

Mental Health Carers NSW Inc.

# Response to the Open Justice Review

**Court and tribunal information: access, disclosure and  
publication**

03 08-2021



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## Introduction

Mental Health Carers NSW (MHCN) is the peak body for carers of people who experience mental illness in NSW. It is a community-based, non-government organisation that provides systemic advocacy, capacity development and education for the carers, family and friends of those experiencing mental illness across NSW. There are currently 2.7 million unpaid carers in Australia, 39% of whom provide more than 40 hours of care per week<sup>1</sup>. Due to the demands of their full-time caring role, carers are at a high risk for developing mental health issues. We work to ensure the voices of mental health carers in NSW are represented and heard in policy and service reform processes to ensure they are recognised and their rights upheld. We endeavour to empower mental health carers across the state to become champions for mental health reform and advocacy.

MHCN supports families and carers of people experiencing mental illness, including forensic patients in a range of ways. MHCN collaborates with Way Ahead's provision of the Carer Helpline, a local service referral telephone Helpline which receives and responds to calls from the families and carers of people experiencing mental health issues, including Forensic patients who are seeking support and advice about treatment and support options for their loved ones. MHCN further supports the families and carers of Forensic patients subject to the Forensic Division of the Mental Health Review Tribunal (MHRT) through the Family and Carer Mental Health Program ('FCMHP') especially that section lead by Erika Ballance of the NSW Justice Health & Forensic Mental Health Network. It does this by supporting and participating in the annual family and carer networking events, and its collaboration in the development of a Forensic Carer Mental Health Network. MHCN also supports families and carers of people subject to the Civil Division of the MHRT through the general FCMHP delivered by Community Managed Organisations (CMO's) contracted by NSW Health across all Local Health Districts (LHDs) in NSW.

Thank you for the opportunity to comment on the [Open Justice Review](#). In our response, MHCN will address (1) opportunistic media coverage of Forensic patients, families and carers; and (2) confidentiality of forensic carers and families providing statements at the MHRT.

## Executive Summary

This document provides MHCN's views on the need to protect Forensic patients, and their carers and family members within the context of media coverage. In addition, this document conveys MHCN's perspective on maintaining confidentiality of disclosures by carers and family members in the processes of the MHRT itself. MHCN agrees that it is timely to consider the current arrangements sanctioning access by the media to criminal proceedings and court reports. MHCN does recognise that the media has an important role in facilitating open justice through providing members of the public with fair and accurate

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<sup>1</sup> Barrett, C & Cramer, P (2015). *An Extra Degree of Difficulty*, La Trobe University.

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reports of court proceedings. However, the truth must be presented fairly and not just a distorting and stigmatising fraction of it for the entertainment of the public.

MHCN believes that a significantly greater protection of identify and confidentiality is needed for Forensic patients, and their carers and family members, when Forensic patients are subject to criminal prosecution and the Forensic Division of the MHRT; and also for the statements of carers given to the MHRT generally. This specifically includes disclosures of carer evidence to the Forensic patient or the consumer of mental health services (commonly known as ‘consumers’ generally in the mental health sector), subject to the Civil Division of the MHRT, (although this might still be disclosed to their *advocates*). Both of these positions are driven by the overriding need to protect the safety of consumers and carers and to promote the recovery of the consumers subject to the Tribunal’s jurisdiction.

MHCN recently hosted an online event on June 28, 2021 for families and carers of Forensic patients, in collaboration with Justice Health & Forensic Mental Health Network Family and Carer Mental Health Program, with senior Tribunal staff and other related services presenting (see appendix for the program agenda). Approximately 25 people attended the event which culminated in a vibrant discussion forum with forensic carers and family members, service providers and researchers about carers experience and ambitions for reform. Themes generated in discussions with families and carers indicated that privacy and confidentiality is a significant concern for them, and their loved ones; the Forensic patients themselves.

Specifically, they strenuously object to opportunistic media coverage that focuses on Forensic patients as fodder for sensationalist reporting, which highlights the tragic outcomes of their disordered behaviour without fair context, frequently publishing their identity and addresses or places of custody, as well as those of their families and carers. This ‘pollutes’ the public discourse with stigma and fear and effectively increases the ignorance and prejudice of the public, rather than enlightening people as to the true plight of those experiencing mental illness. This undermines the promotion of fair treatment for all those experiencing mental health issues and prejudices recovery from mental illness. It is stigmatising and psychologically distressing for Forensic patients and their friends and family members. It can severely damage the mental health of Forensic patients, as well as increasing suicidality and mental illness among their families and carers. This is far from a just or therapeutic approach to those who should be considered to be vulnerable and less culpable for their wrongdoing due to their experience of mental illness which precipitated it.

Carers and family members are also concerned about protecting confidentiality within the context of providing evidence at the MHRT. Frank disclosures by carers and family members on occasion have the potential to damage their relationship with their loved ones. They may also impact upon their safety (either the consumer’s or the carer’s or both) if statements are disclosed to loved ones in the course of proceedings. This is especially so if they are not heeded and that person is discharged from care prematurely. This will often mean they return to the residences of families or carers who may have been expressing concern about the consumer’s mental state or the threats to their own safety such a state might pose in the context of discharge or discontinuation of treatment orders. If they are to have a role in

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the ongoing support of a loved one it is crucial that harmonious relationship be nurtured between Forensic patients and their family members and carers. The safety of families and carers should be given the same priority as victims of Forensic patient's disordered behaviour, in order to prevent them too from becoming victims of poorly managed mental illness and inadequately accessible or resourced mental health services.

## **1. Opportunistic media coverage of Forensic patients, families and carers**

Media has a powerful impact on the attitudes and perceptions of the public in relation to mental health and people experiencing mental health disorders (Reavley et al. 2016). Opportunistic media reporting that focuses on people experiencing mental health disorders in the context of dangerousness exacerbates stigmatisation of mental health generally and Forensic patients in particular. Furthermore, sensational headline grabbing stories cause pain and re-traumatisation to Forensic patients, carers and families. This exacerbates illness and prejudices recovery, which must be seen as a threat to public safety. This is because Forensic patients and their families and carers are members of the public with human rights which are directly harmed by these cruel and unjust practices, up to and including suicidality by family members who have been responsible for no criminal or otherwise disordered behaviour at all. If a person has demonstrated that they might harm others when acutely symptomatic from their mental illness, behaviour which has the potential to exacerbate their illness, such as traumatisation by foot-in-the-door journalists seeking interviews or footage; or sensationalist reporting and victimisation in published materials by the press obviously increases risks to them and to the public at large as well.

### ***Impact of the media on carers and family members***

Discussions held by MHCN with Forensic carers and family members demonstrate that media reporting has serious negative impacts on the health and wellbeing of Forensic patients, Forensic carers and other family members. Our discussions highlighted that some Forensic carers have been forced to move interstate because of intrusive media reporting. However, even then the media has continued to report on these carers and family members in an invasive manner. One of the carer advocates highlighted how distressing it is that Forensic patients do not have a right to privacy, and that the media continues to focus on certain Forensic patients many decades after they have committed the crime. In this way, Forensic carers and family members are retraumatised through media coverage that focuses on stigmatising stories of people with mental health in a context of violence and dangerousness (see Reavley et al. 2016).

Our discussions with health professionals working day to day with Forensic carers also highlighted the need to support Forensic carers and family members impacted by the media. For example, Erika Ballance, Family & Carer Consultant from Justice Health & Forensic Mental Health Network, described her first-hand knowledge of the impacts that opportunistic media reporting has had on a number of people's everyday lives, both carers and the person attempting to make a recovery from serious mental illness. This was in spite

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of the fact that they (or their loved ones) had been judged not criminally responsible for whatever acts they might have committed.

Carers and family members also become retraumatised and consequently experience further isolation and worsening mental health. Findings from our discussions are not new and have been canvassed extensively in literature on mental health carers. For example, studies highlight that mental health carers from all different backgrounds experience high levels of anxiety and depression (Broady and Stone 2015) as well as social isolation, psychological distress and diminished quality of life (Hayes et al. 2015; Poon et al. 2015). Our discussions with Forensic carers and family members contextualises the way in which this particularly stigmatised group of carers is impacted by media opportunism, and the need to address these issues through combatting sensationalist media reporting and providing greater supports.

Due to inadequate service provision many carers play a vital role in supporting Forensic patients in their rehabilitation and recovery, and their attempts to live in the community (Eagle et al. 2020). Yet Forensic patients and Forensic carers are provided a bare minimum of protection and support. Indeed, our discussions with families and carers highlighted that many are struggling alone with their issues and without even sufficient psychosocial support services to address the predicament in which their loved one's mental health condition has placed them through no fault of their own. For instance, one carer pointed out that even without being the direct victim of assault and violent behaviour by the Forensic patient, (a common experience for Forensic carers whose loved one's receive inadequate support from our public mental health system, which is also a common experience), family members suffer trauma and also require support to deal just with witnessing the impacts of their loved one's mental ill health and disordered behaviour. One Forensic carer stated:

*I was a family and carer representative. I did work with forensic patients and carers for quite some time. They have the same question as I have. Where do they go? I know some who have tried to go to Victims Support group but we don't fit in that category. It's something that is missing. We shouldn't have to be dealing with this after all these years of pain and suffering.*

Yet, assistance through Victims Support Services does not automatically recognise the collateral trauma suffered by this group, and therefore forms of assistance available to other 'victims' of mental illness is not assured.

### ***Opportunistic media coverage destabilises recovery of Forensic patients***

Crucially, sensationalist media reporting also destabilises the capacity of Forensic patients to create meaningful lives once they are released, which also impacts recovery and their carers and family members. Mental health facilities that Forensic patients may eventually access often do offer a high standard of care. But this process can easily take three or four years and there are limited beds in mental health hospitals, leaving many to remain in correctional facilities and without sufficient access to much needed interventions for much longer than is clinically appropriate. However, as stated by Anina Johnson, the Deputy President of the MHRT in her presentation to the Forensic Carer Event, once Forensic

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patients are able to receive the services, e.g. regular psychiatric follow-up, high quality nursing staff and allied staff, different types of therapists and so on, a high success rate is achieved for rehabilitation.

It is a serious failing of our system that this care is not universally available to people *before* they commit hideous acts for which they are then found not responsible due to their experience of mental illness. Yet this is a story which we heard repeatedly from Forensic carers about their loved ones and is backed by research (Eagle et al. 2020). Many had been unable to access adequate care *for years* in spite of the family's resolute advocacy to services for it to be provided. Many had been denied support shortly before committing the act which caused them to enter the forensic system. *Worthwhile* media coverage might focus on this aspect of our system and oblige its remedy, but too often instead it concentrates on 'othering' and victimising the perpetrator of the disordered acts, even though they too are plainly victims of a grossly inadequate mental health system. The stigma such reporting fosters allows chronic under provision of services to be perpetuated. Furthermore, there is a significant waiting list for access to the forensic hospital even once in custody and authorities are well aware that many with mental illness in our custodial system need mental health services and are not being provided with them, to the enormous cost of them and our community.

Should they succeed in receiving treatment Forensic patients often do reattain mental health and wellbeing and experience a life that does not bring them into contact with the criminal justice system again, or cause them to commit more crimes against other members of the community, to the enduring benefit of all. Yet mental health is fragile for all people always and for people with past experience of mental illness especially. There is a need to ensure that hard fought gains, often requiring significant community investment in service provision and careful long-term and sustained support, are not destabilised through sensationalist media reporting for the enrichment of a few.

The need to protect the privacy of Forensic patients is undertaken successfully in many places across the globe, including the United Kingdom. There it is achieved through the application of the UK Dept of Health's *Confidentiality: NHS Code of Practice* (UK Department of Health 2003). Under the Code of Practice disclosures by employees require consent by Forensic patients. Furthermore, contractors and employees must let employees know that failure to adhere to the Code of Practice may result in disciplinary action (UK Department of Health 2003). MHCN believes strongly in implementing a similar Code of Practice in Australia to that in the UK protecting the confidentiality of Forensic patients.

However, MHCN also thinks this should be taken further. In New South Wales the *Anti-Discrimination Act (NSW) 1977* specifically covers discrimination against people experiencing illness or disability, and carers. However, in this legislation, the rules against *vilification* are set out separately with regard to different types of discrimination, for example racial vilification, homosexual or transgender vilification, and no principles are generally applicable. No 'anti-vilification' provisions for example apply to sex discrimination or disability discrimination.

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Where there are anti-vilification provisions, they prohibit speech likely to stir up hatred and discrimination against a vulnerable population. For example, racial vilification is prohibited under section 20C.:

*(1) It is unlawful for a person, by a public act, to incite hatred towards, serious contempt for, or severe ridicule of, a person or group of persons on the ground of the race of the person or members of the group."*

Discrimination against people experiencing a disability or illness is already allegedly banned under this legislation but no anti-vilification protections are afforded, especially not to those experiencing mental illness. Therefore, this legislation does nothing to prevent these most egregious examples of abusive media practices which stir up stigma, hatred and fear of people who commit crimes when not responsible for their actions by reason of mental illness. There is no requirement on reporting to responsibly place such behaviour in a proper context of illness (and often service denial). This reporting of partial facts distorts the public's awareness of the true situation and amounts to hate speech, stirring up hatred and discrimination against a highly vulnerable population.

Nothing in these laws is available to protect the identity of these vulnerable people or their families and carers either. Yet this would be far from an innovation in our laws. The legal system already routinely suppresses the name of children in both family law and abuse cases, (or even the names of perpetrators for fear of disclosing children's identities), because the children are innocent and vulnerable and lacking full legal capacity. By the same principles the legal system should be open to extending the same protections to Forensic patients and their families and carers. As discussed, Forensic patients experience mental health illness of such debilitating impact that they have been judged not criminally responsible. They are therefore innocent and vulnerable. Similarly, carers and family members are even more innocent and often just as vulnerable and should be protected to the same extent.

Antidiscrimination laws should simply ban outright the disclosure of names and personal details of people subject to the proceedings of the MHRT and harassment of Forensic patients and Forensic carers by journalists or at least give the Tribunal itself and other courts the power to do so. This is necessary to protect the human rights of these people to the best possible chance of recovery and good health, and so secure the public interest. This is a humane and necessary act to advance community safety and harmony in Australia, and would be an important step to address widespread stigma against people who experience mental illness and their families and carers.

## **2. Confidentiality of Forensic carers and family members providing statements at the MHRT**

Carers and family members provide important information at MHRT hearings. In her presentation at MHCN's Forensic Carer Event, MHRT Deputy President, Anina Johnson, stated that observations from family members are both helpful and useful in assisting both

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clinicians and the MHRT in understanding the nature of the mental condition the person is experiencing and in enabling provision of appropriate and sustained support.

Families and carers are specifically empowered under the *Mental Health Act (NSW) 2007*, ('MHA') to provide their views and observations to clinicians and others assessing their loved one's condition. Families and carers are also allowed to attend hearings of the MHRT and to provide evidence and statements to its proceedings. However, many carers and family members are also concerned about protecting confidentiality within the context of their statements and evidence provided to the MHRT.

Disclosures by carers and family members have the potential to damage their relationship with their loved ones when they are honest but not consistent with the ambitions of their loved one for early discharge or discontinuation of involuntary treatment (typically medication) under a Community Treatment Order. Yet, it is carers and family members who play a critical role in supporting the recovery of Forensic and civil patients and as previously mentioned are often obliged to provide accommodation for their loved one due to the lamentably inadequate provision of social or public housing and related supports for people experiencing even serious and persistent mental illness, (the so-called 'missing middle' or specifically the 'missing middle to deep end' of the Australian mental health system).

Therefore, it is important that a harmonious relationship be nurtured between Forensic patients or patients subject to the orders of the (far larger) civil division of the MHRT that deals with involuntary care in non-forensic hospitals and psychiatric facilities or in the community across the state, and their family members and carers. It is important even when the family or carers do not live with the person, as people with experience of mental illness often have low levels of engagement with people outside of their family and social isolation is not only common but a significant risk to mental health and deterioration or exacerbation of symptoms in its own right.

Further too this, while it is well understood that people who experience mental illness are in general *less* violent than the social 'milieu' from which they originate or inhabit, the important exception to this for some is when they are not receiving adequate recognition of, or support or assistance with, their mental ill health. Research is showing increasingly that domestic violence can sometimes be the result of this kind of unrecognised and unsupported mental illness of various kinds, from personality disorder, to Post Traumatic Stress to anxiety or depression exacerbated by substance misuse disorders. This underlines the horrific community cost of inadequate provision of mental health services to all who need them.

As can be imagined some people experiencing these conditions do come before the MHRT and in theory their carer and families are able to provide evidence to the MHRT about their views of their loved one's condition, including whether they are ready for discharge or constitute a threat to their physical safety. This could occur simply because a person did not like the side effects of their medication and unwittingly becomes aggressive when they don't take it, or because the medication simply isn't effective, either of which could result in cases of potential or actual domestic abuse. It would obviously be highly dangerous to either disclose such carer concerns to the consumer in some circumstances or to refuse to



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consider it when determining if someone should be discharged or medicated, especially if they are then discharged back to cohabitation with those carers or family members.

However, in response to inquiry by MHCN the Tribunal provided the following advice regarding the provision of evidence to the MHRT proceedings by carers and family members (see appendix 2 for full text) (email communication, M. Bisogni 28 04 2021).

*“4....However, the Tribunal cannot generally accept confidential evidence. Unless the carer is happy for the substance of their written submission to be disclosed to the consumer, the Tribunal will say that it cannot consider the information. It is usual for carers to withdraw it.*

*5. The reasons for this cautious approach to confidential evidence is that that the rules of procedural fairness apply to Tribunal hearings. This means that a consumer is entitled to know the evidence before the Tribunal and be given a fair opportunity to respond. Also, as part an accountable and transparent process there is a legitimate public interest in decisions being made in an open forum. However, exceptionally, the tribunal can hear from parties in the absence of the consumer and it can wholly or partly restrict the evidence given to the parties. Before the tribunal could do any of these things it would need to be satisfied that there were compelling reasons for confidential evidence or that it was for the clear ‘welfare’ of the consumer.”*

While MHCN fully supports the principles of natural justice explained, it is not satisfied with the current processes of the MHRT around these issues. In the first place, clinicians routinely receive information from families and carers to assist with making assessments under the Mental Health Act (NSW) 2007 (‘MHA’). Authority for the proposition that carers information must always be considered by clinicians in making a clinical assessment, is provided in the MHA as amended in 2014 in section 72B: *Requirement to consider information provided by other persons about patients or detained persons when making detention or discharge decisions:*

*“An authorised medical officer or other medical practitioner or accredited person who examines an involuntary patient or person detained in a mental health facility for the purposes of determining whether the person is a mentally ill person or a mentally disordered person or whether to discharge the patient or person is to consider any information provided by the following persons, if it is reasonably practicable to do so—*

*(a) any designated carer, principal care provider, relative or friend of the patient or person,*

*(b) any medical practitioner or other health professional who has treated the patient or person in relation to a relevant matter,*

*(c) any person who brought the patient or person to the mental health facility.”*

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There is no requirement that ‘equal time’ be provided to the consumer to rebut these statements, and nor should there be. It is expected that the clinicians will consider these statements, but also speak with the consumer and tactfully explore issues raised, exercising due caution and ‘clinical judgement’ when considering them in the course of their deliberation about the nature of the mental health issue that their patient is experiencing. These deliberations will form the basis of the medical evidence provided to the MHRT. If the clinician accepts tainted evidence, so their evidence will be tainted, but it is reasonable to be satisfied to rely upon expert clinical judgement to manage this possibility.

Secondly, the MHRT is NOT an adversarial process, where each ‘side’ brings conflicting evidence to allow a judgement between them. It is an *inquisitorial* process meant to allow a rational weighing of evidence to determine a matter (the least restrictive care available to the consumer) by a decision maker (the MHRT) with an investigative role, and in so doing has its own rights and prerogatives to weigh, seek and consider evidence, just as a clinician does. If it hears evidence from a carer, it is fully at liberty to examine the consumer or the clinicians concerned about issues raised to satisfy itself. In most cases it could canvass issues without the need to blatantly disclose the source of all the evidence provided by carers or the identity of who exactly raised an issue (or even to suggest that any party did; it could just be satisfying itself as to key issues in order to make a judgement).

Finally, while MHCN would absolutely support the MHRT satisfying itself as to ‘compelling reasons to hear confidential evidence’, MHCN notes that there is no formal process about which it can inform carers to allow them to initiate the MHRT’s consideration of reasons to hear confidential evidence, so it can determine if they are sufficiently compelling). For example, there is no form to fill out, no pleading to enter, and no question to pose to the Tribunal in session to initiate the MHRT’s inquiry into such evidence at the instance of the carer or family member or other interested party.

As a result, too often, information vital to the carer’s safety, and often that of the consumer, (such as whether the consumer is sufficiently recovered for discharge or whether there are safety concerns for the carer) is simply left out of MHRT deliberations with predictable consequences in too many cases for the safety and welfare of either or both parties. Sometimes the carers let them return to their residence at the peril of the consumer of carer or both, or sometimes they simply refuse to let the person ‘come home’ and they are discharged into homelessness or Boarding houses or other unappealing housing options which they may not be prepared to remain in. In both cases, confidential evidence would allow issues to be better addressed and offer hope of a more positive and productive outcome.

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## Recommendations

MHCN's recommendation to this Justice System Review are:

1. A Code of Confidentiality binding upon the staff of public institutions in NSW prohibit the publication of the identity of Forensic patients and their families and carers.
2. The Anti-Discrimination Act be amended to include vilification of people who experience mental illness and their families and carers, and that this be extended to include prohibitions on the publication of the identity of Forensic patients and their addresses, places of incarceration or residence or release and those of their families and carers.
3. Courts be empowered to make orders protecting the identify of Forensic patients and their families and carers in the same way as they are able to protect the identity of children in legal matters.
4. The MHRT be obliged to develop a practise direction to establish an ethical and transparent process for both forensic and civil divisions to allow families and carers to provide confidential statements to their proceedings, which may be subject to clinical review and disclosed to Forensic patient's or consumer's *advocates*, but which may be withheld from Forensic patients or consumers *themselves* at the order of the MHRT when it is deemed necessary to preserve the relationship or safety of the families and carers making the statement (or others), while preserving natural justice and the integrity of the MHRT process.

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## Appendix A

### Networking Event for Families and Carers

**Monday 28<sup>th</sup> June 2021**

**Join us for a day of discussion and networking tailored specially for families and carers of forensic and correctional patients hosted by MHCN and the NSW Family and Carer Mental Health Program (FCMHP).**

*This event will be recorded – if you do not wish to be seen in any footage, please let us know when you register for the event*

10.00 – 10.05	Acknowledgement of country, introduction and housekeeping by Jonathan Harms
10.05 - 10.15	Meditation, Justice Health & Forensic Mental Health Network
10.15 – 10.45	<b>The Tribunal and the Mental Health Forensic Provisions &amp; Confidentiality in Forensic and Corrections– What can Families and Carers expect?</b> Anina Johnson, Dept President MHRT
<b>10.45 – 11.00</b>	<b>SHORT BREAK</b>
11.00 – 11.20	<b>Victims Support Scheme and Specialist Victims Support Service</b> Kha Huynh & Michelle Boom, Victims Services
11.20 – 11.30	<b>Clinical Risk Assessment Management (CRAM) for Carers.</b> Lyn Anderson, Carer Peer Worker , North Sydney
11.30 – 12.00	<b>Panel Discussion with our speakers:</b> Anina Johnson, Kha Huynh, Michelle Boom and Lyn Anderson
<b>12.00 - 1.00</b>	<b>LUNCH BREAK</b>
1.00 – 2.45	<b>Families and Carers Discussions –</b> <i>1. What extra information and resources do carers need?</i> <i>2. What changes would carers like to see in mental health and forensic laws and services?</i> <i>3. How could MHCN support more forensic &amp; correctional carers?</i>
2.45 – 3.00	<b>Carer Event Debrief –</b> Erika Ballance Justice Health & Forensic Mental Health Network

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## Appendix B

### Full Text MHRT Advice to MHCN on MHRT Proceedings 28 04 2021

1. It is the Tribunal's role in a hearing to gather all the relevant evidence to inform its decisions. Carers can play an important role in providing information to the tribunal that go to issues of least restriction, effectiveness of treatment and safety. For example, carers may be able to comment on the progress of their loved one and assist in supporting leave from a facility in preparation for discharge. They may provide collateral information, especially if a consumer has just had a first episode of ill health or involuntary treatment. Carers may provide insights into the consumer's needs and preferences; what does or does not aid recovery; or what is required to sustain it. Carers often have a very good idea of where the gaps in service provision lie.
2. Of course, there are tensions in this exercise. Often there will be cases strong and conflicting opinions as to the evidence and what order should be made. Often the insights offered by carers are not welcomed by your loved one or the treating team. Sometimes this leads carers deciding not to participate in hearings for fear of damaging their relationship with a consumer.
3. Unfortunately, some clinicians do not appreciate that Tribunal hearings are open to the public and it is the Tribunal's call as to whether a carer or any other person should be excluded. Care providers have an obligation to notify carers, in a timely way that would allow them to attend.
4. If attendance at a hearing is likely to cause tension, it is important to bear in mind that the Tribunal can be flexible about how it might involve carers in hearings. Carers can attend in person or by telephone. The Tribunal can also accept a written submission. However, the Tribunal cannot generally accept confidential evidence. Unless the carer is happy for the substance of their written submission to be disclosed to the consumer, the Tribunal will say that it cannot consider the information. It is usual for carers to withdraw it.
5. The reasons for this cautious approach to confidential evidence is that the rules of procedural fairness apply to Tribunal hearings. This means that a consumer is entitled to know the evidence before the Tribunal and be given a fair opportunity to respond. Also as part of an accountable and transparent process there is a legitimate public interest in decisions being made in an open forum. However, exceptionally, the tribunal can hear from parties in the absence of the consumer and it can wholly or partly restrict the evidence given to the parties. Before the tribunal could do any of these things it would need to be satisfied that there were compelling reasons for confidential evidence or that it was for the clear 'welfare' of the consumer.

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6. Of course it is preferable that such procedural orders are sorted before a hearing. A single member of the tribunal can make orders about whether to close the hearing or restrict the evidence before the hearing day. It also happens that such orders are made in the middle of a hearing.
  7. Facilitating the early participation of consumers and carers in treatment decisions may lead to more collaborative decision making. When this has occurred it is very obvious at a hearing. Having a good understanding of treatment and care plans also means that if there is any difference of opinion between carers and consumers it will be often noted in a report to the Tribunal. If a carer considers that their participation in a hearing is likely to be fraught they can make an informed decision not to attend and make that known to the treating team who will often pass that information onto the Tribunal.
  8. It has been well recognized that consumer and carer participation results in better health outcomes for consumers and are an integral part of recovery-oriented mental health practice. It is clear that unless a carer is validly excluded from receiving information by a consumer that their participation in a consumer's journey should occur at the earliest opportunity. Moreover, treating teams should seek to work with carers and consumers, and be open to their perspectives on mental health care more generally.

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