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Submission: Australian Law Reform Commission - Issues paper 44 Equality, Capacity and Disability in Commonwealth Laws

The Mental Health Coordinating Council (MHCC) is the peak body representing mental health community managed organisations (CMOs)¹ in NSW. Our members provide a range of psychosocial and clinical services, and support programs, as well as advocacy, education, training and information services with a focus on recovery-oriented practice. MHCC's membership consists of over 200 organisations whose business or activity is wholly or in part related to the promotion and/or delivery of services for the wellbeing and recovery of people affected by mental health conditions. We work in partnership with both State and Commonwealth Governments to promote recovery and social inclusion for people affected by mental health conditions, participate extensively in policy and sector development and facilitate linkages between government, community and private sectors in order to affect systemic change. MHCC manages and conducts research projects and develops collaborative projects on behalf of the sector. MHCC is also a registered training organisation (MHCC Learning & Development) delivering nationally accredited mental health training and professional development to the community managed workforce across all human services.

MHCC is a founding member of Community Mental Health Australia (CMHA) the alliance of all eight State and territory community sector mental health (MH) peak bodies. Together we represent more than 800 CMOs delivering mental health services nationally.

MHCC alert the ALRC that in this submission we refer to people with 'psychosocial disability' as 'consumers'. Consumers are people with lived experience of mental health conditions and may experience for example: co-existing difficulties including physical health problems, coexisting substance misuse, cognitive and intellectual disabilities.

MHCC do not address all the questions listed in the Issues Paper, as they may have limited experience concerning some issues. Therefore questions answered are sequential but some questions have been omitted.

¹ Also known as NGOs (non-government organisations).

Questions

United Nations Convention on the Rights of Persons with Disabilities

Question 1

Australia has an Interpretative Declaration in relation to Article 12 of the United Nations Convention on the Rights of Persons with Disabilities. What impact does this have in Australia on?

(a) provision for supported or substitute decision-making arrangements; and

Supported decision-making is quite loosely defined and articulated in the scant literature, but is referred to in the United Nations Convention on the Rights of Persons with Disabilities 2006 (UNCPD) in Article 12 (3) on Equal Recognition before the Law, as providing that the: 'states parties shall take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity'.

Australia has ratified the UNCRPD and as such is bound to uphold the Articles in the Convention. MHCC recommend the inclusion of supported decision-making in an amended *NSW Mental Health Act 2007* (MHA) as well as amending the *NSW Guardianship Act 1987* and the *NSW Disability Services Act 1993* (DSA) and that all legislation align with Commonwealth legislation. This will then go some way towards meeting the international movement towards embedding the rights of persons with disabilities in both state and national law.

Supported decision-making provides an alternative to guardianship or other people taking on decision-making roles. Decision-making should be supported, not substituted. In supported decision-making, consumers are actively helped to identify their values, goals and choices even at times when this is particularly difficult.

Supported decision-making is an important part of service and care coordination. A basic premise of this approach is that autonomy does not need to be replaced with substitute decision-making, but can exist alongside it. People must be assisted to identify and express their choices even when capacity is in doubt, rather than excluding them from the decision-making process.

Supported decision-making can take many forms. Those assisting a person may communicate the individual's intentions to others or help him/her understand the choices available. They may help others to realise that a person with significant disabilities is also a person with a history, interests and aims in life, and is someone capable of exercising his/her legal capacity. While some good models of supported decision-making exist there is no clear policy framework; and guardianship laws and practice still dominate.

MHCC recommend principles informed by those outlined in Victorian paper: Office of the Public Advocate, 2009.ⁱ Supported decision-making: Background Paper, 7.2, p. 20 and the United Kingdom, *Mental Capacity Act 2005*,ⁱⁱ which while similar, includes additional Principles 3 and 5 which we recommend be included in Commonwealth law:

1. The interests of the person with a disability are paramount in supported decision-making arrangements.
2. Every adult has the right to make his or her own decisions and must be assumed to have capacity unless proved otherwise.
3. A person must be given all practicable help before treated as lacking the capacity to make their own decisions.
4. Support and assistance with decision-making should be available to any person with a disability.
5. Any supported decision-making arrangement must have the consent of the person and their supporters.
6. The person with a disability may terminate the arrangement at any time and a supporter may withdraw from the arrangement at any time.
7. Decisions made under supported decision-making arrangements cannot override the will of the person with a disability.
8. If a decision made by an individual is considered unwise, the person should not be assumed as lacking decision-making capacity.
9. Any action or any decision made on behalf of a person who lacks capacity, must be in their best interests.
10. Any action or any decision made on behalf of a person who lacks capacity should ensure the least restrictive of their basic rights and freedoms.
11. Any action or any decision made on behalf of a person must be decision specific.

b) the recognition of people with disability before the law and their ability to exercise legal capacity?

The UNCRPD sets out: “the rights for people with disability to recognition before the law, to legal capacity and to access to justice on an equal basis with others, and a general principle of respect for inherent dignity, individual autonomy, including freedom to make one’s own choices, and independence of persons,” and in the context of the NDIA, the Australian Governments’ commitment to the National Disability Strategy, includes ‘rights protection, justice and legislation’ as a priority area for action. Therefore MHCC propose that these international instruments must be incorporated into domestic law by statute, and that state laws must align with that statute.

Additionally other international instruments as mentioned in the Issues paper IP44, including: the Universal Declaration of Human Rights, UN Doc A/810 (1948); International Covenant on Civil and Political Rights (1976); International Covenant on Economic, Social and Cultural Rights, (1976); Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, (1987) (CAT); Convention on the Elimination of All Forms of Discrimination against Women, (1981); Convention on the Rights of the Child, (1990) and the Declaration on the Rights of Indigenous Peoples, (2007). These conventions enshrine a variety of inalienable rights and protection and particularly suggest that restrictive practices in respect to people with disability might contravene the CAT.

MHCC therefore propose that it is important to establish national consistency and that the objective of the *National Disability Insurance Scheme Act 2013* that enactment give effect to a number of international conventions in order that Australia can appropriately meet its obligations.

As part of this exercise it is necessary to establish a nationally consistent approach to defining capacity and assessing a person's ability to exercise their legal capacity including uniformity across Commonwealth, state and territory laws. Currently definitions vary across states and a set of principles must be established to apply across a range of areas and contexts.

National Disability Strategy 2010–2020

Question 2

What changes, if any, should be made to the National Disability Strategy 2010–2020 to ensure equal recognition of people with disability before the law and their ability to exercise legal capacity?

The National Disability Strategy 2010–2020,ⁱⁱⁱ identifies twelve areas for future action in relation to rights, protection, justice and legislation. MHCC strongly support these identified areas because people with psychosocial disability are over-represented in the justice system whether as complainants, litigants, defendants, or victims.

Whilst Australian governments fund some legal services specifically for people with disability and Australian courts have begun to introduce some disability access schemes,^{iv} people with mental health conditions often experience difficulty in participating in the legal system and characteristically encounter significant barriers, with many finding access to justice too difficult, intimidating or inadequate. As a result, consumers are often left without legal redress.^v

Access to justice often relies on access to legal representation, and consumers on disability support pensions or those living in poverty because they are unable to meet their living costs possibly due to difficulties in securing employment that can accommodate their needs, cannot afford to pay for legal services, or risk engaging in a process that may result in them bearing the cost if unsuccessful.^{vi}

“Underfunding of public legal services has resulted in a significant tightening of eligibility criteria. As a result, legal representation is primarily available only to the very poor and generally only in criminal matters” (PWD, 2013).^{vii} MHCC therefore strongly urge that the Commonwealth support increased access to legal advocacy to protect the rights of people with disability.

Framing principles

Question 3

The ALRC has identified as framing principles: dignity; equality; autonomy; inclusion and participation; and accountability. Are there other key principles that should inform the ALRC's work in this area?

Whilst the framing principles identify that people with disability should be able to exercise their autonomy and participate fully in all aspects of life, there needs to be clearer statement that within these principles exists a right to be assisted in the exercise of self-determination as described by the WHO in their ten basic principles of mental health care law, (World Health Organization).^{viii} It must also be assistance and support that is free from coercion.

A uniform approach to legal capacity?

Question 4

Should there be a Commonwealth or nationally consistent approach to defining capacity and assessing a person's ability to exercise their legal capacity? If so, what is the most appropriate mechanism and what are the key elements?

The issues paper clearly identifies that "in Australia, there is no uniform standard for capacity. Each area of the law has developed a standard of capacity generally relevant to the transaction in question. For example, in some contexts the relevant standard is that the person be of 'sound mind, memory and understanding' in others there is a need to understand the nature and significance of the particular transaction or activity" (item 92).

MHCC propose that that the ALRC need to consider the issues that arise in relation to people under state mental health laws. Historically mental health laws all over the world use a risk of harm criteria as the basis for involuntary treatment. The *NSW Mental Health Act 2007* (NSW MHA) currently permits treatment of persons living with mental illness if it is considered by two doctors to be necessary to prevent serious harm to the person or to others (s14). Victoria and Tasmania have exposure mental health bills before parliament that have shifted towards a position whereby mentally ill people who retain legal capacity to make medical decisions should be able to refuse medical treatment if they do not wish it, regardless of perceived risk of harm without that treatment. This would give persons with mental illness the same rights as all patients in general medical matters - and is reflected in legislation in Scotland, the *Mental Health (Care and Treatment) (Scotland) Act 2003*, and in proposed new legislation in Tasmania, Victoria and India (*Mental Health Care Bill, 2011*). These instruments more appropriately reflect human rights obligations under the UN Convention on the Rights of Persons with Disabilities.

Provision for advance directives about treatment could also be considered. Such provisions would allow people to specify while well, the treatment they wish or do not wish to be given in circumstances where they lose decision making capacity due to mental illness. The law permits general medical patients to make advance directives and their use should be considered as a way of enhancing self-determination for people with a psychiatric diagnosis.

MHCC agree with the Law Council of Australia that a nationally consistent approach to the assessment of capacity in the context of substitute decision-making "is highly desirable in order to promote greater clarity and ultimately, to more effectively provide protection and foster individual autonomy as circumstances require."^{ix}

MHCC propose that Australia develop a Capacity Act and in this context that the ALRC review the United Kingdom *Mental Capacity Act 2005*^x for guidance. Its primary purpose is to provide a legal framework for acting and making decisions on behalf of adults who lack the capacity to make particular decisions for themselves, and for protecting their rights.^{xi}

The Act has a code of practice which identifies the key elements to provide the framework necessary to underpin the legislation.^{xii}

The role of family, carers and supporters

Question 5

How should the role of family members, carers and others in supporting people with disability to exercise legal capacity be recognised by Commonwealth laws and legal frameworks?

The role of family members and carers should be recognised in Commonwealth laws. The supporting policy frameworks must reflect that those assessing capacity and supporting decision-making must listen to, learn from and act upon communications from the individual and their carers about what is important to each individual. This involves acknowledging each individual is an expert on their own life and that their ‘recovery’^{xiii} and care involves working in partnership with individuals and their carers to provide support in a way that makes sense to them and that assists them realise their own hopes, goals and aspirations.

Incorporated into the *NSW Mental Health Act 2007*^{xiv} are some important concepts concerning carer rights with regards to notification and information sharing including about medication, notification about initial detention, mental health inquiries, appeal rights, events affecting detained persons and discharge planning. These concepts should be reflected similarly in Commonwealth law.

Anti-discrimination law

Question 6

What issues arise in relation to Commonwealth anti-discrimination law that may affect the equal recognition before the law of people with disability and their ability to exercise legal capacity? What changes, if any, should be made to the Disability Discrimination Act 1992 (Cth) to address these issues?

MHCC understand that if a complaint under the *Disability Discrimination Act 1992* (Cth) (DDA) fails to be conciliated by the Australian Human Rights Commission (AHRC), that it can be referred to the Federal Court for adjudication.

Since the Federal Court is a cost jurisdiction “this means people with disability making complaints may have to pay the other party’s costs if their case is unsuccessful. While this provides a safeguard against potentially vexatious litigants and frivolous claims, the current costs regime creates a barrier for people with disability who wish to pursue litigation matters in the public interest. The Australian court costs regime in effect acts as a disincentive to the enforcement of disability rights, and hampers access to justice as provided under Article 13(1)”.^{xv}

Privacy

Question 11

What issues arise in relation to privacy that may affect the equal recognition before the law of people with disability and their ability to exercise legal capacity? What changes, if any, should be made to Commonwealth laws and legal frameworks relating to privacy to address these issues?

Each State and Territory in Australia has its own legislation with respect to the privacy of information collected and collated by public authorities. MHCC propose that there should be nationally consistent laws and legal frameworks.

The National Disability Insurance Scheme

Question 12

What changes, if any, should be made to the National Disability Insurance Scheme Act 2013 (Cth) and NDIS Rules, or disability services, to ensure people with disability are recognised as equal before the law and able to exercise legal capacity?

- People with psychosocial disability may experience difficulty accessing services under the NDIS whereby a participant has to generate an application (where no substitute decision-making exists). Decision making supports will have to be very well advertised and accessible for people needing such assistance, offered via a variety of delivery models including in person, by phone, or through home visit arrangements.
- There may be a number of people who fit the eligibility criteria for a package under the NDIS but have no fixed abode, or have no access to documentation. Consideration must be paid to maximising equality under the Commonwealth legislation. Similarly attention must be paid to those people with disability who currently access mental health and human services that will be ineligible for a NDIA package, and whether as a result they will fall through the service delivery gaps.
- Monitoring and safeguards mechanisms, advocacy and complaints procedures are complex and confusing systems and processes to navigate. People with mental health conditions particularly when unwell, their carers and those engaged in the provision of mental health services equally struggle to understand rights and responsibilities and determine where accountability rests as to service provision access, and the treatment, care and support provided.

MHCC propose that the recent establishment of the NSW Mental Health Commission and the review of the *NSW Mental Health Act 2007* (MHA) represent a timely opportunity to review the monitoring and oversight functions of the various bodies in NSW. Part of such a process should include an investigation into international monitoring and regulatory mechanisms in order to consider and develop a best practice model applicable to community managed mental health and social care in NSW and across all other jurisdictions, and involving the NDIS.

The Official Visitor Program in NSW is unique in its remit compared to some similar Western jurisdictions. The Program is strongly consumer focused and whilst much can be learnt from international examples with greater powers to bring about direct and systemic change, it is important that while enhancing regulatory authority that consumer focus remain a central undertaking.

Monitoring and safeguards mechanisms need to reflect a Recovery approach particularly in the light of the emphasis of care and support in the community rather than in acute settings. It is important in this new environment of the NDIS and Partners in Recovery that Commonwealth law is consistent with state and territory legislation

Citizenship rights

Question 17

What issues arise in relation to electoral matters that may affect the equal recognition before the law of people with disability or their ability to exercise legal capacity? What changes, if any, should be made to Commonwealth laws and legal frameworks to address these issues?

People with mental health conditions may have considerable difficulty in exercising their citizen rights particularly in relation to voting. People with no fixed abode or spending long periods in hospital should be assisted in this regard. Often Centrelink is the only real point of engagement and should be investigated as a potential for improving access to information on citizen rights matters, whether in hospital or in the community.

Question 21

In what ways do Commonwealth laws and legal frameworks relating to membership of, or participation on, boards diminish or facilitate the equal recognition of people with disability before the law and their ability to exercise legal capacity?

MHCC propose that there are numerous laws in which the language is both unclear and discriminatory in terms of someone who is temporarily incapacitated as a consequence of mental illness. This matter came to MHCC's attention when reviewing model rules under the Associations Incorporation Act 2009 with regards to casual vacancy of a board/membership committee.

NSW Fair Trading confirmed that what MHCC consider discriminatory terms were being widely used throughout NSW Legislation all of which utilise the language determined in the NSW Interpretation Act 1987. This leads us to suggest that Commonwealth anti-discrimination law should seek to eradicate any stigmatising and discriminating practice towards people with a mental health conditions in this context likewise where it may exist in Commonwealth law.

Embedded in state and Commonwealth policy and practice surrounding governance of mental health organisations and agencies across service systems, it is clearly established that all provide for consumer participation in all aspects of their organisation. For MHCC, as the NSW mental health peak body whose members represent the mental health community managed sector, not only our own board but members' boards/ executive management committees are constituted with at least one public representative who is a person with lived experience of mental illness (consumer).

We emphasise that loss of capacity or becoming incapacitated as a consequence of mental illness should be regarded as no different to any other medical condition that a person may recover from. An episode of mental illness is similar in this respect to any medical or physical health condition. Therefore a committee/ board member of any organisation should not be required to step down from the board unless they become permanently incapacitated. On this basis we strongly advocate that any legislation using this basis on which to require a person to step down permanently from a board needs to be amended.

We were informed by NSW Fair Trading that this terminology relates to Section 21 of the Interpretation Act 1987 which defines the term mentally incapacitated person as a person who is an involuntary patient, a forensic or correctional patient within the meaning of the *NSW Mental Health Act 2007* or a protected person within the meaning of the *NSW Trustee and Guardian Act 2009*.

Unlike circumstances in which a person becomes a forensic or correctional patient or loses mental capacity permanently we argue that because a person becomes an involuntary patient does not mean that they will not recovery from their illness or loose capacity permanently. This would be akin to requiring a person step down from such a role as a consequence of physical disability or an ongoing medical condition that flares up from time to time. We strongly recommend that the terminology to be utilised in legislation should reflect this understanding and propose the wording used be altered to read: *becomes permanently incapacitated*.

Health care and aged care

Question 34

What issues arise in relation to health care that may affect the equal recognition before the law of people with disability and their ability to exercise legal capacity? What changes, if any, should be made to Commonwealth laws and legal frameworks relating to health care to address these issues?

- People who lack decision-making capacity should be able to access treatment that is in their best interests, without having to show that they are at risk of some kind of "serious harm" additional to the harm involved in just having a treatable illness. MHCC recommend that the issue of people refused admission to mental health facilities and their right to appeal a non-admission decision are matters for consideration. If appeal processes are unsuccessful, people should have recourse to the Federal Court (with legal advocacy support).

- The scope of powers to treat involuntary patients under the *NSW Mental Health Act 2007* need to be discussed:

In terms of psychiatric treatment, the MHA provides little detail about the basis upon which decisions to treat detained patients should be made, and how, if at all, patients' preferences about treatment should be taken into account when initiating involuntary treatment. This is problematic bearing in mind that some patients retain decision making capacity in relation to certain treatment decisions and may have a point of view about which treatments they prefer, or if they wish to forgo certain treatments entirely, particularly if it is not their first experience of mental illness. It is important to discuss how these preferences should be taken into account by doctors and decisions to override expressed patient preferences is limited to circumstances in which a patient lacks capacity to make a decision, and the particular treatment is manifestly in the person's best interests.

- Provision for advance directives about treatment could also be considered. Such provisions would allow patients to specify while well, the treatment they wish or do not wish to be given in circumstances where they lose decision making capacity due to mental illness. The law permits general medical patients to make advance directives and their use should be considered as a way of enhancing self-determination for involuntary/ psychiatric consumers.
- The scope of doctors' abilities to provide non-psychiatric treatment is unclear. In particular, there is no clear power for doctors to provide medical treatment without consent to competent detained patients. Although emergency surgical treatment will be permitted after a patient is admitted, this cannot be provided to a competent "assessable person" who may for example be in the Emergency Department of a general hospital waiting for admission under the MHA. (MHCC have been advised that this issue can arise in many different circumstances. For example, patients with anorexia nervosa refuse artificial feeding and hydration, patients with renal conditions refuse haemodialysis; pregnant patients refuse obstetric interventions including Caesarean sections and so on).

The MHA is unclear about what is and is not permitted and doctors have interpreted the provisions differently in various circumstances. Discussion is necessary as to the rights of patients to refuse and receive treatment clearly laid out in the Act. While this matter is a state issue, MHCC suggest national consistency reflected in a Capacity Act.

Question 35

What issues arise in relation to aged care that may affect the equal recognition before the law of people with disability and their ability to exercise legal capacity? What changes, if any, should be made to Commonwealth laws and legal frameworks relating to aged care to address these issues?

It is necessary for Commonwealth legislation specifically to refer to supported decision-making processes as utilised under the *NSW Guardianship Act 1987* for people with dementia. Supported decision-making is extremely important for this group of particularly vulnerable people, who the system characteristically ‘medicates’ and ‘manages’. It is critical that the mental health and age care services work closely together so that a vulnerable and isolated person does not fall between service gaps and that older people are appropriately cared for in mental health and age care facilities using principles of recovery and enablement.

It is particularly problematic when consumers are in age care facilities where their behaviours may present ‘challenges’ for care givers and other residents. They are frequently found to be over sedated and have little access to alternative therapeutic interventions that attend to their psychological needs.

It is critical that doctors and other people treating people with early stage dementia encourage individuals to provide Advanced Directives so that as the dementia progresses they can take into account the wishes about how the individual would choose to be treated when they lack capacity.

Restrictive practices

Question 36

In what ways, if any, should the proposed National Framework for Reducing the Use of Restrictive Practices in the Disability Service Sector be improved?

The National Mental Health Seclusion and Restraint Project (2005) was a collaborative initiative initiated by the Australian Government and State and Territory Governments. In line with the *National Safety Priorities in Mental Health: a National Plan for Reducing Harm*, the project aimed to reduce and, where possible, eliminate the use of seclusion and restraint in public mental health services.

The National Mental Health Commission is currently undertaking further work in this area broadly addressing practices in health facilities, community settings and in agencies such as the police and ambulance services. They have developed a Declaration detailing agreed principles to eliminate these practices.² MHCC suggest discussion take place as to whether the key principles for seclusion and reduction practice in all contexts be clearly reflected in the Commonwealth legislation as outlined in the Declaration and the National Plan for Reducing Harm.

² For more detail on the National MH Commission’s approach visit www.mentalhealthcommission.gov.au/

MHCC thank the Australian Law Reform Commission for providing this opportunity to input into this important inquiry. For any further information on this submission, please contact Corinne Henderson, Senior Policy Advisor, E: corinne@mhcc.org.au or T: (02)9555 8388 #101.



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- ^v Submissions provided during the CRPD Shadow Report consultations in SA, NSW & WA in November 2009.
- ^{vi} Submissions provided during the CRPD Shadow Report consultations in SA, NSW & WA in November 2009.
- ^{vii} People with Disability Australia (PWDA), 2013, Submission Productivity Commission Issues Paper: 'Access to Justice Arrangements'.
- ^{viii} World Health Organization, 2003, 'Mental health legislation and human rights, Mental health care law: ten basic principles', (World Health Organization, 1996b).
- ^{ix} The Law Council Australia, 2012, Submission 056, 'Inquiry into Dementia: Early Diagnosis and Intervention', Item 21.

^x *Mental Health Capacity Act 2005*, United Kingdom,
<http://www.legislation.gov.uk/ukpga/2005/9/introduction>

^{xi} Information, *Mental Health Capacity Act 2005*, United Kingdom,
<http://www.mentalhealth.org.uk/help-information/mental-health-a-z/M/mental-capacity-act-2005/>

^{xii} Department for Constitutional Affairs, Code of Practice, *Mental Health Capacity Act 2005*, United Kingdom, <http://www.justice.gov.uk/downloads/protecting-the-vulnerable/mca/mca-code-practice-0509.pdf>

^{xiii} From the perspective of the individual with mental illness, recovery means gaining and retaining hope, understanding of one's abilities and disabilities, engagement in an active life, personal autonomy, social identity, meaning and purpose in life, and a positive sense of self. It is important to remember that recovery is not synonymous with cure. Recovery refers to both internal conditions experienced by persons who describe themselves as being in recovery—hope, healing, empowerment and connection—and external conditions that facilitate recovery—implementation of human rights, a positive culture of healing, and recovery-oriented services (Jacobson, N & Greenley, D, 2001, 'What Is Recovery? A Conceptual Model and Explication', *Psychiatric Services* 2001, p. 482).

^{xiv} *NSW Mental Health Act 2007*, Chapter 4- Care & Treatment , part 1 – Rights of Patients or Detained Persons and Primary Carers Division 2 – Notification and Information Sharing, Available: http://www.austlii.edu.au/au/legis/nsw/consol_act/mha2007128/

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