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Legal capacity and the mental health social worker role: An international comparison

Jim Campbell, Lisa Brophy, Gavin Davidson and Ann-Marie O'Brien

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Abstract

New capacity laws have been introduced to many jurisdictions over the last decade. These laws have substantially changed the way in which mental health social workers and other professionals approach decisions about, and for, clients. Most notably there is now an expectation that mental health social workers engage more in supported decision-making to prevent the need for substitute decision-making. This article describes the legal and policy drivers that have led to these changes in practice, with a particular emphasis on the significance of the United Nations Convention on the Rights of Persons with Disabilities (the UNCRPD) and the importance of recovery approaches in mental health services. It then uses selected literature to explore the efficacy of the laws and decision-making in this area. The second part of the article identifies the role that mental health social workers can play in supporting legal capacity, drawing from the authors' experience and knowledge of mental health social work and law in four jurisdictions: Victoria, Australia; Ontario, Canada; England and Wales; and Northern Ireland. It is concluded that mental health and other social workers need to refine skills, knowledge and values to accommodate this paradigm shift in law, policy and practice.

Introduction

Over the last two decades there have been considerable changes to mental health laws in the UK, Australasia and North America. This in turn has affected the role of social workers both in terms of assessing client need and risk, and in relation to their participation in multi-disciplinary teamwork. The most notable of these changes has been a move towards the use of community-based, coercive laws by social workers and other mental health professionals. More recently the introduction of laws on capacity has created more complex decision-making processes, in particular at the interface with mental health laws. The authors will draw upon their experiences of comparing the mental health social work role in these contexts, and across jurisdictions (Davidson et al, 2016a; Davidson et al 2016b; Campbell et al, 2006). This paper will examine how mental health social workers may provide support for legal capacity in the context of compulsory powers in the UK, Ireland, Victoria, Australia and Ontario Canada. It will focus on three themes: the assessment of decision making ability; support for decision making and legal capacity; and the use of safeguards.

The paper begins with a critical analysis of the policy drivers that created the conditions for law reform and the introduction of capacity laws in some of these jurisdictions, and then examine how different sets of principles and practices shape professional decision-making. These ideas will be illustrated by reference to a vignette that will illustrate contrasts and comparisons in the mental health social work role, contingent on these legal and policy contexts. The paper concludes by arguing that these changes in the mental health social work role offer more space for empowering practice where clients are enabled to make their own decisions and professional judgements that are less risk averse.

The policy context

Issues of professional decision-making in mental health services must be viewed in terms of historical contexts and legacies, reaching back to the Victorian asylum where the judgements about care and control were exclusively the domain of the authority, and patients had little say in their lives. This overarching sense of paternalism was matched by pessimism about the potential for any meaningful change in the lives of those with mental illnesses. Towards the end of the twentieth century a series of critical narratives about the nature of mental health systems, laws and professional decision-making processes led to debates about the legal and human rights of clients and their families. The mental health laws devised in the mid to late twentieth century represented improvements to older decision-making processes, for example in terms of increase safeguards, more rigorous methods of assessment and access to due process when compulsory powers were being used (Gostin et al, 2010).

By the end of the century a number of legal, policy and societal drivers further challenged organisational and professional assumptions about the rights and capacity of clients, with a gradual shift of expectation away from substitute towards supported decision-making. In England and Wales, for example the Mental Capacity Act (2005) established the important principle of presumption of capacity and introduced a number of additional safeguards, including the creation of the role of the Independent Mental Capacity Advocate (IMCA). IMCAs meet and interview the person, exam relevant documents, access the views of professionals and others who can provide information about the views of the persons. They also have a duty to consider how the person has been involved in decision making, and to represent the views of the person when decisions are taken about deprivation of liberty, as well as forms of care and treatment (Manthorpe et al., 2009). Other attempts to protect the rights of service users have been less successful. The introduction of Deprivation of Liberty Safeguards (DOLS) in 2009, a mechanism to close what is described as the 'Bournewood gap' have been widely criticised. In particular the exceptionally complex systems of communication and professional decision-making processes are viewed to be problematic and outcomes are hard to establish (Algrahi et al, 2016).

A considerable volume of literature has been generated about the importance, but also the complexities, of the United Nations Convention on the Rights of Persons with Disabilities (the UNCRPD) and implications for professional decision-making where national capacity laws exist (Maylea, 2016; Ryan and Callaghan, 2017). Of particular concern is the way that governments and lawyers have struggled to

operationalise the principles and intentions of the Convention. For example, the concept of mental illness is defined as a disability (described as a mental impairment) but, rather confusingly, reference is also made to 'long-term' impairment. Given that many mental health problems are fluctuating and short term in nature, this has led to difficulties of interpretation when professionals intervene in the lives of service users and their carers. Discussions have also taken place amongst commentators about whether substitute decision-making is even compatible with supported decision making. This is a journey that no government to date has embarked upon; this is largely because it would represent an acceptance of a libertarian position that would absolve the state of its commitment to *parens patriae* (to protect the rights of citizens who are not able to look after their own needs).

As a consequence of these apparent contradictions – between the elevated principles of the Convention and the difficulties in operationalising these in the context of real world policy and practice – a number of conundrums remain. As we will discuss below, most jurisdictions find it difficult to define the mechanisms that are involved in supported decision making, for example in distinguishing between formal supports to ensure legal capacity and general supports for decision-making, with mixed evidence about how this can be managed. An associated point is that the notion of a binary between substitute and supported decision making is not in fact borne out in practice in the way governments and policy makers design and deliver capacity laws. Each jurisdiction has chosen its own particular, some would say at times peculiar, mix of processes and safeguards, as discussed below. Sometimes substitute and supported decision-making can either run parallel or they appear to shade off into each other. Thus most countries have separate mental health, capacity and sometimes guardianship laws, and offer a range of advanced directive type provisions, functional capacity tests and sometimes consent procedures, choice of nominated person, access to peer and other forms of advocacy and diverse forms of independent review processes.

Finally, it is important to recognise how movements 'from below' have shaped these new arrangements for professional decision-making in mental health services. For many years service user voices and movements have sought to challenge the psychiatric system and professional power (O'Hagan, 2012). These views have more recently crystallised in the form of recovery approaches that are now embedded in many jurisdictions, either formally or informally (Slade et al, 2014). Increasingly mental health social workers, as with other professionals, are required to operationalise principles of recovery in everyday practice, often in the absence of a consensus about what the concept means. The value of being person-centred, recovery-orientated, and enabling supported decision-making is an inescapable imperative, it is argued, not least because they are central in legal and practice frameworks. There is emerging evidence that pro recovery interventions are delivering some positive outcomes in terms of reducing coercive interventions, improving housing and employment opportunities for people with mental health problems as well as increasing satisfaction with service delivery (Morgan et al., 2012). Most importantly a recovery focus has the potential to recognise the expertise people have through their lived experience and move to offering opportunities for greater choice and control, including making decision-making about medication and

other forms of care (Stratford et al, 2013). Examples of programmes such as Connectedness, Hope and optimism, Identity, Meaning and purpose, and Empowerment (CHIME), has been found to be fundamental features of a personal recovery approach (Bird et al., 2014). The Victorian Government (2011) *Framework for Recovery-oriented Practice* and the Australian National *Framework for recovery oriented services* (Australian Health Ministers' Advisory Council, 2013) are other projects that demonstrate how the principles of recovery can be mainstreamed, where practitioners are encouraged to engage in positive risk taking and optimising opportunities for informed choices for consumers. These processes, it is argued, should be underpinned by principles of self-determination, self-responsibility, and support for people to decide the level of risk they are prepared to take with their own health and wellbeing. This can also lead to "Robust, mutually respectful and trusting, diverse, active and participatory relationships between the person with mental health issues and the service provider will contribute to that person's successful management of their own safety." (Australian Health Ministers' Advisory Council, 2013, p. 19)

In conclusion to this section, key principles of supported decision-making are now established in many jurisdictions, and directly impact upon professional practice in mental health services. States need to have in place a comprehensive legal framework that protects people's autonomy and, when they lack the capacity, to enable substitute decision making to take place. Those with mental health problems are now to be presumed to have capacity and professionals need to adhere to accompanying safeguards. As a result there are expectations that mental health professionals should more readily consider supported decision-making opportunities rather than the types of substitute decision processes that characterised the mental health policy and practice landscapes of the past. What we will now argue is that more attention is needed to explore this complex decision-making space (Simmons and Gooding, 2017) to better understand a social work role that best attends to the interests and rights of service users.

Evaluating the use of capacity laws

There is some available evidence to help us understand how capacity such laws are operationalised, with some unexpected outcomes. A number of studies have explored how issues of capacity are considered when admissions to psychiatric hospital take place. In a systematic review by Okai et al. (2007) on decision making capacity in the context of admission to psychiatric in-patient care, the authors found that in one study "...approximately 30–50% of participants scored in a range that suggests they were competent to make decisions, a sizeable minority scored in an intermediate range, and as many as 50% had significant impairments of mental capacity despite accepting voluntary admission" (Norko et al, 1990, p. 293). A median finding was that 29% of psychiatric inpatients lacked the capacity to consent to treatment and this was associated with psychosis, severity of symptoms, involuntary admission and treatment refusal. Cairns et al. (2005) assessed the treatment decision making capacity of 112 psychiatric inpatients in England soon

after admission, using the MacArthur Competence Tool for Treatment (MacCAT-T). They found that “Of the 112 participants, 49 (43.8%) lacked treatment-related decisional capacity...Of the 49 patients lacking capacity, 30 (61%) were detained under the Mental Health Act 1983. Of the 63 with capacity, 6 (9.5%) were detained” (p. 379). Owen et al. (2009) assessed the treatment decision making capacity of 200 psychiatric inpatients also using the MacCAT-T and the two stage test of the Mental Capacity Act 2005. They found that 37% had capacity and were informal (voluntary patients); 24% lacked capacity but were informal; 34% lacked capacity and were detained; and 6% had capacity and were detained (although they suggest some of these people may have lacked capacity at the time of admission). These findings reinforce the notion that there needs to be a shift in the way that professionals, service users and carers adjust practices to address the imperatives of capacity laws. This is particularly important given that it would appear that capacity-based approaches to legislation often extend the scope of both compulsory intervention and the associated legal safeguards.

In terms of community settings, Milne et al. (2009) compared a purposive convenience sample of 10 service users under Community Treatment Orders (CTOs) with 10 matched voluntary service users. Using the MacCAT-T, they found that 70% of the CTO group and 20% of the voluntary group lacked capacity and that most people in both groups would continue their current treatment if they were given the choice. Skipworth et al. (2012) assessed a cross-sectional sample of 109 forensic patients both in hospital and in community settings and found that most (67.6%) had treatment-related decision-making capacity. Wong et al. (2000) compared capacity across people with learning disability, mental illness and dementia in a primary care setting and, in the mental illness group, reported that 19/21 (90%) had treatment decision making capacity.

In other jurisdictions, where new mental health and mental capacity laws have been introduced, there has been some, although surprisingly little, research on the knowledge and perspectives of those involved in such professional decision-making. In an early study of stakeholders' views on advance directives in mental health care in Scotland, Atkinson et al. (2004) found there was a wide range of views within and between professional groups about how aspects of the law were interpreted and acted upon. Thus only 28% of psychiatrists reported that advance directives were needed, compared to 89% of voluntary organisations and approximately two-thirds of other stakeholder groups. In England, Manthorpe et al. (2011) reported that, amongst care home managers and staff, there was considerable variation in their understanding of the specific aspects of the Mental Capacity Act 2005. In Australia, Gooding (2015) explored the views of psychiatrists about supported decision making, which is required by both the new laws, and also found variation in interpretation and understanding. Sellers et al (2016) found that, while psychiatrists generally favour supported decision-making mechanisms such as psychiatric advance directives (PAD), they tended to continue to prioritise issues of risk over patient autonomy, and were unlikely to support a patient to create a PAD which requested cessation of pharmacotherapy or remaining out of hospital and not being subject to an involuntary treatment order.

Compulsion, substitute and supported decision-making

The literature on the efficacy of compulsory mental health laws, in both hospital and community settings is similarly equivocal. Priebe et al. (2009) interviewed 778/1570 patients at baseline and 396/778 after a year. They found that 15% of the total sample had been readmitted involuntarily, and 40% of those who consented to follow-up considered their original admission justified. Lower initial treatment satisfaction, being on benefits, living with others and being of African and/or Caribbean origin were associated with higher involuntary readmission rates. Higher initial treatment satisfaction, poorer initial global functioning and living alone were linked with more positive retrospective views of the admission. Berry et al. (2013) reviewed 24 studies, published between 1980 and 2011. Elevated levels of PTSD resulting from the trauma of symptoms and/or hospitalisation were found, with prevalence rates for actual PTSD resulting from these traumas varying from 11% to 67%. In addition there were potential impact upon a number of variables, including sense of self, relationships with others, engagement with services, issues of stigma, internalised stigma, discrimination and anticipated discrimination. Nytingnes et al (2016) present findings from their research in which some people described feeling humiliated by being forced to take medication and used terms like abuse, war or Nazism to describe their experience of coercion in mental health care. Brady et al. (2017) found that restrictive interventions were a common experience amongst people with psychosis and although most reported some benefit, perceptions of benefit were lower among those who experienced a greater number of interventions.

The more recent advent of laws to allow professionals to compulsorily care for and treat clients in the community has attracted considerable attention from the research community, with a similar set of contradictory messages. In a Cochrane Review of three compulsory community treatment studies (Kisley and Campbell, 2014) no significant difference in service use, social functioning or quality of life was found when compared with standard voluntary care. People receiving compulsory community treatment were, however, less likely to be victims of violent or non-violent crime. It is unclear whether this benefit was due to the intensity of treatment or its compulsory nature. Short periods of conditional leave may be as effective (or non-effective) as formal compulsory treatment in the community. The English Randomised Controlled Trial (RCT) carried out by Burns et al (2013) found that, in terms of a key measure of efficacy, decreased hospital admissions, CTOs were not having this effect. Variation in use of compulsory community treatment between and within countries is also of some concern. This can range, for example, from 2 per 100,000 in Ontario, Canada to 99 per 100,000 (Victoria, Australia) (O'Brien, 2014). The UK experience, like other jurisdictions, highlights the way in which, despite the intentions of policy makers, numbers of CTOs continuously rose in the first decade of their use (DeRidder et al., 2016). This maybe be due to a number of factors, including a drift towards risk averse practices or a perception by practitioners of the value of CTOs in maintaining clients in the community.

Some of the limitations of substitute decision-making by social workers in the UK context have been well rehearsed, including problems of models of risk assessment and the overrepresentation of particular groups when compulsory laws are being used (Campbell, 2009). It has been argued that the preoccupation by some mental health social workers with mandated roles, has diluted more important therapeutic and community-based interventions (Ramon, 2009). A libertarian approach has been used to reject social workers' use of involuntary laws (Maylea 2016), particularly when our understanding of risk and risk assessment in mental health services is so partial (Stanford et al, 2017). A more positive view is that a constructive interpretation of Article 12 of the UNCRPD that supports ideas of legal capacity can, in certain circumstance, include what has traditionally been framed as substitute decision making if the person's rights, will and preferences are the central consideration (Martin et al., 2016). Significantly there is some evidence that the way that compulsory powers are used, and thoughtful, deliberative professional decision-making can improve the lives of clients, even when substitute decision making is applied:

“According clients procedural justice by allowing them voice in their treatment and legal proceedings, treating them with respect, and conducting transparent procedures appear to ameliorate the perception of coercion in a significant percentage of clients who are subject to mandated treatment.” (Galon and Wineman, 2010, p314)

This issue of the quality and context of the moment when mental health social workers and other professionals make such fundamental, potentially life-changing decisions on behalf of the client is now discussed at the interface of mental health and capacity laws the four chosen jurisdictions. Although there will always be situations where substitute decision making is necessary, and appears to be more effective when professional work in these empathic ways, the opportunities to engage in alternative, supportive decision-making process, it is argued, should always be considered, a point made by Carney (2017) in his recent review of the evidence base.

International variations in capacity laws

This section of the paper now draws upon a previous analysis of the interface between capacity and mental health laws in England and Wales, Northern Ireland, Victoria Australia and Ontario, Canada (Davidson et al, 2015). It develops our ideas, in particular through the exploration of how such laws impact upon how mental health social workers make judgements about substitute and supported decision-making. Partly because of the ambiguities in decision making created by these new laws, a continuum of views have emerged about how mental health social workers and other professionals can, or should, make assessments in such circumstances. As was mentioned earlier in the paper, governments have tended to interpret the tenets of the UNCRPD quite broadly to meet local legal, organisational and professional demands, as we have described elsewhere (Davidson et al, 2016b).

The Mental Capacity Act (2005) in England and Wales informs decisions made in the context of the Mental Health Act (2007) when professionals make decisions about the capacity of people with mental health problems. Professional decision making is underpinned by five principles: presumption of capacity; supporting individuals to make their own decisions; allowing people to make 'unwise decisions'; where individuals lack capacity then their best interests are central to the process; and the least restrictive option should always be considered. A range of safeguards are used to protect service rights, these include the opportunity to appoint Lasting Power of Attorney. The Court of Protection can appoint a Deputy to manage a person's affairs where they lack capacity, with the Office of Public Guardian overseeing these processes and personnel. Clients can create Advance Directives, for example to determine future treatment when incapacitated, and as discussed earlier, IMCAs carry out a range of protective duties. As in other jurisdictions a capacity test must be used when decisions are made, in this jurisdiction this involves two stages and an assessment about whether the person can understand information, retain the information, weigh up information and communicate decisions. In terms of substitute decision making, the Mental Health Act uses a conventional rationale where professionals make a judgement about evidence of concurrent risk and a diagnosis of a mental disorder when either hospital or community based involuntary care and treatment is being recommended.

The Mental Capacity Act Northern Ireland 2016 will implement, for the first time, the fusion approach (Dawson and Szmukler, 2006). This means that there will no longer be a separate mental health law and the Act will provide the legal framework for everyone whose decision making ability may be impaired, including those with mental health problems. A functional capacity and best interests test will be operationalised and, for the most serious interventions, including those which amount to a deprivation of liberty, interdisciplinary panels will be used to decide when interventions are authorised. Short term (up to 28 days) detention in hospital will still be possible, based on the report of two professionals, but detention beyond 28 days will have to be considered by the panel. In terms of support for decision making the Act requires that "The person is not to be treated as unable to make a decision for himself or herself about the matter unless all practicable help and support to enable the person to make a decision about the matter have been given without success" (Section 1(4)). Additional safeguards will include the involvement of nominated persons and independent advocates. It is anticipated that the Act will be implemented in 2020.

In Victoria, Australia, the Mental health Act, 2014 and Guardianship and Administration Act, 1986 prescribe substitute and supported decision-making processes in relation to people with mental illness. There is a standard criteria for substitute decision making and, as common with elsewhere, and The Guardianship and Administration Act takes a functional approach to assessing capacity. A guardian may be appointed for a person who has a disability that is impairing their judgement and who needs a substitute decision maker to make a specific decision or multiple decisions about lifestyle and healthcare matters, but only after all less restrictive options have been ruled out. An administrator may be appointed to make

financial decisions when a person cannot make reasonable judgements about managing their estate, and there are concerns about the decisions they are making, or about decisions that others are making for them. The Mental Health Act, 2014 involves the principle of a presumption of capacity and respect for the dignity of risk. It includes a range of safeguards in relation to the use of substitute decision making powers that include compulsory mental health treatment in the community on a CTO or in inpatient services. The principles of the Act require a recovery approach to care and an emphasis on people being involved in all decision making about their care and treatment. A range of legal mechanisms are used to enable supported decision-making, including a nominated person's scheme and advance statements alongside improved access to advocacy services and a more rigorous external review system through the mental health tribunal. In the province of Ontario principles of supported decision making are operationalized by the Psychiatric Patient Advocate Office (PPAO), and the Consent and Capacity Board (CCB). The PPAO is a publically funded agency established in 1983 in response to the Canadian Charter of Rights and Freedoms. Independent rights advice is mandated in four provincial statutes: Professional decision making is prescribed by a range of laws, including The Substitute Decisions Act, the Mental Health Act, The Personal Health Information Act, and the Health Care Consent Act. The PPAO provides advocacy service to inpatients in the 10 designated provincial mental health facilities and 84 of the 87 'schedule 1' facilities. Schedule 1 facilities are inpatient mental health/psychiatric units in General Hospitals. Every year, PPAO Rights Advisers help over 3,500 patients apply for a review of their status to the Ontario Consent and Capacity Board. The Consent and Capacity Board is an independent body funded by the government of Ontario under the Health Care Consent Act. It conducts hearings under the Mental Health Act, the Health Care Consent Act, the Personal Health Information Protection Act, the Substitute Decisions Act and the Mandatory Blood Testing Act. Psychiatrists and lawyers are the only mandated professional members of the board. The 'general public' are also mandated to be represented, and social workers may apply to be members under this designation. Board members are appointed by the Lieutenant Governor in Council. Since the Mental Health Act was revised to include CTOs, requests for advice about rights have increased significantly. In 2003 there were 817 requests for rights advice for CTOs, in 2016 that number had ballooned to 10,739. Notably, funding and resources for the PPAO has not increased commiserate with requests for rights advice. This lack of funding to support rights advice is contrary to the policy of supporting recovery, empowerment, and patient centred care.

(https://www.sse.gov.on.ca/mohltc/ppao/en/Pages/PPAOPublications/Annual_Report_2016.aspx?openMenu=smenu_AnnualReports).

The mental health social work role

We now turn to the mental health social work role to explore these complicated types of decision making processes, using a vignette, case study approach.

John is a middle aged man who lives on his own with no close family members in the jurisdiction, although he has been good friends with a few neighbours in his street. He lives in a large, run-down house which he inherited from his parents, along with a considerable amount of money. John has had many contacts with both health and mental health services since his parents died some thirty years ago. He has had a number of compulsory admissions to psychiatric hospital, suffering from depression and anxiety. His type 2 diabetes is of concern to community health services because he is not looking after his diet, has chronic heart disease and his legs have become quite seriously ulcerated. John has reluctantly agreed to have a community mental health nurse visit him on a fortnightly basis. The community nurse has built a reasonably positive relationship with John but is increasingly concerned that some members of the community are seeking to exploit him and his money.

In England and Wales mental health social workers are often involved in a variety of interlocking decision-making processes when dealing with John's individual needs and the social context in this situation. In contrast to some practices of the past, professionals are required to address issues of potential discrimination from the start of their engagement with John. It is crucial that past mental health problems and hospital admissions do not lead to an automatic presumption that he lacks capacity. The literature indicates that service users want professionals to consider strengths-based recovery approaches that have broad-based strategies to understanding and managing risk. All attempts should be made to fulfil the principles of the Mental Capacity Act (2005) when assessing John's situation, and enabling John to make as many decisions as possible to manage risk and seek the least restrictive option. This should involve a careful assessment and, with his permission, engagement with his psychiatric nurse. It may be that helping John to build stronger ties with the community services and the neighbourhood will offer more long-term forms of protection. If John is considered to lack capacity then the range of safeguards can be set in place to protect his financial and personal interests to prevent exploitation. In situations where supported decision making is not possible then the Mental Health Act (2007) permits the mental health social worker and other professionals to become substitute decision makers to admit John involuntarily to hospital and community settings.

In Northern Ireland currently the Mental Health (Northern Ireland) Order 1986, the Common Law (in terms of capacity) and the Adult Safeguarding: Prevention and Protection in Partnership policy could all be relevant. Under the Mental Health (Northern Ireland) Order 1986, if John meets the mental disorder and risk criteria, then compulsory admission to hospital and/or Guardianship could be considered. Guardianship does provide a community option but the powers (which require the person to reside in a specific place, attend for treatments and/or allow access to professionals) are relatively limited and often dependent on the person's cooperation. Under the Common Law, if there was a reasonable belief that John lacked the relevant decision making ability and what was proposed was viewed to be in his best interests, then those who intervened would be protected from liability. Under the adult safeguarding policy there is a process to consider what intervention

might help manage any identified risks but there isn't a separate legal framework for this beyond the relevant criminal law. Under the new Mental Capacity Act (Northern Ireland) 2016, the crucial consideration would be whether John is able to make the relevant decisions. If not, then what support might enable him to do so. If, even with support, John is not able to make one or more of the relevant decisions then, if the relevant safeguards are in place, intervention could proceed.

In Victoria John can be made a compulsory patient on an inpatient or community treatment order under the Mental Health Act, 2017 if he is found to meet specific criteria, including having a mental illness, to prevent serious harm, treatment being available and no less restrictive option being available. However, both policy and law in Victoria would encourage voluntary treatment. If there are concerns that John could be subject to financial abuse and requires substitute decision making regarding his financial circumstances then an Administration Order under the Guardianship and Administration Act, 1986 might be considered. This would require a report by both John's treating doctor and social worker. However, to follow the emphasis on supported decision making, the first step would be to ensure that his views were central to all decision making and he should be supported to express his wishes and preferences. There may be opportunities to build John's informal support network to enable him to maintain his independence and set and reach goals around his health and wellbeing. It is important that John understands his rights and has access to advocacy if substitute decision making is being considered. John may be eligible for Australia's new National Disability Insurance Scheme. The National Disability Insurance Scheme (NDIS) Act (2013) has affirmed Australia's obligations under the United Nations Convention on the Rights of Persons with Disabilities (CRPD) (United Nations, 2008). Like the CRPD, the NDIS shares a commitment to promoting and realising the human rights of people with disability, a key component of which is the removal of barriers to participating fully in social, economic and political spheres of life, including stigma and discrimination. If John is one of the 64,000 people with a primary psychosocial disability who it is anticipated will be eligible for the scheme in Australia, he will be allocated an individual budget to fund 'reasonable and necessary' supports (NDIS Act, 2013) on a no fault basis (Fawcett and Plath, 2014). This represents additional supports and is not a substitute for clinical care by mental health providers in hospital and community. Mental health social workers will form a large component of the rapidly expanding disability workforce and will need to consider what they have to offer such a scheme and how to support increased choice and control by people like John (Brophy et al, 2015).

In Ontario, John's capacity to manage finances would be assessed during one of his compulsory admissions. It is the role of the social worker to meet with John, and conduct a thorough assessment of his housing, finances, social supports, and wishes. If there were concerns about his ability to manage his finances, an assessment of capacity would be completed by his treating psychiatrist usually on the advice of a social worker. If John was found to lack capacity to manage finances, he would receive independent advice from the Psychiatric Patient Advocate Office. The PPAO would send a representative to the hospital to meet with John, and advise him of his rights to challenge the finding of incapacity and his option to have the

finding of incapacity reviewed by the CCB. If John had appointed a Power of Attorney before he was found to be incapable that person would take over his finances. In the absence of a pre-existing PoA the province would appoint a representative of the Public Guardian and Trustee (PGT). In practice, the PGT is required to meet face to face with their client. The social worker is responsible for organizing mental health supports for John upon discharge from hospital. His eligibility for formal community based mental health supports is dependent on the number of inpatient hospital days he has had. If he has had over 90 consecutive days in hospital he may be referred to an Assertive Community Treatment (ACT) Team. If he has had fewer days he may be referred to a hospital outreach case-manager. In both cases, regardless of formal findings of capacity to make treatment decisions, John is required to consent to receiving these supports. It is important to note that the fact that John is housed, and owns his home will be barriers to him receiving community based mental health supports. People who are homeless or vulnerably housed are prioritized.

Conclusions

In this paper we have described how changing legal and policy contexts have created new forms of decision making by mental health social workers and other professionals. It has been argued that the conditions for compulsory admission and treatment under older mental health laws are based on, arguably, mistaken confidence about professionals' abilities to ascertain risk and even what counts as a mental disorder (Davidson et al, 2016a). And despite the evidence that the experience of service users when such laws are being used is generally poor, there seem little doubt that compulsory mental health laws have to remain in place to protect clients' rights, health and care. New laws, however, tend to increasingly restrict arbitrary decision making, and prescribe the limitations of mandated powers. The presumption of capacity for all clients has had the effect of shifting professional attitudes and roles, away from outdated paternalism and professional power, towards potentially more empowering engagement with clients and their families. These issues are variously reflected in the way that States have interpreted their obligations under the UNCRPD; our four chosen jurisdictions reveal the complexities of legal interfaces in which mental health social workers have to make decisions.

For the principles of the UNCRPD to be adhered to, social workers, other mental health professionals, service user and carer movements, and advocacy groups should champion these more listening, engaging approaches when making such profound decisions about the lives of clients who lack or do not capacity in situations of risk and mental ill-health. This implies that disciplinary, as well as professional and client boundaries need to be more permeable and partnership arrangements strengthened. An example from a recent project in Victoria describes how the development of practice guidelines emphasise the use of legal mechanisms such as advance statements, and the development of professional interpersonal skills, service user empowerment and new approaches in management and leadership (Brophy et al 2017). Empowerment, self-determination and respect for the person

are fundamental social work principles. Such principles and practices should be at central to the mental health social work role in decision making about capacity, care and treatment.

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