



Submission

Exposure Draft Mental Health Bill 2010

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beyondblue: opening our eyes to depression throughout Australia

Exposure Draft Mental Health Bill 2010

beyondblue: the national depression initiative

beyondblue is pleased to have the opportunity to present this submission to the Department of Health on the *Exposure Draft Mental Health Bill 2010*. In making this submission, *beyondblue* has focussed on the **high prevalence mental disorders of depression and anxiety**, the impact on consumers and carers and we have responded on 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 reducing stigma associated with the illness. *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 the illness and effective treatment options and promoting their needs and experiences with policy makers and healthcare service providers.
3. Developing depression prevention and early intervention programs.
4. Improving training and support for GPs and other healthcare professionals on depression.
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 Australia¹. 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 year². People experiencing depression and/or anxiety are also more likely to have a comorbid chronic physical illness³.

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 burden⁴. Globally, the World Health Organization predicts depression to become the **leading cause of burden of disease by the year 2030**, surpassing ischaemic heart disease⁵.

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 undiagnosed depression in the workplace costs \$4.3 billion in lost productivity each year⁶. 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 expenses⁷.

beyondblue's response to the Exposure Draft Mental Health Bill 2010

Providing best practice mental health care

Treatment orders

The Exposure Draft Mental Health Bill 2010 allows for the provision of compulsory Treatment Orders for 28 days (Inpatient Treatment Orders) and 3 months (Community Treatment Orders). These Orders can be issued without a second psychiatric opinion and without review by an independent body. While the Bill does require a second psychiatric opinion after treatment has been provided to involuntary patients for three months, this opinion can be disregarded.

The United Nations Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care⁸ and the World Health Organisation⁹ require that the assessment and treatment of involuntary patients includes:

- Two independent medical practitioners examining the patient separately and independently conducting an assessment. If there is a discrepancy between the assessments a third independent practitioner must examine the person and make a recommendation. The majority recommendation should then be implemented.
- The review of the involuntary admission being for a short period, pending review of the admission or retention by a review body.
- A treatment plan being developed by a mental health practitioner, and being reviewed and agreed upon by a second independent practitioner and a review body. The second practitioner should agree on the plan prior to implementation, and the independent review body should assess the plan as soon as possible.

The Exposure Bill's proposed process to assess and treat involuntary patients is not in accordance with these best practice principles. The proposed Bill allows patients to be subject to a Treatment Order without independent reviews, which will pose risks to the patient being inappropriately assessed and diagnosed, and receiving unsuitable and ineffective care.

The New South Wales *Mental Health Act 2007* provides an example of an Australian jurisdiction that requires an examination by a second medical practitioner 'as soon as possible' after the initial assessment¹⁰. The Victorian Bill should utilise this model, together with the principles and

processes outlined by the United Nations and the World Health Organisation, to ensure that people with a mental illness receive best practice care.

The Exposure Bill's Treatment Order process does not provide people with a mental illness recognition and equality before the law – a key intention of the Bill. People experiencing a physical illness are not subject to involuntary treatment without independent assessments and reviews. People experiencing an episode of mental illness are therefore being treated differentially under the Bill. The Fourth National Mental Health Plan¹¹ and the National Standards for Mental Health Services¹² require that health services treat patients with respect and dignity. These principles are not being upheld in the Exposure Bill, and the fundamental freedoms and basic rights of people with a mental illness are being denied.

Recommendation

1. Amend the Bill to implement the best practice principles for assessing and treating people with a mental illness, as outlined by the United Nations and World Health Organisation. This should include:
 - a. Two independent medical practitioners examining an involuntary patient separately and independently conducting an assessment. If there is a discrepancy between the assessments a third independent practitioner must examine the person and make a recommendation. The majority recommendation should then be implemented.
 - b. A review body assessing the involuntary admission as soon as possible.
 - c. Treatment Plans being agreed upon by a second independent medical practitioner and a review body. The review should take place as soon as possible.

Consumer advocates

The National Standards for Mental Health Services include mental health consumers having the right to access advocacy and support services¹³. Advocacy promotes the human rights of people with a mental illness and leads to reduced stigma and discrimination¹⁴. In instances where patients can not actively participate in their treatment and care plan, it is appropriate that an advocate or carer be involved and consulted in relation to a patient's needs, wishes and treatment. Where a patient does not have any person able or willing to act as their carer / advocate, the Mental Health Bill should enable the provision of an independent advocate. While the introduction of Review Officers will ensure that patients receive information on their rights, and procedural checks are undertaken, patients require an independent advocate to ensure that their treatment and care is appropriate to their circumstances and their rights are being upheld.

Recommendation

2. Update the Bill to recommend that all patients have access to independent advocates.

Clinical Practice Guidelines

In March 2011 *beyondblue* is releasing Clinical Practice Guidelines approved by the National Health and Medical Research Council - *Clinical Practice Guidelines: Depression in Adolescents and Young Adults* and *Clinical Practice Guidelines for Depression and Related Disorders* —

Anxiety, Bipolar Disease and Puerperal Psychosis — in the Perinatal Period. These Guidelines are based on the systematic identification and synthesis of the best available scientific evidence. As outlined in the Guidelines, special considerations are required in the assessment and treatment of young people, pregnant women and new mothers. These Guidelines, together with the National Standards for Mental Health Services and the United Nations Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care, promote the principle of ‘least restrictive’ treatment, as this ensures the rights and choices of consumers are considered and respected.

The Mental Health Bill should be updated to incorporate the assessment and treatment models outlined in the Clinical Practice Guidelines, and the integration of the least restrictive care principle across the Bill.

Recommendation

3. Integrate the least restrictive care principle and the assessment and treatment models included in the Clinical Practice Guidelines into the Mental Health Bill.

Electroconvulsive therapy (ECT) for minors

The Exposure Bill enables the provision of ECT for persons aged 13 to 17 years. 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 Organisation¹⁵ and the American Academy of Child and Adolescent Psychiatry¹⁶ prohibit ECT for minors without their consent. As alternative, effective treatments are available, the Mental Health Bill should not allow ECT in persons aged 13 to 17 years without their consent.

Recommendation

4. Amend the Bill to prohibit the provision of ECT to minors without their consent.

Caring for mothers

Special considerations are required for the treatment of mental illness in mothers. The National Inquiry into the Human Rights of People with Mental Illness¹⁷ reported that mental health services were not routinely inquiring about dependent children when interviewing or admitting patients with a mental illness. The needs of children of mentally ill parents were therefore being ignored, and children were not receiving appropriate support services. This has profound and long term impacts on the children.

It is critical that, in accordance with the United Nations Convention on the Rights of the Child, the best interests of the child are a primary consideration in delivering mental health care to parents¹⁸. Identifying a women’s role as a mother on admission to care, and developing and implementing a family-unit assessment and intervention service, is important to protect and promote the wellbeing of mothers and their children. Family-focused services, which integrate

mental health care and child and family care, is an essential component of providing best practice care for mothers and their children¹⁹.

Research suggests that a fear of child protection services removing a mother's children is a barrier to seeking psychiatric care^{20 21}. It is important that mothers receive information about how their mental illness may impact their children, and the roles and expectations of child protection agencies, to ensure that the mothers and children both receive the most appropriate care and support for their needs. Children who may be separated from their parent(s) maintain the right to direct contact with their parent(s) on a regular basis²². It is important that mothers are aware of their rights and obligations in seeking treatment, and that these are supported by the mental health services and the Mental Health Bill.

Recommendation

5. Incorporate special considerations for mothers in the Mental Health Bill. These should include:
 - a. Routine identification of the parental role on admission to mental health services.
 - b. Integrated psychiatric and mother-infant services in family-friends spaces.
 - c. The provision of clear guidelines to mothers about the roles and expectations of child protection agencies.

Implementation of the Bill

It is important that the introduction of the Bill is accompanied by a comprehensive communication strategy. Consumers and carers should be provided with information on the legislative changes; their rights and responsibilities under the Bill; and the timeframe for implementation. This should be complemented with information and resources for service providers on the implications of the Bill, and changes to service models and processes.

Recommendation

6. Develop and implement a *Mental Health Bill* communication strategy.

Conclusion

beyondblue welcomes the community consultation on the Exposure Draft Mental Health Bill. The Bill requires a number of amendments if it is to fulfil the stated charter of protecting the dignity and rights of people with a mental illness. These include:

- amending the assessment and treatment processes and timeframes
- enabling access to consumer advocates
- integrating the 'least restrictive care' principle and the Clinical Practice Guidelines assessment and treatment models
- prohibiting ECT to involuntary minors
- introducing special considerations for mothers
- developing a communication strategy.

These amendments will ensure that the Bill is delivering best practice care to people with a mental illness, and is upholding the principles of the Protection of Persons with Mental Illness and the Improvement of Mental Health Care²³; the 4th National Mental Health Plan²⁴; and the National Standards for Mental Health Services²⁵. These principles are not being upheld in the Exposure Bill, and the fundamental freedoms and basic rights of people with a mental illness are being denied. *beyondblue* looks forward to reviewing a revised Bill which protects and promotes the needs and rights of mental health consumers and carers.

¹ Australian Bureau of Statistics (2008). *2007 National Survey of Mental Health and Wellbeing: Summary of Results (4326.0)*. Canberra: ABS.

² Australian Bureau of Statistics (2008). *2007 National Survey of Mental Health and Wellbeing: Summary of Results (4326.0)*. Canberra: ABS.

³ 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.

⁴ Begg, S., et al. (2007). *The burden of disease and injury in Australia 2003*. Canberra: AIHW.

⁵ World Health Organization (2008). *Global Burden of Disease 2004*. Switzerland: World Health Organization

⁶ Hilton, M. (2004). *Assessing the financial return on investment of good management strategies and the WORC Project*. Brisbane: The University of Queensland.

⁷ 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.

⁸ United Nations (1991). *Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care*. Accessed 21 February 2011 <http://www.un.org/documents/ga/res/46/a46r119.htm>

⁹ 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

¹⁰ New South Wales Government (2007). *Mental Health Act 2007, No 8, Chapter 3*. Accessed 21 February 2011 www.legislation.nsw.gov.au

¹¹ Australian Government (2009). *Fourth National Mental Health Plan – An agenda for collaborative government action in mental health 2009 – 2014*. Accessed 21 February 2011 [http://www.health.gov.au/internet/main/publishing.nsf/content/360EB322114EC906CA2576700014A817/\\$File/plan09v2.pdf](http://www.health.gov.au/internet/main/publishing.nsf/content/360EB322114EC906CA2576700014A817/$File/plan09v2.pdf)

¹² Australian Government (2010). *National Standards for Mental Health Services*. Canberra: Australian Government

¹³ Australian Government (2010). *National Standards for Mental Health Services*. Canberra: Australian Government

¹⁴ World Health Organisation (2003). *Advocacy for Mental Health*. Accessed 21 February 2011 http://www.who.int/mental_health/resources/en/Advocacy.pdf

¹⁵ 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

¹⁶ 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

¹⁷ Human Rights and Equal Opportunity Commission (1993). *Report of the National Inquiry into the Human right of People with mental illness: findings and recommendations*. Accessed 21 February 2011 http://www.hreoc.gov.au/disability_rights/inquiries/mii.htm

¹⁸ United Nations (1989). *Convention on the Rights of the Child*. Accessed 21 February 2011 <http://www2.ohchr.org/english/law/crc.htm>

¹⁹ Australian Infant Child Adolescent and Family Mental Health Association (2004). *Principles and Actions for Services and People Working With Children of Parents with a Mental Illness*. Stepney: Australian Infant Child Adolescent and Family Mental Health Association.

²⁰ Lagan, M, Knights, K, Barton, J & Boyce, P.M. (2009). 'Advocacy for mothers with psychiatric illness: a clinical perspective' *International Journal of Mental Health Nursing*, 18, 53 - 61.

²¹ World Health Organisation, *Gender Disparities in Mental Health*. Switzerland: World Health Organization.

²² United Nations (1989). *Convention on the Rights of the Child*. Accessed 21 February 2011 <http://www2.ohchr.org/english/law/crc.htm>

²³ United Nations (1991). *Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care*. Accessed 21 February 2011 <http://www.un.org/documents/ga/res/46/a46r119.htm>

²⁴ Australian Government (2009). *Fourth National Mental Health Plan – An agenda for collaborative government action in mental health 2009 – 2014*. Accessed 21 February 2011 [http://www.health.gov.au/internet/main/publishing.nsf/content/360EB322114EC906CA2576700014A817/\\$File/plan09v2.pdf](http://www.health.gov.au/internet/main/publishing.nsf/content/360EB322114EC906CA2576700014A817/$File/plan09v2.pdf)

²⁵ Australian Government (2010). *National Standards for Mental Health Services*. Canberra: Australian Government