Submission

Mental Health Bill 2011: Exposure Draft

September 2011

beyondblue
PO Box 6100
HAWTHORN WEST VIC 3122

Tel: (03) 9810 6100
Fax: (03) 9810 6111
www.beyondblue.org.au

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beyondblue, the national depression and anxiety initiative, is pleased to present this submission to the Department of Health and Human Services on the *Mental Health Bill 2011: Exposure Draft.* In making this submission, *beyondblue* has focussed on the **high prevalence mental health disorders of depression and anxiety**, the impact on consumers and carers, and areas that are most relevant to our work and research findings.

beyondblue is a national, independent, not-for-profit organisation working to address issues associated with depression, anxiety and related disorders in Australia. Established in 2000, initially by the Commonwealth and Victorian Governments, *beyondblue* is a bipartisan initiative of the Australian, State and Territory Governments, with the key goals of raising community awareness about depression and anxiety and reducing stigma associated with the illnesses. *beyondblue* works in partnership with health services, schools, workplaces, universities, media and community organisations, as well as people living with depression and anxiety, to bring together their expertise. Our **five priorities** are:

1. Increasing community awareness of depression, anxiety and related disorders and addressing associated stigma.
2. Providing people living with depression and anxiety and their carers with information on these illnesses and effective treatment options and promoting their needs and experiences with policy makers and healthcare service providers.
3. Developing depression and anxiety prevention and early intervention programs.
4. Improving training and support for GPs and other healthcare professionals on depression and anxiety.
5. Initiating and supporting depression and anxiety-related research.

Specific population groups that *beyondblue* targets include young people, Indigenous peoples, people from culturally and linguistically diverse backgrounds, people living in rural areas, and older people.

Prevalence and impact of depression and anxiety disorders

Depression, anxiety and substance use conditions are the most prevalent mental health disorders in Australia.[i] One in three Australians will experience depression and/or anxiety at some point in their lifetime and approximately 20 per cent of all Australians will have experienced depression, anxiety or a substance use disorder in the last year.[ii] People experiencing depression and/or anxiety disorders are also more likely to have a comorbid chronic physical illness.[iii]

Mental illness is the leading cause of non-fatal disability in Australia, and it is important to note that depression and anxiety accounts for over half of this burden.[iv] Globally, the World Health Organisation predicts depression to become the **leading cause of burden of disease by the year 2030**, surpassing ischaemic heart disease.[v]

Mental illness costs the community in many different ways. There are social and service costs in terms of time and productivity lost to disability or death, and the stresses that mental illnesses place upon the people experiencing mental illness, their carers and the community generally. There are financial costs to the economy which results from the loss of productivity brought on by the illness, as well as expenditure by governments, health funds, and individuals associated with mental health care. These costs are not just to the health sector but include direct and indirect costs on other portfolio areas, for example welfare and disability support costs. **It is estimated that depression in the workforce costs the Australian society $12.6 billion over one year, with the majority of these costs related to lost productivity and job turnover**.[vi] The individual financial costs are of course not exclusively borne by those with mental illness. It is often their carers who experience financial hardship due to lost earnings, as well as increased living and medical expenses.[vii] It is also important to recognise the differences in mental and physical disabilities, and the impact on workforce participation. In 2003 **28.3 per cent of people with a mental illness participated in the labour force, compared to 48.3 per cent of people with a physical disability**.[viii]

beyondblue's response to the *Mental Health Bill 2011: Exposure Draft*

Part 4: Involuntary patients

The proposed legislation regarding involuntary patients supports important safeguards to protect the rights of people with depression and anxiety. However the following improvements are needed:

- Seeking informed consent – the Exposure Draft suggests that when it is 'futile or inappropriate' to attempt to obtain a patient's consent, an Assessment Order may be affirmed. Additional guidelines may be needed to explain and support the process of obtaining consumer consent, to ensure that patient rights are protected and promoted through the legislation.
- Supported decision making - while the legislation suggests that decision making capacity is to be presumed (Clauses 8 – 9), additional mechanisms are needed to ensure that this approach is adopted. Features such as advanced statements could be included in the legislation. These statements would include information about consumer preferences, and would be referred to during times when the consumer is unable to consent or make informed decisions about treatment.

Recommendations

1. Integrate guidelines on informed consent into the Mental Health Bill, and consider how these can be implemented and supported in practice.
2. Develop additional mechanisms to facilitate supported decision making, such as advanced statements.

Part 6: Special Psychiatric Treatment

The inclusion of additional safeguards for 'special psychiatric treatment' is an important component of ensuring that patients receive appropriate treatment. Additional guidelines and definitions are needed on the scope of this treatment, to ensure that it is implemented as planned. This should include information on the inclusion or exclusion of Electroconvulsive Therapy (ECT), and specific considerations and safeguards for minors. While the *Clinical Practice Guidelines: Depression in Adolescents and Young Adults* recommend considering ECT in rare cases, such as severe depression with psychotic features where other approaches have not been successful, there are risks associated with having a general anaesthetic and common side-effects of ECT are confusion and memory problems. The World Health Organisation[ix] and the American Academy of Child and Adolescent Psychiatry[x] prohibit ECT for minors without their consent. The Mental Health Bill should not permit the administration of ECT to persons aged 13 to 17 years without their informed consent, unless this treatment option is included in an advanced statement.

Recommendations

3. Include information on ECT in the legislation on 'special psychiatric treatment'.
4. Prohibit ECT for minors without their informed consent, unless this treatment option is included in an advanced statement.

Part 7: Information

The proposed approach of providing information to 'interested persons' regarding a patient's admission, transfer or discharge to or from an approved hospital or secure mental health unit may potentially impact patient privacy. While supporting carers to be involved in a consumer's mental health care and treatment is important, default nomination mechanisms, such as that being suggested, may result in information being provided to individuals without the consent of the consumer.

The 'nominated person scheme' that has been proposed in the Victorian *Exposure Draft Mental Health Bill 2010* provides an alternative approach to improve information sharing with a person's carer, and promote their involvement in treatment and management decisions. The proposed Victorian scheme will enable a consumer to nominate an individual or individuals who may be provided with relevant information relating to their health. This will protect patient privacy, while also actively supporting carer participation in healthcare decisions. This scheme could also be supported through the implementation of advanced statements, which would identify who can be provided with information on the patient's treatment, and in what circumstances.

Recommendation

5. Implement a 'nominated person scheme' to guide information sharing.

Part 8 and Schedule 5: Official Visitors

The Official Visitor role and function provides a mechanism to make complaints regarding treatment and care. Additional regulations and safeguards are needed to support an adequate and timely complaints management process. Standards on the complaints handling process (for example, the timeframe to process a complaint, expected outcomes and how to review a decision) need to be developed and integrated into the legislation. This will ensure that the mental health system is adequately resourced to implement the complaints handling process and monitor compliance.

While the Official Visitor role will play a part in ensuring that patient rights are being upheld, the legislation should be strengthened by incorporating the role of advocates. Advocates play an important role in promoting the wellbeing and rights of a consumer and helping to facilitate access to appropriate and effective care. Providing all consumers with the ability to access an advocate, through the legislation, will improve the legislation and promote consumer rights.

Recommendations

6. Integrate standards and processes for complaint management in the Mental Health Bill.
7. Adopt and support a consumer advocate program within the Bill.

Part 10 and Schedules 3 and 4: Mental Health Tribunal and Tribunal Membership and Proceedings

The Mental Health Tribunal provides a mechanism to ensure that Assessment and Treatment Orders are appropriate, and are in line with the best interests of the consumer. The automatic review process that will occur by the Tribunal at 30 and 90 days will help to ensure that treatment and care is regularly assessed and in accordance with best practice approaches. Given the role and importance of the Mental Health Tribunal in making clinical decisions, it is crucial that the members of the Tribunal include health professionals with the appropriate expertise to make clinical assessments regarding treatment, and consider how treatment decisions may impact on quality of life and functioning. The membership of the Tribunal should also be flexible, to ensure that the skills and expertise of health professionals matches the needs of the consumer – for example, including specialists in child development and child / adolescent psychiatry on the Tribunal when considering the assessment and treatment of young people under 16 years of age.

It is also important that there is an independent body that is able to conduct reviews of decisions made by the Tribunal. This will help to ensure that the decision making and review process is open and transparent, and consumer complaints about assessment and treatment decisions can be independently assessed. There may be a conflict of interest in the proposed legislation, in which Tribunal members are responsible for both making decisions regarding treatment, and reviewing these decisions.

Recommendations

8. Ensure that the membership of the Mental Health Tribunal includes appropriately qualified and skilled health professionals, which matches the needs of the consumer.
9. Establish an independent body to monitor decisions made by the Tribunal.
10. Enable all consumers to have their case reviewed by the Tribunal on an as needs basis.

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[i] Australian Bureau of Statistics (2008). *2007 National Survey of Mental Health and Wellbeing: Summary of Results (4326.0)*. Canberra: ABS.
[ii] Australian Bureau of Statistics (2008). *2007 National Survey of Mental Health and Wellbeing: Summary of Results (4326.0)*. Canberra: ABS.
[iii] Clarke, D.M. & Currie, K.C. (2009). 'Depression, anxiety and their relationship with chronic diseases: a review of the epidemiology, risk and treatment evidence'. *MJA Supplement, 190*, S54 - S60.
[iv] Begg, S., et al. (2007). *The burden of disease and injury in Australia 2003*. Canberra: AIHW.
[v] World Health Organization (2008). *Global Burden of Disease 2004*. Switzerland: World Health Organization
[vi] LaMontagne, AD., Sanderson, K. & Cocker, F. (2010). *Estimating the economic benefits of eliminating job strain as a risk factor for depression: summary report.* Melbourne: Victorian Health Promotion Foundation (VicHealth).
[vii] Cummins, R.A., et al. (2007). *Australian Unity Wellbeing Index, Survey 16.1, Special Report*, in *The Wellbeing of Australians - Carer Health and Wellbeing*. Victoria: Deakin University.
[viii] Australian Government (2009). *National Mental Health and Disability Employment Strategy*. Accessed online 29 April 2011: http://www.workplace.gov.au/NR/rdonlyres/6AA4D8AD-B1A6-4EAD-9FD5-BFFFEBF77BBF/0/NHMDES_paper.pdf
[ix] World Health Organisation (2005). *Resource Book on Mental Health, Human Rights and Legislation*. Accessed 21 February 2011 http://www.who.int/mental_health/policy/resource_book_MHLeg.pdf
[x] American Academy of Child and Adolescent Psychiatry (2002). *Summary of the practice parameters for use of electroconvulsive therapy with adolescents*. Accessed 21 February 2011 http://www.aacap.org/cs/root/member_information/practice_information/practice_parameters/summaries/summary_of_the_practice_parameter_for_use_of_electroconvulsive_therapy_with_adolescents