visits and telephone contact.

169. What is presently an impediment in the plaintiff's ongoing treatment appears to be an institutional resistance on the part of the defendant to working with the plaintiff to enable her "to live, work and participate in the community" (to quote section 68(c) of the Mental Health Act) without unnecessary "interference with her rights, dignity and self-respect" (to quote section 68(f) of the Act). Paraphrasing section 68(d) of the Act, care needs to be taken not to impose on the plaintiff a treatment plan governed more by the administrative convenience of service providers than the individual needs of the plaintiff.

170. I commend to the parties the possibility that by working together, on a voluntary basis, they might devise a programme in which the plaintiff can retain medical professionals of her choice and nevertheless receive, from time to time, the encouragement and support of the defendant's caseworkers. Small empathetic acts, combined with a weather eye for potential problems, might prove more effective than formal, clinical appointments with battle lines drawn.

171. Independently of any question of compulsion by law, a regime of "regular supervision" (of oral medication), similar to that proposed by Brereton J in *S v South Eastern Sydney & Illawarra Area Health Service and Anor* [2010] NSWSC 178 at [38], extracted above, might not be far removed from what is "appropriate" in the circumstances of the present case.

36. The Tribunal submits that the Supreme Court was highlighting the need for the CTO treatment plan to be formulated having regard to consumer's individual treatment needs.

37. There have been many hearings where the Tribunal is presented with evidence that the CTO has provided benefits to consumers, who but for the order may have relapsed and required inpatient treatment. Without a large qualitative and quantitative study, it is unknown whether such successes are due to an increased level of services offered to the consumer or to a multitude of factors. What is clear is that each case is different and successful treatment is based on an individualised program and engagement.

In Closing

38. The Tribunal sees examples of excellence in the provision of community based care and treatment. The dedication of health workers, and mental health clinicians, is recognised and respected. However, the Tribunal remains concerned by the evidence presented in hearings which indicates that community based services may not be adequately resourced to fully meet treatment needs. The Tribunal would support community based mental health services being resourced at a level which can provide care that promotes sustained recovery, meaningful community integration, and the capacity to live the life that consumers would choose for themselves. Resource provision should allow individualised recovery and treatment planning as part of community treatment.

39. We thank the Committee for the opportunity to make submissions to this inquiry.

Yours faithfully

President | Mental Health Review Tribunal

11 September 2023