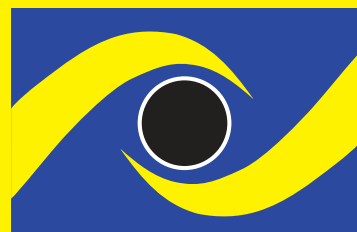


MHA GUIDE BOOK



NSW INSTITUTE
OF PSYCHIATRY



MENTAL HEALTH ACT GUIDE BOOK

Amended May 2003

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Last year the Carr Government embarked on reform of the *Mental Health Act*. This reflected a concern that the *Act* was not making appropriate provision for the care of people with mental illness when they were not well enough to make safe decisions for themselves. The amendments made to the *Act* were the result of a broad consultation process with those directly affected as consumers, carers or service providers.

This rewrite of the *Mental Health Act Guide Book* embraces those amendments to the legislation. It provides a clear explanation of the most commonly used parts of the legislation and is a valuable reference tool for all of those who work with the *Mental Health Act*.



Andrew Refshauge MP
Deputy Premier
Minister for Health
Minister for Aboriginal Affairs

The NSW Institute of Psychiatry is pleased to be involved in the production of the *Mental Health Act Guide Book*, that was prepared with financial support from the Department of Health.

The *Guide* represents the coordinated activity and enthusiasm of many people, but particularly the members of the Mental Health Act Project Steering Committee.

The Institute of Psychiatry is committed to the production of high quality effective educational material in the field of mental health and sees this *Guide* as a significant achievement.



Dr Louise Newman

Director

NSW Institute of Psychiatry

Introduction

The *Mental Health Act* establishes the legislative framework within which care, control and treatment can be provided for people with a mental illness in NSW. A good understanding of the major objectives and requirements of the *Act* is therefore important for all of those who work within the mental health system.

As the *Act* itself can often seem like a daunting maze of interconnecting rules and procedures, the *Guide* has been written to provide mental health practitioners with a clear and practical source of information about the most commonly used parts of the *Act*. Thus it focuses on the procedures surrounding involuntary admission and the implementation of Community Orders, while also highlighting the importance of consumer rights and the external processes of review.

This edition of the *Guide* contains updated material to take into account amendments to the legislation, as well as some new sections. Appendix 1 contains the Forms which are used in conjunction with the *Act*, while material which can assist in preparing for Tribunal hearings appears in Appendix 2. There is a list of Contacts for times when further information about the *Act* is required, and three training sessions have also been included to encourage ongoing education in the *Mental Health Act* within agencies.

On behalf of the NSW Institute of Psychiatry, I wish to thank many people who assisted me in this endeavour. In particular I would like to mention Mr Dennis Bale, Ms Sandra Hoot, Ms Maria Cassaniti, Mr Robert Wheeler, Mr Chris D'Aeth, Ms Robyn Shields, Ms Kath Thorburn, Ms Marion Brown and Ms Nicola Watt for their comments and suggestions on earlier drafts of the material, Ms Fiona Dix for her word processing skills, and Ms Liz Hay for layout.

I hope this manual will assist those who work with the mentally ill in NSW to use the legislation as an effective means of providing the best possible care and treatment within the least restrictive environment.

Pamela Verrall

Mental Health Act Project

NSW Institute of Psychiatry

November 1998

Summary of Major 1997 Amendments

Accredited persons

- in areas where there is a shortage of medical practitioners, experienced mental health professionals can be given the authority to write Schedule 2 certificates.

Definition of a mentally ill person

- replacement of requirement for 'serious physical harm' with 'serious harm'
- deletion of separate criteria relating to bipolar disorder so that new criteria apply to all forms of mental illness
- expansion and clarification of 'continuing condition'.

Duration of Community Treatment Orders

- maximum increased from 3 to 6 months.

ECT for involuntary patients

- Mental Health Review Tribunal approval is mandatory in all cases.

Magistrate's power of adjournment

- a magistrate may adjourn an inquiry from time to time for up to 14 days where this is seen to be in the best interests of the patient.

Official visitors

- are appointed to visit area health services rather than individual hospitals
- response time to a patient's request to see an official visitor reduced from 7 to 2 days.

Police powers

- police may take a person directly to hospital if they appear to be seriously mentally disturbed whether they have been apprehended in a public or private place.

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Aims and Objectives of the Mental Health Act

The aims and objectives of the *Act* are set out in 4 sections.

1.1 Care, treatment and control of mentally ill and mentally disordered persons (s4)

- people are to receive the best possible care and treatment in the least restrictive environment enabling the treatment to be effectively given
- any restriction of liberty and interference with the rights, dignity and self-respect of the person is to be kept to a minimum.

1.2 Administrative objectives (s5)

- establish the Mental Health Review Tribunal
- provide for the appointment of official visitors and authorised officers
- complement the operation of the *Guardianship Act*
- allow proceedings before magistrates, the Tribunal or the Psychosurgery Review Board to be conducted with as little formality and technicality as appropriate.

1.3 Objectives of the Department of Health (s6)

Establish, develop, promote, assist and encourage mental health services that:

- develop standards and conditions of care that are at least as beneficial as those provided for other illnesses
- take the religious, cultural and language needs of people into account
- are comprehensive and accessible
- support the patient in the community and liaise with other providers.

Ensure that people are informed of their rights and entitlements under the *Act*, in a language and manner that they are most likely to understand.

1.4 Functions of the Director-General (s7)

- ensure that provision is made for the care, treatment, control and rehabilitation of those who are mentally ill or disordered
- promote the establishment of community mental health services
- promote research into mental illness
- assist in the training and education of those responsible for the care and treatment of those affected by the *Act*
- make recommendations to the Minister about matters which concern the care and welfare of those affected by the *Act*
- promote informed public opinion in relation to mental health.

Definitions

There are 2 key definitions that anyone working with the *Mental Health Act* should understand:

- a mentally ill person
- a mentally disordered person.

These definitions provide the framework for many of the decisions made by mental health professionals. In particular, it is these definitions that determine who can be involuntarily admitted to hospital, and who can be required to comply with a Community Order. As with any definition however, elements of interpretation and professional judgement are always involved.

2.1 Who is a mentally ill person under the Act?

Definition (s9)

A mentally ill person is someone who is suffering from a mental illness and owing to that illness there are reasonable grounds for believing that care, treatment or control of the person is necessary:

- for the person's own protection from serious harm, or
- for the protection of others from serious harm.

In considering whether someone is a mentally ill person, their continuing condition, including any likely deterioration in their condition, is to be taken into account.

What is a mental illness for the purposes of the Act? (Schedule 1)

Mental illness for the purposes of the *Act* means a condition that seriously impairs, either temporarily or permanently, the mental functioning of a person and is characterised by the presence of any one or more of the following symptoms:

- delusions
- hallucinations
- serious disorder of thought form
- severe disturbance of mood
- sustained or repeated irrational behaviour indicating the symptoms mentioned above.

This definition is based on symptoms and not on diagnoses.

What is serious harm?

Serious harm is a broad term that can be best understood in terms of its everyday usage. It can include:

- physical harm
- harm to reputation and relationships
- financial harm
- self-neglect
- neglect of others, e.g. the person's children.

A continuing or deteriorating condition?

This is a broad and open expression that invites the clinician or decision maker to consider:

- a person's clinical history including their degree of insight and their capacity or willingness to follow a voluntary treatment plan
- the likely impact on the person's prospects for improvement or recovery if there is a failure to comply with a treatment plan.

! Continuing condition

"The phrase 'continuing condition' invites the clinician and the decision maker to use an involuntary treatment order to assist a person in avoiding the 'revolving door syndrome'. This can be done by ensuring that the person is admitted when necessary, and receives involuntary treatment for long enough to lessen the risk of an early serious relapse." MHRT

Putting it all together – deciding who is a mentally ill person under the Act

For someone to be a mentally ill person for the purposes of the Act, a number of criteria need to be considered:

- is there a mental illness as defined in Schedule 1
and;
- is there a risk of serious harm to the person or others
and;
- has the person's continuing condition or likelihood of deterioration been considered
and;
- what is the least restrictive environment in which appropriate care, control and treatment can be effectively provided?

2.2

Who is a mentally disordered person under the Act?**Definition (s10)**

A mentally disordered person is someone whose behaviour is so irrational that there are reasonable grounds for deciding that the temporary care, treatment or control of the person is necessary to protect them or others from serious physical harm.

What is irrational behaviour?

It has no special legal meaning and is to be understood in its everyday usage.

What is serious physical harm?

It has no special legal meaning and is to be understood in its everyday usage.

Putting it all together – deciding who is a mentally disordered person under the Act

For someone to be a mentally disordered person for the purposes of the Act, a number of criteria need to be considered:

- is the behaviour so irrational that temporary care, treatment or control is necessary
and;
- is there a risk of serious physical harm to the person or others
and;
- what is the least restrictive environment in which appropriate care, control and treatment can be effectively provided?

! Mentally disordered

This category is most commonly used where a person is actively suicidal or out of control following a personal crisis. It can also be useful where a person is suffering from a condition such as dementia. It may provide caregivers with the breathing space in which to sort out other more appropriate care.

This section is not intended to include those who are simply drunk and disorderly, or who have engaged in some other form of antisocial behaviour. Evidence of mental disorder is required before this provision can be used.

2.3 Exclusion criteria (s11)

These have been included to prevent the potentially broad compulsory detention powers in the *Act* being used to control behaviour that is not related to mental illness.

A person is NOT to be defined as ‘mentally ill’ or ‘mentally disordered’ merely because of any one or more of the following:

- a particular political opinion or belief or activity
- a particular religious opinion or belief or activity
- a particular philosophy
- a particular sexual preference or orientation
- engaging in immoral or illegal conduct or antisocial behaviour
- engaging in sexual promiscuity
- taking drugs or alcohol
- having a developmental disability.

2.4 Differences between a mentally ill and mentally disordered person under the Act

The *Mental Health Act* specifies a different set of procedures and consequences for each category. These are dealt with under Involuntary Admissions (see *Guide*, Section 5).

2.5 Some other important definitions

Accredited person

An accredited person is a suitably qualified and experienced mental health practitioner who is specifically empowered to write Schedule 2 certificates, usually in areas where there are insufficient doctors.

Temporary patient

A temporary patient is someone who has been found to be a mentally ill person at a hearing before a magistrate, and placed under a Temporary Patient Order (TPO). The order may last up to 3 months. It may be extended by the Mental Health Review Tribunal for a further 3 months.

Continued treatment patient

A continued treatment patient is someone who requires longer-term involuntary detention in a psychiatric inpatient facility. A person can only be classified in this way by the Mental Health Review Tribunal. Such patients must have their cases reviewed by the Tribunal every 6 months (see *Guide*, Section 7.3).

Consumer Rights in Mental Health

People with a mental illness enjoy the same rights as anyone else in the community. These include the right to self-determination and to go freely about their daily business without undue interference. At times, however, a mental illness may result in behaviour that leads to those rights being curtailed.

It is the purpose of the *Mental Health Act* to:

- set out the circumstances in which this can happen
- provide a framework of checks and balances
- ensure that the interference with a person's rights, dignity and self-respect is kept to a minimum.

This section sets out the rights enshrined in the *Mental Health Act* in relation to:

- involuntary patients
- those under Community Orders.

It also looks at some of the agencies and individuals who have a particular role to play in ensuring that patients have the opportunity to exercise those rights.

3.1 Rights of involuntary patients

Right to liberty

The presumption of liberty is embedded throughout the *Act*.

It is generally expressed in:

- the concept of the 'least restrictive environment' (see *Guide*, Section 1).

It is specifically expressed in:

- the right to internal review by the medical superintendent
- the right to external review by the magistrate and/or the Mental Health Review Tribunal (see *Guide*, Section 7).

Right to procedural fairness

This right is expressed by the sections of the *Act* that require specific procedures to be followed in:

- the process of involuntary admission (see *Guide*, Section 5)
- the processes of external review (see *Guide*, Section 7).

Right to information

Before a person is certified as 'mentally ill' or 'mentally disordered' they must be given:

- an oral explanation, and
- a written statement of their legal rights (see *Guide*, Appendix 1)
- where the person is from a NESB or Aboriginal background, the assistance of interpreters, cross-cultural consultants and Aboriginal health workers is important (see *Guide*, Section 12).

If the person has not understood the first explanation it must be repeated:

- at least 24 hours before the magistrate's inquiry.

If a Temporary Patient Order is made the person must be informed of:

- their right of appeal to the medical superintendent (s67)
- their right of appeal to the Mental Health Review Tribunal if the medical superintendent refuses to discharge them (s69).

Right to representation

The *Act* requires that patients be represented by a lawyer (or other person of their choosing):

- when the issue of their involuntary detention is being considered by a magistrate (see *Guide*, Section 7)
- unless they decide not to be represented.

This representation is provided free of charge by solicitors from the Mental Health Advocacy Service (see *Guide*, Section 3.3).

The *Act* allows patients to be represented by a lawyer (or other person of their choosing) in other matters that come before the Tribunal, e.g. the authorisation of ECT. The Mental Health Advocacy Service offers representation in some of these matters.

Right to wear street clothes to a hearing

The *Act* specifically provides patients with the right to wear their own clothes to any hearing before the magistrate or Tribunal. This is an important way of preserving the person's dignity.

Right to have other people notified

Where a person is involuntarily detained, the hospital must:

- notify the person's family or nominated friend of the hospital's intention to have the person seen by a magistrate (see *Guide*, Appendix 1) unless the person objects
- notify the person's guardian, even when the person objects.

Right to an interpreter

Where the patient has a limited grasp of English, or does not speak it at all, the hospital must provide an interpreter to:

- explain the person's rights and entitlements (s30)
- assist in interviews with medical staff where reasonably practical (s292)
- assist at a magistrate's inquiry (s41) or Tribunal hearing (s275) (see *Guide*, Section 12).

Right to access medical records

Under the *Mental Health Act*, patients and/or their lawyers have the right to access their medical records in relation to:

- a magistrate's inquiry.

Access may be restricted to the patient's lawyer:

- where a medical practitioner believes the disclosure of the records would be harmful to the patient.

In these cases the lawyer is not obliged to disclose information to the patient.

Reference should also be made to the Department of Health's Code of Practice on Information Privacy. This supports the general right of clients and patients to see and obtain copies of information held about them by a health care facility, and also lists the circumstances in which access may be refused.

Right to apply to be discharged

A Temporary or Continued Treatment Patient has the right to apply to the medical superintendent, either orally or in writing, to be discharged (s67).

- the medical superintendent has 3 working days to make a decision
- if the person's application is refused they can appeal to the MHRT (s69)
- if the person indicates their wish to appeal, this must be brought to the attention of the Tribunal.

A written request is useful but not essential.

Rights in relation to medication

Involuntary patients:

- do not have the right to refuse medication, but
- do have the right to information about their medication, including side effects and dosages (s300).

The patient's lawyer also has the right to information about their client's medication.

In prescribing medication the hospital must:

- have due regard to the possible effects of the medication on the particular patient
- prescribe the minimum dose consistent with proper care
- monitor and review the drug administration practices of the hospital in general (s199).
- prescribe with proper regard to current professional standards (s198).

Magistrates and Tribunals must:

- inquire into the medication of the patient before them
- take into account the effect of the medication on the patient's ability to communicate at the hearing.

Right to privacy and confidentiality

Where a person is seen by a magistrate or the Tribunal their name is not to be broadcast or published in any way, without their consent and the approval of the magistrate or Tribunal.

Right to protection from ill-treatment

No person employed in a hospital is allowed to willfully strike, wound, ill-treat or willfully neglect a patient (s298).

Other general rights

Patients have other rights that are not mandated by the *Mental Health Act*. These may be drawn from other pieces of legislation or may generally be considered to comply with good practice.

Some of these include:

- right to receive and send mail without interference
- right to receive and make telephone calls
- right to speak with friends, lawyers, relatives etc. in privacy
- right to be spoken to respectfully
- right to refuse to have students or others present while being interviewed or treated.

3.2 Rights under a Community Order

As those who are being treated under a Community Order (see *Guide*, Section 6) are under fewer restrictions than those in hospital, the *Mental Health Act* does not need to set out the framework of their rights in such detail. However, the following rights apply:

- a limited right to have the Community Order reviewed by the MHRT (the person needs to show that there has been a substantial or material change in their circumstances (s148))
- to procedural fairness before the magistrate and the Tribunal (see *Guide*, Section 7)
- to be represented by a lawyer or other advocate before the Tribunal
- to put their point of view to the Tribunal about the Order
- to an interpreter
- to have access to their medical records in accordance with the Department of Health's Code of Practice on Information Privacy
- to information about the medication they are required to take.

3.3 Assisting consumers to exercise their rights

Although the *Act* makes provision for a variety of rights, it will often be difficult, if not impossible for the person to exercise these rights without assistance. It is therefore important to consider who is the best position to provide such assistance. In some cases this may be the staff from the hospital or the community team. In other cases it may be more appropriate to involve someone outside the treating team. Where the person is from a NESB or Aboriginal background, cross-cultural consultants and Aboriginal health workers have a particularly important role to play (see *Guide*, Section 12).

This section looks at some of the individuals and agencies who may be involved in:

- assisting consumers to exercise their rights
- handling consumer complaints.

Mental Health Advocacy Service

The Mental Health Advocacy Service is part of the Legal Aid Commission of NSW.

It provides:

- a free telephone advice service on mental health law.

It also provides free representation in the following circumstances:

- a magistrate's inquiry
- a Tribunal hearing into an extension of a Temporary Patient Order
- a Tribunal hearing into the care of a Continued Treatment Patient
- an appeal to the Tribunal over the medical superintendent's refusal to discharge
- a magistrate or Tribunal hearing into a Protected Estates Order
- all forensic hearings.

In other cases a merit and/or means test is applied.

It is the lawyer's role to act on their client's instructions, and to ensure that the procedures and rights set out in the *Mental Health Act* are respected.

Official visitors

Official visitors are appointed by the Minister for Health (s228) to visit the facilities within each Area Health Service. They visit psychiatric hospitals and wards, both public and private, at least once a month, and community health care agencies at least once every 6 months.

– *What is their role?*

Official visitors:

- inspect the records and facilities of hospitals and health care agencies
- make inquiries into the care, treatment and control of voluntary and involuntary patients
- make inquiries into the care, treatment and control of those who are under Community Orders
- report to the Principal Official Visitor and the Minister on their impressions and findings.

– *Contacting an official visitor*

A patient or person under a Community Order may ask to see an official visitor at any time. The hospital or agency must pass on the request within 2 days (s238).

Hospitals and agencies are to facilitate consumers making direct contact with official visitors by:

- displaying a poster (available from the Centre for Mental Health) about the role of official visitors with a telephone number on which they can be contacted
- providing a locked box in an accessible area where confidential messages can be left.

! **Contacting an official visitor**

Consumers do not have to go through the hospital or agency to contact an official visitor. Steps should be taken to facilitate direct access.

NSW Health Care Complaints Commission

The NSW Health Care Complaints Commission is an independent body established by the NSW Government to investigate and prosecute complaints made against health service providers, and to provide information to health consumers about their rights.

The Commission has the power to investigate a wide range of matters including:

- an aspect of treatment, individual rights such as privacy and inappropriate behaviour or administration
- a hospital, nursing home, community health centre, private clinic or any other place that administers health care
- the care and treatment a person receives from a health practitioner.

The Health Care Complaints Commission also employs *Patient Support Officers*. They do not investigate complaints. Their role is to:

- provide information about health rights
- provide information on complaint resolution options
- provide information on health support services
- generally assist the person to resolve their problem at the local level.

Consumer representatives

The development of consumer networks throughout the mental health system is a relatively recent development. In some areas of NSW consumer representative training has started, and new ways of working together are gradually being established. As these networks develop, consumer representatives may take on new roles in providing support and advocacy.

3.4

Relatives and friends

The rights outlined in the *Mental Health Act* relate primarily to the patient/consumer. However, as relatives and friends often play a major role in the person's ongoing care it is important to involve and inform them in appropriate ways wherever possible. This can sometimes require a balancing act between the patient's rights to privacy and confidentiality and the genuine interests of other parties. The involvement of families is specifically encouraged in the case of Aboriginal patients, and particular consideration must be given to seeking advice on involving the families of NESB patients (see *Guide*, Section 12).

Right to information

Where a person is to have the issue of their involuntary detention considered by a magistrate, relatives and/or friends must be notified unless the person objects (s38).

Right to apply for discharge

A relative or friend of a Temporary or Continued Treatment Patient may apply at any time, either orally or in writing, to the medical superintendent for the patient's discharge (s68).

The patient may be discharged if:

- the relative or friend gives a written undertaking that the patient will be properly taken care of, and
- the medical superintendent is satisfied that adequate measures will be taken to prevent the patient causing harm to self or others.

Where the medical superintendent refuses to discharge the person the relative or friend may appeal to the Mental Health Review Tribunal.

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Informal (Voluntary) Admissions

The *Mental Health Act* uses the term informal to refer to patients who are admitted voluntarily.

4.1 Who is an informal (voluntary) patient? (s12)

- a person who voluntarily remains in a psychiatric hospital
- a person who is admitted by their guardian (see *Guide*, Section 8)
- a person who has been admitted as an involuntary patient and is reclassified through an agreement between the person and the medical superintendent (ss 54 and 64).

4.2 Criteria for admission (s17)

- the medical superintendent needs to be satisfied that the person is likely to benefit from inpatient care and treatment.

4.3 Reclassifying a patient from informal (voluntary) to involuntary (s18A)

Where the hospital decides to detain an informal (voluntary) patient:

- the same rights apply as with any involuntary admission (see *Guide*, Section 3)
- the same procedures apply as with any involuntary admission BUT an initial schedule is NOT required (see *Guide*, Section 5).

4.4 Discharge of an informal (voluntary) patient (s65)

- a voluntary patient may discharge themselves at any time
- the hospital may discharge the person where a decision is taken that they are unlikely to benefit from further hospital care and treatment
- if the person has a legal guardian the hospital must inform the guardian of the discharge (see *Guide*, Section 8).

4.5 Avenues of review

Internal review (s19)

- a person who has been refused admission as an informal (voluntary) patient may apply to have that decision reviewed by the medical superintendent
- a person who has been discharged by the hospital may apply to have that decision reviewed by the medical superintendent
- the medical superintendent must review the decision as soon as practicable.

External Review (s63)

- the Mental Health Review Tribunal must review the case of every informal (voluntary) patient who has been in hospital for a continuous period of more than 12 months
- these cases must be reviewed at least once a year
- the Tribunal may order the person's discharge (see *Guide*, Section 7.3).

Involuntary Admissions

The *Mental Health Act* provides a number of ways in which the process of involuntary admission can be initiated. In 1996, for example, there were 7601 involuntary admissions in NSW. Most of these (64%) were initiated by a doctor's certificate, 15% arose when a patient was reclassified from informal (voluntary) to involuntary, and 13% occurred on the written request of a relative or friend. The rest (8%) were initiated by welfare officers, the police or a court order. Most of those who were involuntarily admitted were detained as 'mentally ill' (80%), rather than as 'mentally disordered' (20%) persons.

5.1 Pathways to involuntary admission – getting the person to hospital

Detention on certificate of a medical practitioner (s21)

A person may be taken to and detained in a hospital on the certificate of a medical practitioner (or accredited person) where:

- the practitioner has personally examined or observed the person immediately or shortly before completing the certificate, and
- the practitioner has formed the opinion that the person is either a 'mentally ill' (s9), or a 'mentally disordered' person (s10), and
- the practitioner is satisfied that involuntary admission and detention is necessary (and that there are no other appropriate means available for dealing with the person), and
- the practitioner is not a near relative of the person.

The certificate completed by the medical practitioner:

- must be in the form set out in Part 1 of Schedule 2 (see *Guide*, Appendix 1)
- is valid for 5 days for a 'mentally ill' person and for 1 day where the person is 'mentally disordered'.

? **Q** *Does a person have to be dangerous before the medical practitioner can fill out a schedule?*

A *No. The criteria for a 'mentally ill, or 'mentally disordered' person need to be satisfied.*

Request for police assistance (s22)

A medical practitioner (or accredited person) who has completed a Schedule under Section 21 may enlist the assistance of the police in taking the person to hospital where:

- they believe such assistance is required, and
- there is no other means reasonably available.

In such circumstances the medical practitioner must complete Part 2 of Schedule 2 (see *Guide*, Appendix 1).

The police must assist as soon as is practicable (see *Guide*, Section 11).

? **Q** *Who may use force in taking a person to hospital?*
A *Only the police.*

Detention on request of a relative or friend (s23)

A person may be detained on the written request of a relative or friend to the medical superintendent of the hospital. This section is only to be used in remote areas where distance and the urgency of the situation make it impractical for the person to be seen by a medical practitioner.

Detention by the police (s24)

The police may apprehend someone and take them to a hospital where:

- the person appears to be mentally disturbed, and
 - the police have reasonable grounds for believing that the person is committing or has recently committed an offence, and
 - it would be beneficial if that person were to be admitted to a hospital rather than being dealt with under the criminal law;
- or
- the person has recently attempted or is at risk of killing themselves or attempting to cause serious bodily injury to themselves.

Police do not need a warrant in these circumstances.

They may apprehend a person in any place, either public or private (see *Guide*, Section 11).

Detention on order of the court (s25)

This occurs where a magistrate is of the opinion that the person appearing before them is a mentally ill person who requires assessment at a psychiatric hospital. The person may be taken to and detained in a hospital in accordance with an order made under Section 33 of the *Mental Health (Criminal Procedure) Act 1990*.

Detention on information of welfare officer (s26)

A person may be detained if they are accompanied to the hospital by a welfare officer. The welfare officer must inform the medical superintendent in writing that they believe the person to be 'mentally ill' or 'mentally disordered'. Welfare officers are generally community mental health staff who are specifically designated by Area Health Directors.

Detention following order for medical examination or observation (s27)

If a magistrate is satisfied that:

- a person may be 'mentally ill' or 'mentally disordered', and
- the person could not be personally examined due to physical inaccessibility, then the magistrate may make an order authorising:
 - a medical practitioner to visit and personally examine or observe the person
 - a police officer to accompany and assist the medical practitioner
 - the use of reasonable force to enable the examination or observation to be carried out.

Where this section is used the medical practitioner may complete a Schedule 2 (see *Guide*, Appendix 1).

! Other situations

Sometimes a person will arrive at a hospital in need of psychiatric care, but not by one of the ways outlined above. They may for example be brought into an Accident and Emergency Unit by ambulance, after attempting suicide. In these cases a doctor still needs to complete a Schedule 2, which complies with Section 21 of the 'Mental Health Act', before the person can be transferred involuntarily to a psychiatric unit.

5.2 After the person gets to hospital – examination requirements

The different processes set out above deal with getting a person lawfully to hospital. Once they have arrived however, the *Mental Health Act* requires 2 (and in some cases 3) further examinations, for the person to continue to be detained. The results of these examinations must be written up on the appropriate form (see *Guide*, Appendix 1).

This procedure has been established to ensure that people are not detained unnecessarily. However, the complexity of the process means that it may contribute to the patient's confusion and distress. Admission protocols should therefore aim to minimise these adverse consequences, while complying with the *Act*.

First examination (s29)

The first examination must:

- be conducted by a doctor as soon as practicable (within 12 hours).

Where this doctor finds the person:

- neither 'mentally ill' nor 'mentally disordered' they must be released
- either 'mentally ill' or 'mentally disordered' they must be seen by a second doctor.

Second examination (s32)

The second examination must:

- occur as soon as practicable
- be done by a psychiatrist (unless the doctor conducting the first examination was a psychiatrist).

Where at least one of these doctors finds that the person is 'mentally ill':

- the person must be seen by a magistrate.

Where both doctors agree that the person is 'mentally disordered':

- the person can be detained for 3 days.

Where the second doctor finds the person not 'mentally ill' or 'mentally disordered';

- a third examination must occur.

Third examination (s33)

The third examination must:

- occur as soon as practicable
- be conducted by a psychiatrist.

The decision made by the third doctor determines whether the person is released, or detained as a 'mentally disordered' or as a 'mentally ill' person.

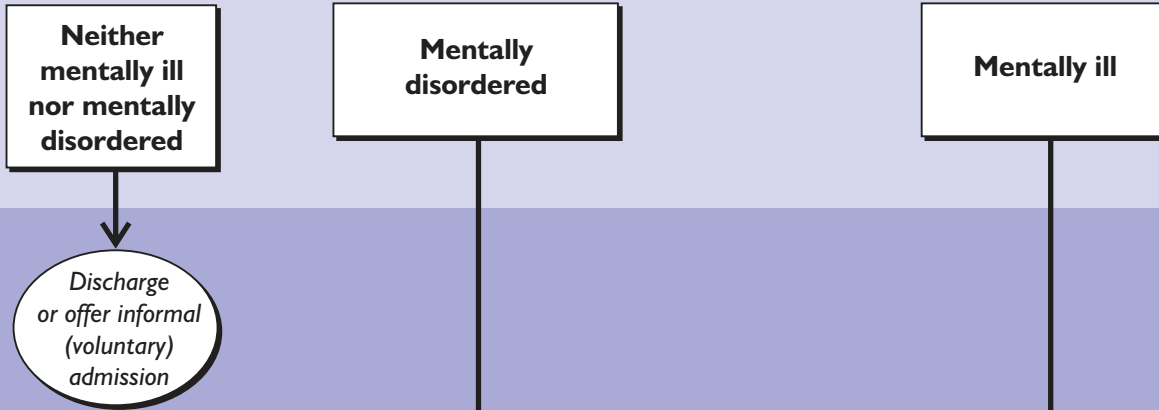
? **Q** *Can patients be transferred between units, or between hospitals during the scheduling and examination process?*

A Yes

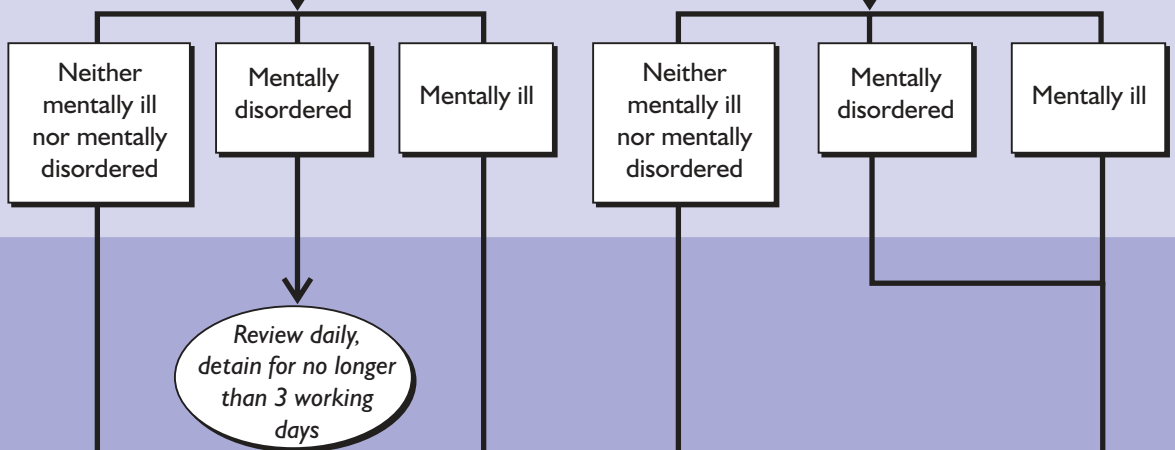
Examination Procedures UNDER THE MENTAL HEALTH ACT

Before 1st examination check that Schedule 2 (or other admission documents) are completed.
If not, complete Schedule 2.

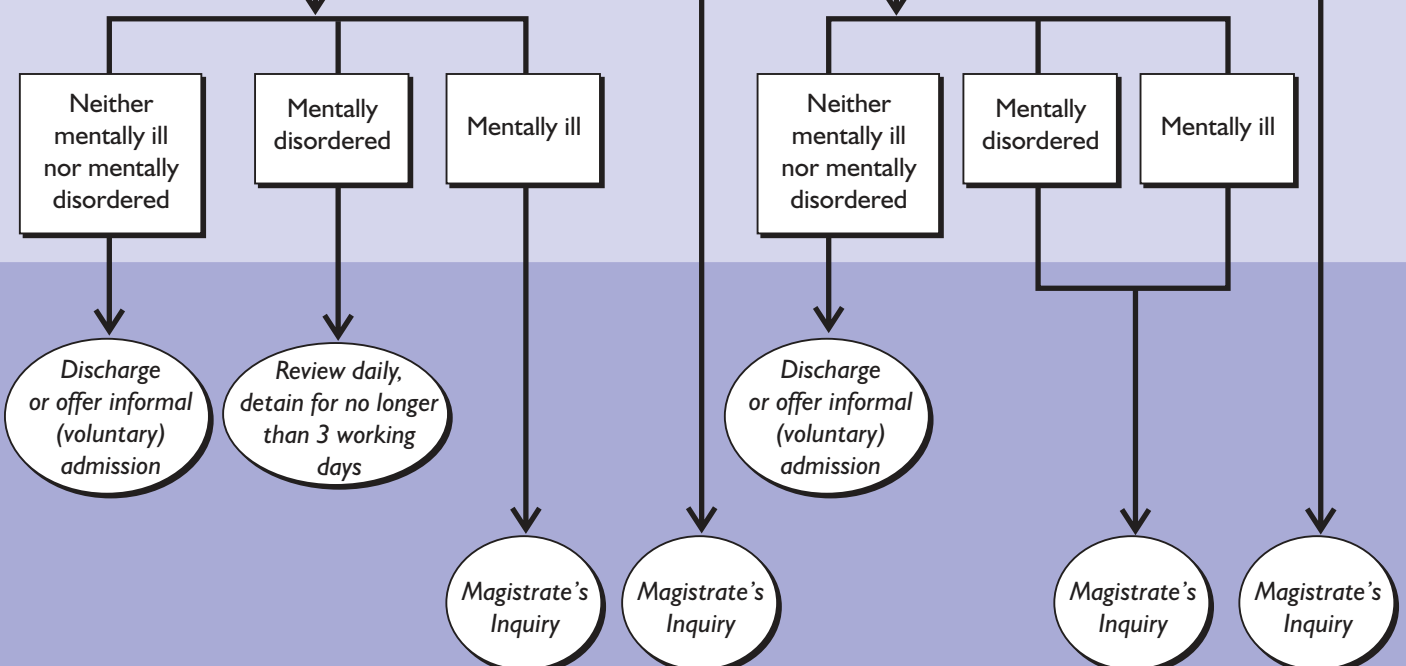
1st Examination



2nd Examination



3rd Examination



5.4

Being detained as a mentally ill or mentally disordered person

Consequences of being detained as mentally disordered

From the time of the first medical examination after the person's arrival at the hospital, they can only be detained for 3 days, not including weekends and public holidays. They may be confined and given treatment against their wishes.

In addition the person:

- must be examined at least every 24 hours by a doctor
- must be released if the doctor decides the person is no longer mentally disordered
- may not be detained on more than 3 occasions in any 1 month
- may be detained for 3 consecutive 3-day periods.

Where the person is to be detained beyond the first 3 working day period, the scheduling and examination procedures required by the *Act* must be complied with again.



Q John was scheduled as a mentally disordered person on Wednesday the 16th, and held for 2 consecutive periods. As weekends are excluded, John was discharged on the 23rd. He was readmitted the following month on Monday the 11th. Can he be detained for another 2 consecutive periods?

A No. He would have to be discharged after the first 3-day period. This is because the 'month' stipulated in the 'Mental Health Act', is a rolling calendar month. It does not start anew on the first day of the new month. Individual cases may be checked with the MHRT or Centre for Mental Health.

Consequences of being detained as mentally ill

The person must be seen by a magistrate as soon as practicable (see *Guide*, Section 7.2). They can be confined, and given treatment against their wishes. However, medication should be prescribed at the minimum level consistent with proper care, to ensure that the person can communicate with their legal representative (s31).

5.5 Detained person's right to information (s30)

Once a person has been taken to hospital they must be given:

- an oral explanation and written statement of their rights (see *Guide*, Appendix 1)
- as soon as is practicable
- in a language they understand.

Where the person has not been capable of understanding the first explanation, this must be repeated no later than 24 hours before the magistrate's inquiry.

During this interim period the person has no right to appeal to the Mental Health Review Tribunal. They can however, seek advice from the Mental Health Advocacy Service in regard to their detention.

5.6 Release of those who do not meet criteria for involuntary admission

General discharge procedure

In discharging a person who has been assessed and not found to satisfy the criteria for involuntary admission, consideration should be given to the person's welfare and their ability to return safely to the community. While this is not specified by the *Mental Health Act*, such practice is consistent with the hospital's duty of care.

! Discharge

An involuntary patient must be discharged at any time if the medical superintendent decides that care of a less restrictive kind is appropriate and available, or decides that the patient has ceased to be a 'mentally ill', or 'mentally disordered' person. The person may be immediately re-admitted as an informal (voluntary) patient where appropriate.

Person referred for assessment by court order

Where a person has been referred to a hospital for assessment under *the Mental Health (Criminal Procedures) Act*, the court order will specify whether the person is to be returned to court if they are not found to meet the criteria for involuntary admission.

Where they are to be returned to court the hospital must:

- notify the police of the decision and detain the person until the police arrive
- release the person into police custody.

The police must take charge of the person as soon as practicable (ss 36 and 37a).

Person detained after being apprehended by police

Where the person is not found to meet the criteria for involuntary admission the hospital must:

- notify the police of that decision
- if the police are present release the person into police custody (See *Guide*, Section 11).

If the police do not wish to proceed any further with the matter the hospital may:

- discharge the person into the care of a relative or friend where possible, or
- admit the person as an informal (voluntary) patient where appropriate, or
- discharge the person with consideration to their welfare.

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Community Orders

Community Treatment Orders and Community Counselling Orders were introduced in the *Mental Health Act* to provide a community-based alternative to involuntary hospitalisation. They require a person to accept medication and other treatment for a period of 6 months, and may be renewed. They are intended to allow those, who might otherwise be detained in hospital, to live in the community and get the treatment, care and support they need in a less restrictive setting than a hospital.

6.1 Community Treatment Orders

What is a Community Treatment Order (CTO)? (s131)

A CTO is a legal order made by the Mental Health Review Tribunal or a magistrate. It sets out the terms under which a person must accept medication, therapy, rehabilitation or other services. It is implemented by a health care agency that has developed an appropriate treatment plan.

When can a CTO be made?

The Magistrate can make a CTO where :

- a person is found to be 'mentally ill', and
- an order for community treatment is seen as the 'least restrictive alternative'.

The Tribunal can make a CTO where a person is:

- a temporary patient, or
- a continued treatment patient, or
- on a CTO that is about to expire, or
- on an appeal from the medical superintendent's refusal to discharge.

A CTO can only be made if the person (s133):

- has been for the first time diagnosed as suffering from a mental illness; or
- has previously refused treatment, and
- experienced a relapse into mental illness when treatment was refused, and
- in the absence of treatment involuntary admission occurred, or was likely.

Before an order will be granted the Tribunal or magistrate must be satisfied that:

- the person would benefit from the order because it provides for consistent, safe and effective care in an environment that is less restrictive than the hospital, and
- the health care agency agrees with and can provide the suggested care.

Where an application is made to renew a CTO, or made soon after the person has come off a previous Community Order, the health care agency must provide the Tribunal or magistrate with a report on the outcome of the previous CTO or CCO (s134).

The treatment plan

It sets out how the person is to be managed while on a CTO and:

- is usually prepared by the psychiatric case manager
- must be presented to the Tribunal or magistrate for approval (see *Guide*, Appendix 2).

What should be in the treatment plan?

Treatment plans should only contain:

- treatments with a demonstrated therapeutic benefit for the person
- conditions considered essential to maintain the person in the community
- conditions the agency is prepared to enforce.

! A good treatment plan:

- *is specifically tailored to the needs of the individual*
- *sets out the agency's obligations to provide specific treatment and support along with the person's obligations*
- *is specifically discussed and negotiated with the person. (MHRT)*

A poor treatment plan:

- *sets out only the person's obligations*
- *is not clear or comprehensible*
- *is vague and ill-defined. (MHRT)*

Breaching a CTO

This may happen when a person refuses or fails to comply with an Order.

Before a breach can be said to have occurred, however, a clinical decision must be made. A person's failure to comply with the terms of the Order does not, of itself, automatically trigger breach proceedings.

The director of the health care agency must consider the case to:

- assess whether the agency has taken all reasonable steps to implement the Order, and
- decide whether there is a significant risk of deterioration in the mental or physical condition of the client, and
- make a written record of his or her opinions, and the facts upon which these are based.

Breach process

The breach process commences and continues at the discretion of the director of the health care agency supervising the Community Order.

– **The first warning – verbal** (s137)

If the director decides that all reasonable steps have been taken by the agency, and that there is significant risk of deterioration, the case manager will then give the client a warning that continued failure to comply may result in the client being taken to the agency or a hospital for treatment.

– **The second warning – written** (s138)

If the person still fails to comply the director may give the client a written notice:

- requiring the person to accompany a member of staff to the agency or a hospital for treatment, and
- notifying them that police assistance may be obtained to ensure compliance.

– ***Where the client agrees***

If the client agrees to come to the health care agency they may be:

- given treatment in accordance with the CTO
- assessed for involuntary admission if appropriate.

Force may not be used to administer treatment at the agency.

– ***Where the client refuses – issuing a written order*** (s139)

Where the client refuses to comply with the second warning, the director or case manager may:

- put that order in writing
- order that the client be taken to the agency or a hospital.

This Order may be implemented by a mental health worker, but not by force (s139).

– ***Involving the police***

If the mental health worker cannot implement the Section 139 Order, it may be given to the police. Following a formal notice requesting assistance the police must respond as soon as possible. The police may use force to enter premises, apprehend the person, and take them to either the agency or to hospital (see *Guide*, Section 11).

– ***Arriving at the hospital following a breach***

On arrival at the hospital, the client has the right to:

- apply for discharge (s142) (see *Guide*, Appendix 1)
- apply to the Mental Health Review Tribunal for a review of the order in limited circumstances (s148).

The medical superintendent:

- must review the client's condition
- may give the client treatment in accordance with the CTO, without their consent if necessary.

– ***Detention in hospital following a breach if the person is found to be a mentally ill person***

If the medical superintendent decides that the person is a 'mentally ill' person for whom no other care of a less restrictive kind is appropriate or reasonably available, the person can be detained as a temporary patient for the remainder of the CTO.

The person must however, be seen by the Mental Health Review Tribunal no later than 3 months after being detained. This is the case even if the CTO has another 4 or 5 months to run. The Tribunal considers whether the person is still a 'mentally ill' person and then decides whether to:

- discharge with the same or varied CTO
- continue the person's detention (see *Guide*, Section 7.3).

The person must, of course, be discharged at any time the medical superintendent decides they are no longer a 'mentally ill' person.

Where discharge occurs before the original CTO has expired it continues to operate.

– ***If the person is found to be mentally disordered***

If the medical superintendent decides that the person is 'mentally disordered' then they may be detained for the remainder of the CTO or for a period of 3 days, whichever is the sooner.

Where the person is discharged before the CTO has expired it continues to operate.

Duration of a CTO

A CTO can be made for a period of up to 6 months.

The director of the health care agency providing case management can revoke the CTO at any time where appropriate.

If the health care agency feels that it is necessary to keep a person on a CTO for longer it must:

- apply to the Tribunal for a new CTO before the existing CTO expires.

! Negotiation

Resentment and resistance to Community Orders can be minimised by consulting and negotiating with clients and where possible working towards the client's goals.

The Tribunal

- informs people of the hearing in writing
- encourages them to attend
 - but
- can renew a CTO in the patient's absence (see *Guide*, Section 7.3).

6.2 Community Counselling Orders

What is a Community Counselling Order (CCO)? (s118)

A CCO is a legal order made by the Mental Health Review Tribunal or a magistrate. It sets out the terms under which a person must accept medication, therapy, rehabilitation or other services. It is implemented by a health care agency that has developed an appropriate treatment plan.

When can a CCO be made? (s120)

The Tribunal or magistrate can only make a CCO for a person who:

- in the opinion of a psychiatrist or suitably qualified and appointed medical practitioner, is likely to become mentally ill within 3 months.

Before a CCO can be made, it must also be shown that the person:

- has previously refused treatment more than once, and
- experienced mental illness when treatment was refused, and
- in the absence of treatment involuntary admission occurred or was likely, and
- the illness could have been eased by providing treatment.

Either the person or their legal representative must be present at the hearing.

The health care agency must show that it has:

- made reasonable attempts to maintain contact with the person in order to gain their consent to treatment
- an appropriate treatment plan.

The treatment plan

The treatment plan sets out how the person is to be managed while on a CCO and:

- is usually prepared by the psychiatric case manager
- must be presented to the Tribunal or Magistrate for approval.

(see CTOs for ‘What should be in the treatment plan?’)

Breaching a CCO

This may happen when the person refuses or fails to comply with the treatment plan. Before a breach can be said to have occurred, however, a clinical decision must be made.

The director of the health care agency must consider the case to:

- assess whether the agency has taken all reasonable steps to implement the Order, and
- decide whether there is a significant risk of deterioration in the mental or physical condition of the affected person, and
- make a written record of his or her opinions and the facts upon which these are based (s127).

– **The first warning – verbal** (s127)

The director of the health care agency may then, through the psychiatric case manager:

- inform the person that if they do not comply they can be taken to the health care agency for treatment and counselling.

– **The second warning – written** (s128)

If the person continues to fail to comply they may be given a written notice stating that:

- they must attend the health care agency for treatment, and
- informing them that the police can be called on to assist.

The person cannot, however, be forced to take treatment at the health care agency.

Once at the health care agency the person may be assessed by a medical practitioner and steps taken to admit the person to hospital as an involuntary patient.

Duration of a CCO

A CCO can be made for a maximum period of 6 months.

If an order is made for more than 3 months the psychiatric case manager must review the client's progress after 3 months, and report to the director of the health care agency.

The director of the health care agency providing case management can revoke the CCO at any time where appropriate.

The Tribunal

- informs people of the hearing in writing
- encourages them to attend
 - but
- cannot renew a CCO in the person's absence (see *Guide*, Section 7.3).

6.3 Choosing between a CTO and a CCO

CCOs have tended to fall into disuse in the last few years, as they are more difficult to enforce when a breach occurs. However, some agencies use them effectively where a client has been on a CTO, and a less restrictive alternative is considered appropriate.

6.4 Applying to the Tribunal for a subsequent Community Order

Appendix 2 of the *Guide* contains some additional material from the Tribunal to assist in preparing for and attending a Tribunal hearing.

Preparing the application

If a health care agency applies for a second or further Community Order the agency must:

- provide the Tribunal with a report on the effectiveness of the previous order,
 - and
- present this at the hearing.

The report should be prepared on letterhead indicating when it was prepared and by whom. It should clearly outline:

- the name of the client
- the name of the case manager
- the health care agency
- the type of order previously made
- when that order was made
- the duration of that order.

It should also contain:

- a summary of the previous treatment plan
- how that plan was implemented
- why a further order is sought.

If the agency is applying for a CCO following a CTO, the report should indicate why a CCO is now considered appropriate.

Reports

All reports for video and tele-conference hearings should be provided to the Tribunal at least 3 working days before the hearing so that they can be copied for Tribunal members. In the case of face-to-face hearings 3 copies should be brought to the hearing.

Attending the Tribunal hearing

It is the Tribunal's role to ensure that the provisions of the *Mental Health Act* have been complied with. They may therefore ask questions that relate to the legal criteria for Community Orders. The Tribunal also expects the case manager to have a good understanding of the client and their situation.

The case manager should therefore be prepared to answer questions about:

- the client's attitude toward the previous or proposed treatment plan
- the client's history of compliance with aspects of the plan (including the consequences of compliance/non-compliance)
- any rehabilitation, training, or social activities that the client has been involved in or is proposing
- the client's interactions with family, friends, and others
- accommodation, employment, legal and mobility issues.

The Tribunal requires that the client be informed of the application and made aware of the proposed treatment plan.

! Client participation

Most renewal applications occur without client participation, representation or advocacy of any sort. Client participation at these hearings should be encouraged.

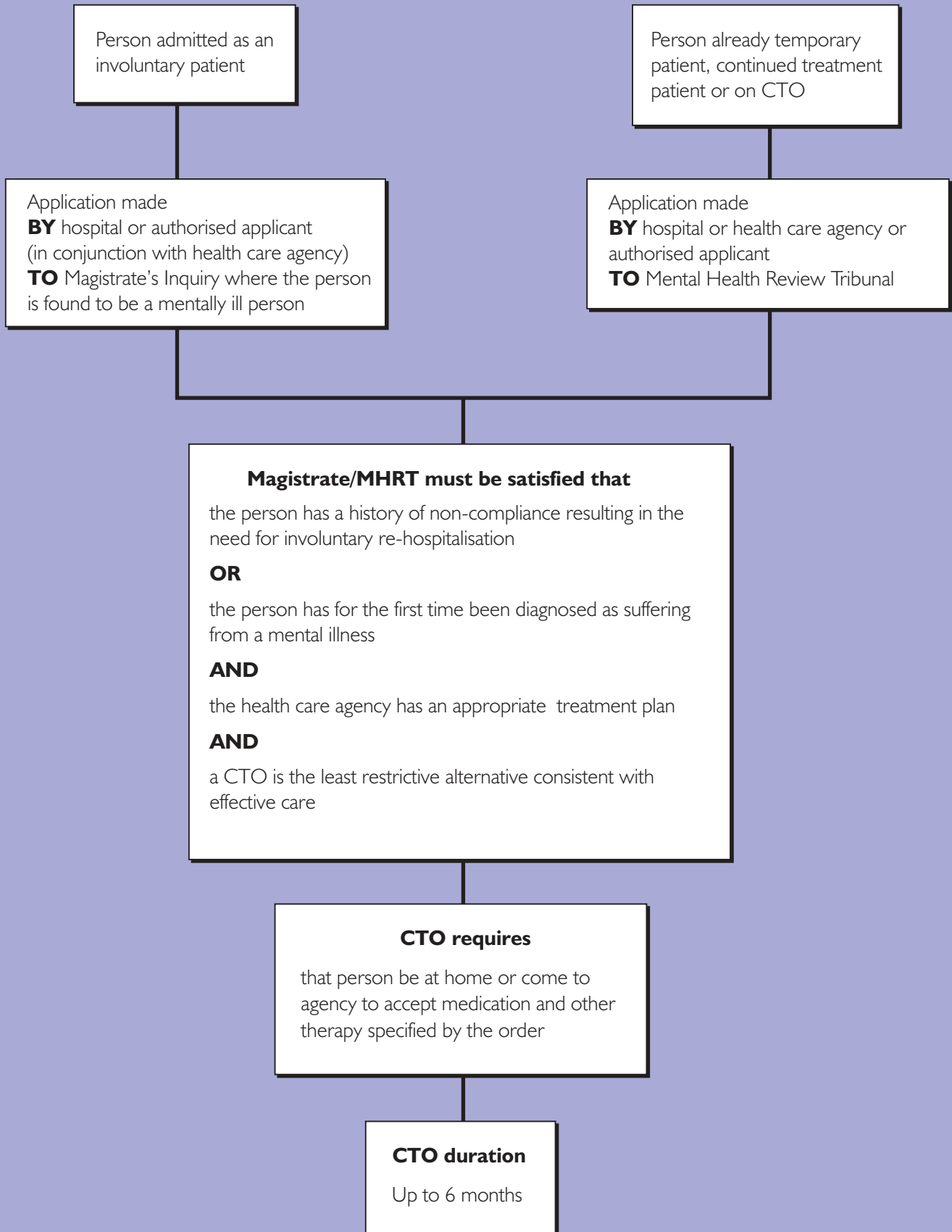
6.5 Effectiveness of Community Orders

Compulsory community treatment is now a major tool for the treatment and control of mental illness, and the review of these orders provides the Mental Health Review Tribunal with its major workload. Initial research suggests that Community Orders have had a positive impact upon hospital readmission and compliance with medication. However, less is known about the impact of compulsory community treatment on the person's psychosocial functioning, quality of life, perceived distress and rehabilitation outcomes.

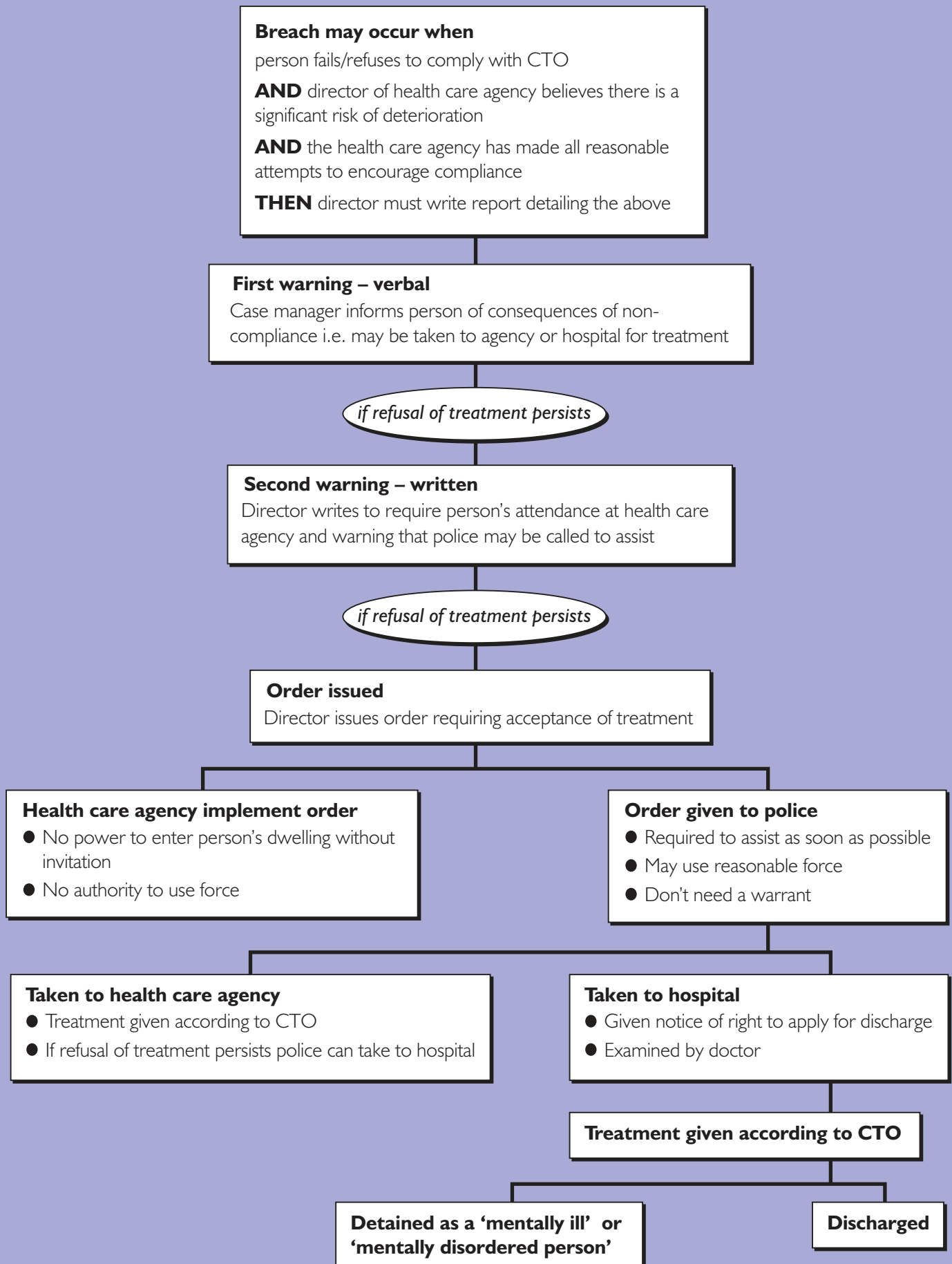
Studies into the use of coercive community orders suggest that the client perceptions of the following factors play an important part in determining their effectiveness:

- motivation – did the client see concern for their particular situation as the motivation behind the treatment order
- respect – how respected did the client feel during the process
- being heard – did the client feel that they had an opportunity to express their opinion
- validation – did the client believe they were taken seriously
- fairness – did the client believe they were treated fairly or that decisions were taken behind their backs
- persuasion or threats – what sort of pressure did clients feel was applied in their case?

Applying for a COMMUNITY TREATMENT ORDER



Breaching a COMMUNITY TREATMENT ORDER



The breach process is not automatic. It is initiated and continued by the decisions and judgements made by the health care agency. A person may be assessed by a medical practitioner for involuntary admission at any time during the process. A Schedule 2 is not required however, where the person is taken to hospital by the police as a consequence of breaching a CTO.

Processes of Review

The *Mental Health Act* establishes two important external processes of review for people whose liberty or rights are significantly interfered with as a result of their mental illness. These are the Magistrate's Inquiry and the Mental Health Review Tribunal.

The *Act* specifies that in general:

- these processes are to be conducted with 'as little formality and legal technicality as the circumstances of the case permit'.

! Preparation

"Magistrate's Inquiries (and Tribunal hearings) can, if conducted properly and efficiently, have a therapeutic effect on the patient. The person can see that the 'outside world' is interested in their problems and that the hospital is accountable for what it does. Poorly prepared and presented cases, on the other hand, can have the opposite effect."

NSW Magistrate

7.1

Procedural fairness and a non-adversarial approach

The concept of procedural fairness in general requires that:

- the magistrate or Tribunal be fully informed of all relevant aspects of the person's case, and
- the person concerned be able to hear what is being proposed, and have the opportunity to state their views.

The *Mental Health Act* promotes procedural fairness in a number of specific ways:

- hearings are open to the public (unless the person or their legal representative objects, and the objection is upheld by the magistrate or Tribunal)
- the person may be represented by a lawyer, or another person of their choosing (unless they decide that they don't want such representation)
- a relative, guardian or friend of the person may speak at the hearing with the approval of the magistrate or Tribunal
- the person's name is not published or broadcast (without their consent and the approval of the magistrate or Tribunal)

- the person is entitled to have access to their medical records when being brought before a magistrate (unless the magistrate decides this would be harmful)
- the person's representative is entitled to have access to the relevant medical records (and may withhold harmful information from the person)
- the proceedings are recorded but generally not transcribed.

While these sections of the *Act* establish some rules for the conduct of hearings, individual magistrates and Tribunals have a wide discretion in determining how they will proceed.

The mental health and legal systems do not always sit easily together, and frustration on all sides is not uncommon. While there is still a long way to go in establishing a non-adversarial approach as the norm in these hearings, the careful preparation of reports by mental health professionals can make a significant difference to the conduct of these matters. It should also be recognised that where the patient believes that they should not be detained, a more adversarial approach may be unavoidable.

7.2 Magistrate's Inquiry

Magistrates have an important role to play in considering the cases of involuntary patients who are found to be 'mentally ill'. They make sure that the correct procedures have been followed, and also decide whether the person is still in need of detention.

Magistrate's Inquiries usually take place on a regular weekly basis at each hospital. This means that most patients have their case considered by the magistrate within 3–10 days.

Magistrate's Inquiry

Patients and their families should be told that the Magistrate's Inquiry is not a criminal proceeding.

Preparing for an Inquiry

Once a person has been detained as an involuntary patient the hospital must:

- notify relatives and/or friends of the hearing, unless the person objects, and must notify the person's guardian (s38) (see *Guide*, Appendix 1)
- prescribe the minimum medication, consistent with proper care, to ensure that the person can communicate adequately with their legal representative before the hearing (s31)
- ensure that the person is given an explanation of the magistrate's hearing in a language that they understand (s30)
- ensure that, where reasonably practicable, the person appears before the magistrate in street clothes (s39)
- ensure that all the appropriate medical witnesses and relevant medical evidence is ready for the hearing (s41)
- arrange for a competent interpreter to be present where necessary (s41).

Preparing a report

The report from the consultant psychiatrist or psychiatric registrar plays a crucial role in the Inquiry. (An example is included in Appendix 2 of the *Guide*).

The report should address the following issues:

- that the person is a 'mentally ill person' as defined by the *Act*
- that the order requested is the least restrictive alternative consistent with effective treatment and care.

All other matters are irrelevant to the purpose of the Magistrate's Inquiry.

The report should clearly state:

- person's name, address and date of birth
- author's name and relationship to the person/patient
- relevant treatment history
- kind of order requested – temporary patient order, community order, adjournment
- proposed duration of order requested
- treatment plan or options
- person's attitude to treatment
- relevant symptomatic behavioural issues.

A report should:

- summarise the facts and opinions upon which the request is made
- state whether these facts and opinions have been drawn from the author's direct observations or from other specified parties.

Some hospitals routinely prepare a social work report in addition to the medical reports. These can assist the magistrate by providing relevant information about the patient's background, social and family context. This information is often important in examining the issue of 'least restrictive alternative'.

! A good report can:

- *obviate the need for distressing background details about the patient to be raised (or emphasised) during the hearing*
- *provide a basis for understanding and/or negotiation between the hospital, the patient and patient's legal representative*
- *focus the scope of the inquiry and therefore reduce the patient's confusion and/or distress.*

Precise documentation

The magistrate will need to see the following documents:

- the Schedule or other admitting document
- the forms completed by the examining doctors (there will be either 2 or 3 of these)
- the patient's file and hospital notes.

Answering questions at an Inquiry

The written report should provide the basic information that the magistrate will need to consider in making a decision. However, the magistrate and the patient's representative will often wish to ask questions that:

- clarify or expand on matters contained in the report
- test matters of opinion expressed
- explore alternative treatment options
- build a clearer picture of the patient's individual circumstances.

There is often a difficult balance to be struck between:

- giving the patient an opportunity to hear what the hospital considers is in the best interests of the patient, and
- conveying information that is unnecessarily distressing or humiliating.

It is therefore important to think about:

- what needs to be said
- how this can be clearly expressed in lay language (to minimise confusion for the lawyer, magistrate and patient)

Assisting the patient to prepare for an inquiry

While the individual patient's ability to comprehend and participate in the proceedings will vary widely, hospital staff (along with the patient's legal representative) can play an important role in assisting the patient to prepare for their hearing. The involvement of interpreters, cross-cultural consultants and Aboriginal mental health workers must also be considered at this stage.

Before the inquiry patients should be given:

- a clear explanation of their rights
- a clear explanation of the order the hospital is seeking
- a brief description of the hearing including:
 - where it will be held
 - who will be there
 - who will speak and in what order
 - the kinds of things the magistrate might ask them
 - the kind of decision that the magistrate might make
- a private and appropriate place to discuss the matter with their lawyer
- an opportunity to ask questions about the process
- encouragement to think about what they might want to tell the magistrate
- the opportunity to have someone else present at the inquiry to speak about their situation.

The Inquiry

Each magistrate will have their own approach though all will be guided by the need to avoid unnecessary technicality. It is their job, however, to ensure that the requirements of *Mental Health Act* are observed.

The magistrate must also:

- ensure that the patient has been given a written statement of their rights and entitlements (see *Guide*, Appendix 1)
- ensure that the patient's relative, guardian or friend was notified (see *Guide*, Appendix 1)
- inquire into the patient's medication and take into account its effect on the person's ability to communicate
- take into consideration any cultural factors that may be relevant to the question of mental illness.

Having heard from all the parties the magistrate then decides, on the balance of probabilities, whether the person is or is not a 'mentally ill person'.

What can the magistrate decide?

– *Adjourning the matter* (s42)

The magistrate may decide to adjourn the hearing for up to 14 days if they:

- are of the opinion that it is in the best interests of the person, and
- have considered all the relevant documentation.

If the matter is adjourned the person continues to be detained in the hospital and may be given treatment against their wishes.

– *Finding the person to be a mentally ill person* (s51)

If the magistrate decides that the person is a 'mentally ill' person they may:

- discharge the person to the care of a relative or friend who is able to provide proper care
- discharge the person on a Community Treatment Order of not more than 6 months
- make a Temporary Patient Order directing that the patient be detained for a period of not more than 3 months.

Once a person has been made a temporary patient they must be:

- advised of their right of appeal to the medical superintendent (s69).

– ***Finding the person not to be a mentally ill person*** (s52)

If the magistrate decides that the person is not a ‘mentally ill’ person they may:

- discharge the person
- defer the discharge for up to 14 days
- make a Community Counselling Order for up to 6 months.

! Temporary Patient Order

A Temporary Patient Order is not a criminal record.

Considering the options

Some of the difficulties that accompany the Magistrate’s Inquiry may be unavoidable. However, a better understanding of the legal framework can promote a non-adversarial approach and in certain cases give mental health practitioners more flexibility in working with involuntary patients.

Requesting an adjournment may be appropriate where:

- it is the first time the patient has been scheduled
- the patient is a recent admission and there has been insufficient time to observe and/or diagnose and/or formulate a treatment approach
- there is a reasonable likelihood that the person might agree to continue treatment as a voluntary patient
- only a 2 to 3–week order is being considered anyway
- a health care agency is preparing a treatment plan as a less restrictive alternative.

Whatever the outcome of the Inquiry, the patient will undoubtedly need someone to talk to about the process. Consideration should be given to enabling some kind of ‘debriefing’ to occur, preferably with someone outside the official framework of the hospital, such as a friend, a consumer representative, or an official visitor.

7.3 The Mental Health Review Tribunal

The Mental Health Review Tribunal (MHRT) is a specialist quasi-judicial body established under the *Mental Health Act 1990*. It has a wide range of powers that enable it to make and review orders, as well as hear appeals about the treatment and care of people with a mental illness.

The Tribunal produces an Annual Report that includes details about the numbers of people taken to and detained in hospitals, and the kinds of orders made. These reports provide the best source of information about the ways in which the *Mental Health Act* is used across NSW.

The decisions made by the Tribunal are legally binding on the agency and the individual. In most cases the Tribunal's decisions are exclusively based on the individual's situation. However, in certain cases the Tribunal will make a decision that also provides useful guidance on how a certain section of the *Act* is to be interpreted. These decisions are published with the identifying features removed in the Tribunal's Annual Reports and in the journal, *Mental Health Review*.

Who sits on the Tribunal?

The Tribunal sits as a panel of 3 including:

- a barrister or solicitor (who chairs the panel)
- a psychiatrist
- a suitably qualified person (a consumer, carer or person with other extensive experience in mental health).

What does the Tribunal deal with?

– Civil patients

The MHRT reviews:

- the continued detention of a temporary patient beyond the period of the initial magistrate's order
- the care and detention of a continued treatment patient, every 6 months
- the care of an informal (voluntary) patient who has been hospitalised for a year or more, every 12 months.

The MHRT hears appeals on:

- medical superintendent's refusal to discharge a temporary patient
- medical superintendent's refusal to discharge a continued treatment patient
- magistrate's decision to place a person on a Community Order (s151(2)).

The MHRT hears:

- applications for ECT concerning involuntary patients
- revocations and variations of Community Orders in limited circumstances
- applications for Community Orders
- Protected Estates applications.

– ***Forensic patients (see Guide, Section 10)***

The MHRT reviews the cases of all forensic patients including:

- those who have been found to be 'unfit to be tried'
- those who have been found to be 'not guilty by reason of mental illness'
- those transferred from prison to hospital due to mental illness.

Making an application to the Tribunal

The Tribunal responds to requests for hearings as soon as possible:

- urgent matters can be dealt with promptly by teleconferencing
- Community Orders require at least 2 weeks notice.

Applications should be in writing and may be faxed to the Listing Officer (see *Guide*, Appendix 2).

Preparing a report for the Tribunal

Psychiatric registrars, consultant psychiatrists, social workers and case managers will often be required to provide written reports to the Tribunal. (Examples can be found in Appendix 2 of the *Guide*). In each case the report must address the relevant legal criteria. For example the Tribunal cannot grant a new Temporary Patient Order unless:

- the person is still a 'mentally ill person' as defined by the *Act*, and
- the order being requested can be demonstrated to be the least restrictive alternative consistent with effective, care and treatment.

The reports should be prepared on letterhead, and clearly set out the following information:

- person's name, address and date of birth
- author's name and relationship to the person/patient
- diagnosis
- relevant treatment history
- kind of order requested
- proposed duration of order requested
- treatment plan or options
- person's attitude to treatment
- any relevant behavioural issues.

Precise documentation

The Tribunal needs to see particular documents in each case. This has been summarised in a table that appears in Appendix 2. Wherever possible this material should be sent to the Tribunal in advance so that members can familiarise themselves with the case before the hearing. Adequate preparation avoids unnecessary adjournments.

Answering questions at the hearing

While a report provides the Tribunal with important information they will be interested in asking questions that:

- clarify or expand on matters contained in the report
- explore alternative treatment options where appropriate
- build a comprehensive picture of the patient's individual circumstances
- ensure that the legal criteria have been met (see *Guide*, Appendix 2).

Assisting the consumer to prepare for a hearing

This is as important as the formal preparation of reports and documentation. The involvement of interpreters, cross-cultural consultants and Aboriginal mental health workers must also be considered at this stage (see *Guide*, Section 12).

Consumers should be provided with:

- a clear explanation of their rights
- a clear explanation of the nature of the hearing including:
 - where it will be held
 - who will be there
 - the kinds of questions they are likely to be asked
 - the kinds of matters they might like to raise
 - the kind of decision the Tribunal can make
- an opportunity to ask questions about the process
- a private and appropriate space should be made available for those who are still hospitalised to discuss the matter with a friend, advocate or legal representative.

Consumers should be:

- encouraged to attend and put their point of view
- encouraged to have a support person/advocate go with them, particularly in those matters where legal representation is not available.

How are the hearings conducted?

The Tribunal travels to hospitals and community health centres throughout NSW to conduct many of its hearings. Those involving patients in rural and remote communities however, are now generally conducted by telephone or video conferencing. It is particularly important in these cases that the Tribunal have all the relevant reports and documentation prior to the hearing, and that the person be given a clear explanation of the procedure beforehand and be encouraged to participate.

What can the Tribunal decide?

The Tribunal must consider the specific requirements of the *Act* in each case and make its decision on the balance of probabilities. This list covers the more common cases which the Tribunal considers.

- ***Temporary patient initial review (s56)***
 - discharge/deferred discharge
 - detain for up to 3 months as a temporary patient
 - classify as a continued treatment patient
 - adjourn.

- ***Temporary patient further review (s58)***
 - discharge/deferred discharge
 - order further detention as a continued treatment patient
 - adjourn.

- ***Informal (voluntary) patient review (s53)***
 - discharge/deferred discharge
 - no order for discharge (person continues as an informal patient)
 - adjourn.

- ***Appeal by temporary or continued treatment patient against refusal to discharge*** (s69)
 - discharge
 - classify as informal (voluntary) patient (not if appeal made by relative or friend)
 - adjourn
 - dismiss the appeal
 - dismiss with no further right of appeal until person due to be seen by Tribunal at end of temporary or continued treatment patient order.

- ***Community order review*** (s118 and s131)
 - make order
 - not make order
 - adjourn.

- ***Detained person under CTO review*** (s143a)
 - release under CTO
 - defer release under CTO
 - detain until expiry of CTO
 - adjourn.

- ***Appeal against community order made by magistrate*** (s151(2))
 - revoke order
 - dismiss appeal
 - vary order
 - adjourn.

7.4 Other Processes of Review

Supreme Court

Decisions of the Mental Health Review Tribunal can be appealed to the Supreme Court. The court may also require the medical superintendent of a hospital to bring a person before it for examination. It may discharge the person where it decides they are not a 'mentally ill' person.

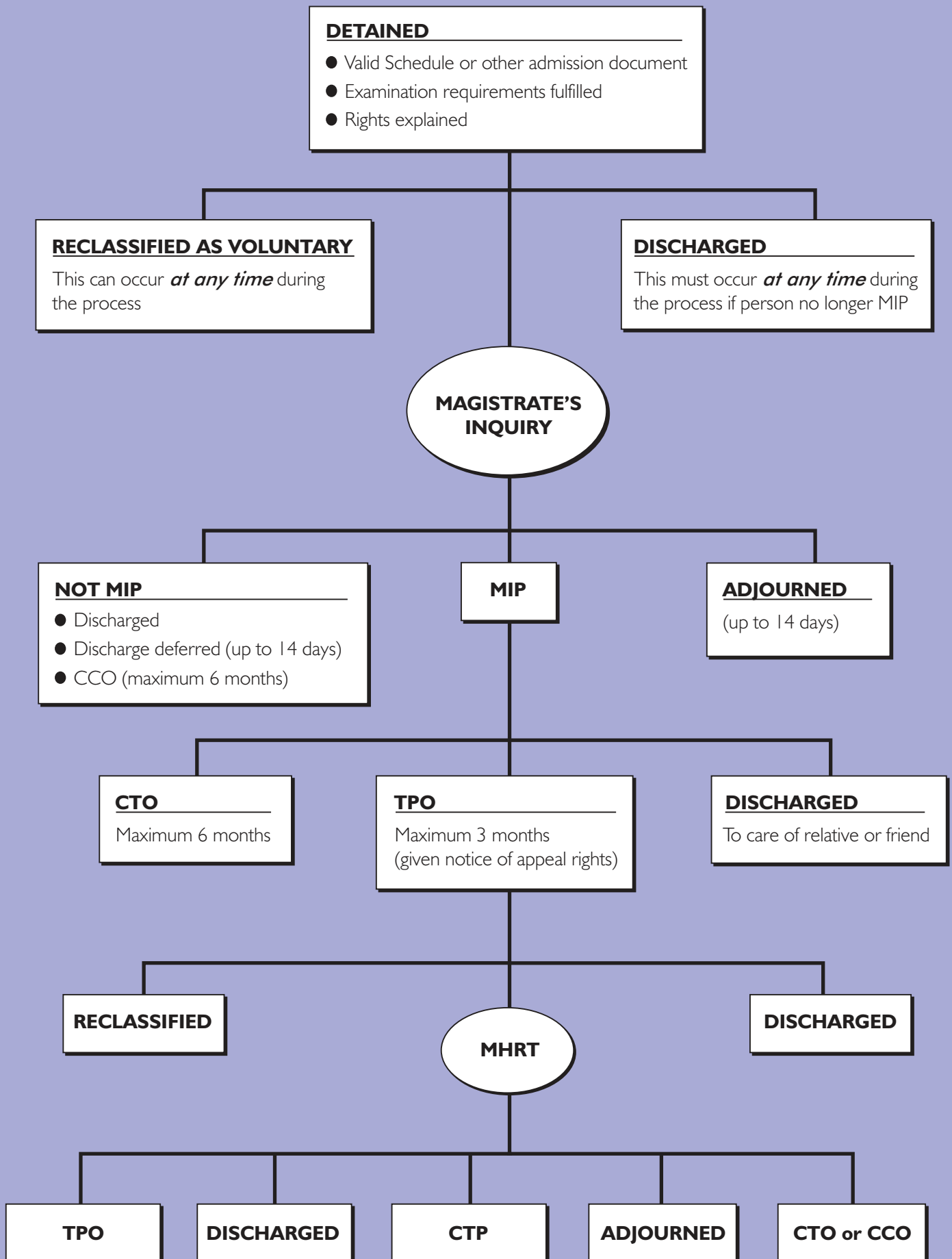
Other Bodies

The following can also play a role in scrutinising the treatment of people under the *Mental Health Act* (see *Guide*, Section 3.4):

- Official visitors
- Mental Health Advocacy Service
- NSW Health Care Complaints Commission
- Consumer representatives.

Processes of Review

MENTALLY ILL PERSON (MIP)



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Guardianship and the Mental Health Act

There are circumstances in which mental health workers will need to take into account both the *Mental Health Act* and the *Guardianship Act*. The two pieces of legislation have been designed to be complementary, and a guardianship order can coexist with an order made under the *Mental Health Act*. The *Mental Health Act*, however, takes precedence where there is a conflict. Decisions about temporary, continued treatment and forensic patients will be made under the *Mental Health Act*. However, where a patient is admitted who is already under a guardianship order, a copy should be obtained from either the guardian or the Guardianship Tribunal. This will make it easier to keep the guardian appropriately informed about the patient's care and treatment and enable them to work with mental health staff in organising support services and accommodation in readiness for discharge.

8.1 What does the Guardianship Tribunal do?

The Guardianship Tribunal appoints guardians and financial managers for persons 16 years and over, who are incapable by reason of their disability (which may include mental illness as defined by the *Mental Health Act*) of making their own personal and financial decisions. It can also provide a substitute consent to medical and dental treatment to be given in situations where people are unable to consent for themselves.

Whereas the *Mental Health Act* requires consideration to be given to the risk both to an individual and to the community if care and treatment is not given, the focus of the *Guardianship Act* is exclusively on the welfare and interests of the person with the disability. Therefore, coercive orders are much less common where guardianship is involved. The Guardianship Tribunal will not make an order where suitable informal arrangements can be agreed to, and they will also tailor the scope of the guardian's authority to the particular and individual circumstances of the person with the disability.

8.2

Admission and discharge of a person under guardianship to psychiatric hospital

Involuntary admission

A person can only be involuntarily admitted to hospital if the criteria laid down by the *Mental Health Act* are met. However, where a person is under guardianship, a copy of the order should be obtained. Guardians have an ongoing interest and involvement in the person's care and treatment, and should be kept informed of decisions particularly in relation to:

- transfers
- granting leave of absence
- discharge.

Involuntary treatment

Q *Can the 'Guardianship Act' be used to detain and provide involuntary treatment in a gazetted public psychiatric unit or hospital?*

A *No. The 'Mental Health Act' must be used.*

Informal (voluntary) admission

A person under guardianship may be admitted under s12(2) of the *Mental Health Act* as an informal (voluntary) patient.

There must be an application by the person's guardian:

- either verbal or written, and
- approval in writing by the Guardianship Tribunal either before the admission or as soon as practicable thereafter.

The hospital should obtain a copy of the guardianship order so that they are aware of the scope of the guardian's authority.

Informal (voluntary) discharge

This is an area that can sometimes cause confusion. However, the following principles apply:

- an informal patient under guardianship may discharge themselves at any time (s65(1))
- notice of the discharge of an informal patient under guardianship must be given to the guardian (s65(3))
- where the guardian withdraws their consent to admission and treatment, the hospital must discharge the person
- where the person seeking discharge is a 'mentally ill' or 'mentally disordered' person, the hospital may reclassify the person as an involuntary patient.

8.3 Admission where no guardianship order but doubt about capacity to give informed consent exists

A person may be admitted in circumstances where the hospital is concerned that they are unable to give informed consent. If involuntary admission is inappropriate, the hospital should seek the advice of the Guardianship Tribunal.

8.4 Using guardianship in the area of mental health

Some people who fall outside the definitions of mental illness or mental disorder specified by the *Mental Health Act* may nonetheless require care and treatment in a psychiatric facility. It is in these cases that the use of the *Guardianship Act* becomes particularly important.

The Guardianship Tribunal may make a guardianship order where a person:

- has a disability that is not a mental illness within the meaning of the *Mental Health Act*, but the care or treatment necessary is only available in a psychiatric facility
- has a mental illness but is not a 'mentally ill person' within the meaning of the *Mental Health Act*, and care and treatment in a psychiatric facility is necessary in that person's interests.

In these cases an application to the Guardianship Tribunal is usually made by the person's treating doctor or a family member, but may be made by 'anyone whom the Tribunal is satisfied has a genuine concern for the welfare of the person'. The Guardianship Tribunal may consent to the person's informal (voluntary) admission.

Where the matter is urgent a hearing may be arranged within a matter of days, but there must be sufficient time to allow for a proper investigation of the issues before the hearing takes place.

! Case study

Janine is a 26-year-old woman suffering from anorexia. When her matter came before the Tribunal she weighed 30 kilos. The Public Guardian, who was seen as the most appropriate person in this case, was given the authority to make decisions in relation to Janine's treatment, behaviour management and accommodation. This meant that she could be given treatment against her wishes.

8.5 Consent to medical treatment

Involuntary patients

While a person is detained as a 'mentally ill' or 'mentally disordered' person, the medical superintendent can in most cases consent to any treatment the person may need, even if they object to it. Some treatments, including ECT and surgical treatments, may require the consent of an officer authorised by the Department of Health.

Informal (voluntary) patients

Under the *Mental Health Act* any voluntary patient must consent to their own medical and dental treatment.

Patients who are admitted under s 12(2) may still be capable of consenting to their own treatment. In these cases:

- a guardian cannot override the objections of a voluntary patient, unless they have been specifically authorised to do so by the Guardianship Tribunal.

Where the person is not capable of consenting to their own treatment the provisions of the *Guardianship Act* apply. This means that consent should be obtained from the patient's 'person responsible'.

The person responsible is either:

- a guardian who has been given the function of consenting to medical and dental treatments, or, if there is no guardian;
- a spouse or de facto spouse with whom the person has a close, continuing relationship, or, if there is no spouse or de facto spouse;
- an unpaid carer who was providing support to the person before their admission, or, if there is no carer;
- a relative or friend who has a close personal relationship with the person.

If the treatment is:

- urgent – no consent is needed
- minor – if no ‘person responsible’ can be located the doctor may treat without consent, though they must note on the patient’s record that the treatment is necessary and will most successfully promote the patient’s health and wellbeing and that the patient did not object
- major – if no ‘person responsible’ can be located, the Guardianship Tribunal must consent
- special – this includes sterilisation, experimental and aversive treatments and requires the Guardianship Tribunal’s consent.

8.6 Financial management

The area of financial management can be very difficult for people with a mental illness. Under the *Protected Estates Act*, a number of bodies can make orders for financial management, including Magistrates, the Supreme Court, and the Guardianship and Mental Health Review Tribunals.

Until recently financial management was an all or nothing matter. The person would have all of their estate managed for the rest of their life, unless they could show that they had regained their capacity. Amendments to the *Guardianship Act* however, allow the Guardianship Tribunal to:

- make orders subject to a specified review period
- exclude part of the person’s estate from management
- replace a manager
- revoke an order on the grounds of the best interests of the person.

This flexibility means that where financial management is an issue for a person with a mental illness, it may be better dealt with by the Guardianship Tribunal. Where an order has already been made by one of the other bodies the Guardianship Tribunal has no power to act. It can only review its own orders.

An order for financial management does not depend on there also being an order for guardianship. In NSW in 1998 only 2,500 people with a disability (including a mental illness) have a guardian, whereas closer to 10,000 people have a financial manager.

Case study

John suffers from schizophrenia, and has been on a CTO for the last 18 months. This has meant that John has been taking his medication regularly. However, for the last 6 months, John has been spending all his pension on the day he receives it. This has made it very difficult for him to retain any stable accommodation. This in turn has led to a marked deterioration in his condition. John's parents approached the Guardianship Tribunal for orders in relation to guardianship and financial management. The Tribunal did not believe that a guardianship order was necessary. However, they did make a financial management order which provides for the Protective Commissioner to manage John's finances and pay his regular bills, such as rent and electricity. The Tribunal ordered that the financial management order be reviewed in 2 years to see if John will still require this kind of assistance.

Electro-Convulsive Therapy

Electro-convulsive therapy (ECT) is a treatment which involves passing a small electric current through the brain. It is most commonly used in the treatment of severe depression, where medication is not an appropriate option or has not been effective. The *Mental Health Act* establishes a strict set of guidelines for its use in all cases.

9.1 Who can administer ECT? (s182)

Two doctors must be present:

- one experienced in administering ECT, and
- one experienced in anaesthesia.

9.2 Informal (voluntary) patients

ECT may be given with a person's written informed consent.

The *Act* sets out a number of conditions that must be met for informed consent to be obtained (s183). These include:

- an explanation of the procedure
- a full description of the possible risks and expected benefits
- information about alternative treatments
- a reply to the person's questions about the procedure in terms they appear to have understood
- notice of the right to obtain legal and medical advice before giving consent (see *Guide*, Appendix 1).

Two doctors (one of whom must be a psychiatrist) must confirm in writing that:

- the treatment is reasonable in all the circumstances, and
- it is necessary or desirable for the person's safety or welfare (s185).

Where the medical superintendent is unsure whether a person is capable of giving informed consent they may apply to the Mental Health Review Tribunal (see *Guide*, Appendix 1). The Tribunal will decide whether or not the person is capable and whether they have actually given informed consent (s185).

! Informal (voluntary) patients

Informal patients cannot be given ECT without their informed consent.

9.3 Involuntary patients

Where two doctors (one of whom must be a psychiatrist) confirm in writing that:

- the treatment is reasonable in all the circumstances, and
- it is necessary or desirable for the person's safety or welfare (s188) then the medical superintendent must apply to the Mental Health Review Tribunal for permission to administer ECT (see *Guide*, Appendix 1).

! ECT Application

The application to the Tribunal should be accompanied by certificates from two medical practitioners (at least one a psychiatrist), stating that ECT is a reasonable, and proper treatment for the patient and necessary or desirable in the circumstances.

9.4 The Tribunal's role

Where a matter has been referred to the Tribunal the medical superintendent must:

- notify the person's nearest relative, guardian or friend with the person's permission (s190) (see *Guide*, Appendix 1)
- ensure that the person appears at the inquiry in street clothes (s191).

The Tribunal must:

- hold an inquiry as soon as practicable (s191)
- consider the views of the patient as well as the medical evidence (s193).

The Tribunal decides:

- whether the person is capable of giving informed consent, and if so, have they given that consent
- if there is no informed consent, then the Tribunal must be satisfied that the treatment is for the safety or welfare of the person (s194).

! Involuntary patients

All ECT for involuntary patients requires prior authorisation by the Mental Health Review Tribunal. Phone hearings can be arranged in urgent cases.

Forensic Patients

Some people appearing before the criminal courts also have mental health problems that lead to them becoming forensic patients. Provisions concerning forensic patients are contained in the *Mental Health Act* and the *Mental Health (Criminal Procedure) Act*. These cases must be considered by the Mental Health Review Tribunal. As this is a small and specialised area, the information presented in this section, does not attempt to provide a comprehensive guide to this area of the law. Further detailed information can be obtained from the Mental Health Review Tribunal or the Mental Health Advocacy Service.

10.1 Who are forensic patients?

The definition of forensic patients is set out in Schedule 1 of the *Mental Health Act*. Basically, forensic patients are those who overlap the criminal justice and mental health systems.

10.2 Forensic issues dealt with by the Mental Health Review Tribunal

The Mental Health Review Tribunal reviews the cases of all forensic patients in the following main areas.

Those who are found to be unfit to be tried

Where a person has been found to be 'unfit to be tried' for an offence, the Tribunal must review the case as soon as practicable and decide whether:

- the person is likely to become fit to be tried over the next 12 months
- the person should be detained in a hospital for the purposes of treatment
- the safety of the person or any member of the public will be seriously endangered by the person's release (s80).

Those who are found to be not guilty by reason of mental illness

Where a person has been found to be 'not guilty by reason of mental illness' the Tribunal must as soon as practicable review the case and make recommendations to the Minister for Health concerning the person's:

- detention, care and treatment, or
- whether it is appropriate to release the person either conditionally or unconditionally (s81).

Those who become mentally ill in prison

If a person becomes mentally ill while in prison, the *Mental Health Act* makes it possible for them to be transferred to a hospital for appropriate care and treatment. Two practitioners, one of whom is a psychiatrist, must state that the person is a 'mentally ill person', before the transfer can be authorised by the Chief Health Officer (s97).

The Mental Health Review Tribunal again plays a role in reviewing these cases and makes recommendations regarding the person's continued detention, care and treatment (s86).

Review of forensic patients

The Tribunal must review the case of each forensic patient, at least once every 6 months, and make a recommendation to the Minister of Health concerning the person's:

- continued detention, care or treatment, or
- the current status of their fitness to be tried for an offence, or
- whether they can be appropriately released (s 82).

Forensic patients have the right to be represented by the Mental Health Advocacy Service when they come before the Tribunal. This representation is provided free of charge. Patients may also choose to be represented by a lawyer of their choosing, but will have to pay for this themselves.

Police and the Mental Health Act

In August 1998 the NSW Police Service and NSW Health released a Memorandum of Understanding to establish a clear framework for the management of situations involving both police and mental health staff. The Memorandum defines the areas of responsibility of each service, and provides specific guidance for developing protocols to meet the particular needs of local areas.

While this section summarises some of the key points, it is important for mental health staff to be familiar with the detailed guidelines contained in the Memorandum.

11.1 Involuntary admissions

Enacting a Schedule (s22)

Police assistance:

- should not be routinely sought in these situations
- should only be requested after consultation between the GP and the mental health team.

Where police assistance is required they should:

- in most cases accompany the person in an ambulance
- use a police vehicle only where there is a risk to the safety of ambulance officers and/or their vehicle. (See *Guide*, Section 5.1 for the specific requirements of the *Act*.)

! Enacting a Schedule

Mental health staff and GPs should not give police a Schedule and expect them to enact it without assistance.

Detention by the police (s24)

This section gives police broad power to take a person who appears to be 'mentally disturbed' directly to a psychiatric unit or hospital for further assessment. They do not need a warrant and may apprehend a person in any place, either public or private (see *Guide*, Section 5.1 for the specific requirements of the *Act*).

Handover responsibility

Whenever a person is brought in by the police it is particularly important for clear communication to occur so that:

- where there is reasonable concern about the safety of the person and/or staff the police presence is maintained
- where continued police presence is not required they are kept informed of decisions made about the person.

11.2 Community Orders

Where police assistance is required to take a person to a hospital or health care agency as a result of breaching their CTO, mental health staff should:

- contact the police and inform them that their assistance will be necessary
- discuss the precise requirements of the case with the Duty Officer including the degree of urgency
- provide background information on the expected situation
- arrange to meet at a time and location which enables the officers to be fully briefed
- hand the relevant documentation to the police. (See *Guide*, Section 6.1 for further information on the breaching of CTOs.)

11.3 Psychiatric inpatients

Psychiatric inpatient services must have established clear internal procedures and security systems for handling psychiatric emergencies involving violence or threats of violence.

Police should only be called for assistance when it has not been possible for staff to manage the situation safely using these internal procedures. Contact arrangements for dealing with emergencies should be negotiated with the police station.

! Not a police role

It is not the role of police to restrain patients for the purposes of chemical sedation.

Groups with Particular Needs under the Mental Health Act

While the provisions of the *Mental Health Act* apply generally to people within NSW, some groups require an additional level of service and attention for the objective of 'the best possible care and treatment in the least restrictive environment' to be achieved.

12.1 Younger clients

The *Mental Health Act* applies to children (those under 18) who come within the definitions of 'mentally ill' or 'mentally disordered' persons. It also contains some specific provisions that are dealt with in this section. While the use of the coercive powers of the legislation may at times be necessary, it is important to provide opportunities for a young person to exercise meaningful choice wherever possible. For adolescents, whose major developmental issues concern individuation, autonomy and identity, attention to this aspect of their care and treatment is crucial.

Involuntary admission

Young people can be admitted as involuntary patients in the same way as adults (see *Guide*, Section 5). It may be possible, in some cases, however, to achieve the necessary care and treatment through an informal (voluntary) admission with the consent and cooperation of the parent(s) or guardian.

Informal (voluntary) admission

The *Act* contains the following specific provisions in relation to the voluntary admission of children:

- a child may request voluntary admission (s12)
- if the child is under 16, the hospital must notify the parent or guardian as soon as practicable of a voluntary admission (s13)
- if the child is 14 or 15 they may choose to continue as a voluntary patient even where a parent or guardian objects (s14)
- if the child is under 14 parental consent is essential for the admission to proceed (s15)
- if the child is under 14, where a parent or guardian objects to the care or treatment, the medical superintendent must discharge them (s15).

Rights of young people under the Act

Young people in general have the same rights as adults under the *Mental Health Act* (see *Guide*, Section 3). In particular, they have the same rights to information and legal representation. Children's inexperience, however, can add another layer of complexity in considering how they can best be assisted to understand and exercise those rights.

Young people and consent to medical treatment

As with adults consent to medical treatment must be informed. This means that a young person must be given relevant information in language they understand. Side effects and reasonable alternative treatments should also be explained.

Where the *Mental Health Act* requires a signed consent form this can be given by the young person in certain circumstances, or by the parent or guardian. In these cases a judgement must be made about the individual child's maturity and capacity to understand what is being proposed.

12.2 Older clients

The *Mental Health Act* contains no specific provisions for the care and treatment of older people, though psychological disorders occur and recur in older people as well. It may therefore be necessary to use the powers of the *Act* to involuntarily detain an older person or place them on a Community Order in certain circumstances. Older men, for example, have the highest rate of suicide in our community. Thus an older person with a depressive illness who is at risk of self-harm may require involuntary treatment. Persisting conditions (such as schizophrenia and bipolar affective disorder) also recur in older people.

Conditions such as dementia and delirium, which occur more often in older than younger people, can cause difficulties in the application of the *Mental Health Act*. Illnesses causing dementia, such as Alzheimer's disease, are not recognised as 'mental illnesses' as defined by the *Mental Health Act*. However, a person suffering from dementia may experience auditory hallucinations, delusions or a serious disorder of mood. This person then has symptoms that are recognised by the *Act*. If the person is at risk of 'serious harm', they may come within the definition of a 'mentally ill' person. In addition, the presence of several disorders and diseases at the same time is a common feature of illness in old age. The comorbid presence of dementia and another mental illness does not preclude the use of the *Mental Health Act*.

At the time of initial assessment it may not be possible to know whether an older person is suffering from dementia, delirium or another mental illness (such as late onset schizophrenia). Urgent admission for assessment may be necessary and is possible on the basis that the person is a 'mentally disordered person'. If the diagnosis subsequently is one of delirium or dementia alone, the *Guardianship Act* (if necessary) may be used. A clear understanding of the relationship between the *Guardianship Act* and the *Mental Health Act* is crucial for those people working with older clients.

There are many social and medical factors associated with old age that add to the complexity of diagnosis and effective treatment for this group. It is, therefore, particularly important that a thorough assessment be conducted in consultation with those who have expertise in this area. Specialised psychogeriatric services are available in many areas and Aged Care Assessment Teams (ACATs) are located throughout NSW.

12.3 Cultural issues

The *Mental Health Act* specifies that the 'religious, cultural and language needs' of clients be taken into account throughout the different stages of their care, control and treatment, and that they be informed of their legal rights and entitlements in 'the language or terms that they are most likely to understand'. These provisions are particularly important in relation to those with an Aboriginal or Non-English speaking background.

NESB clients

A number of recent studies have established that NESB consumers have higher rates of:

- involuntary admission
- police involvement
- ECT
- Community Treatment Orders.

This means that NESB consumers are subject to a relatively higher level of involuntary treatment under the *Mental Health Act* than those from English-speaking backgrounds.

The implementation of practical measures to address language and cultural barriers throughout the assessment, admission and treatment process is essential. This can be achieved through the use of:

- interpreters
- cross-cultural consultants.

Interpreters must be used when necessary:

- to explain the person's rights under the *Act*
- to obtain informed consent to ECT
- at Magistrate's Inquiries and Mental Health Review Tribunal hearings.

Interpreters or bilingual mental health professionals should be involved with:

- the examination process prior to admission as either a voluntary or involuntary patient
- ongoing consultations with treating doctors
- informing relatives about aspects of the person's care and treatment
- the development of discharge plans
- the operation and use of community orders.

Even where language is not an obstacle, aspects of cultural difference may have a profound impact on assessment and treatment issues. The establishment of the Transcultural Mental Health Centre now makes the expertise of cross-cultural consultants much more readily available. It provides:

- information about cultural, political or religious aspects of a diagnosis
- advice about a person who is reluctant to work with a mainstream professional
- assessment from a cultural point of view
- referral to community support services or bilingual mental health professionals
- consultation on cross-cultural skills
- confirmation on diagnosis, approach and care plan.

Aboriginal clients

In dealing with Aboriginal clients reference should be made to the NSW Aboriginal Mental Health Policy. It outlines a number of major issues in relation to improving services for Aboriginal people including the following:

- the need for mainstream services to be culturally sensitive and to address the close association between the physical health, mental health, and social, spiritual, cultural, historical, economic and political factors
- the need for self-determination
- the need for non-Aboriginal mental health workers to acknowledge the historical factors influencing Aboriginal Australians (including the enforced separation of Aboriginal children from their families)
- the need for appropriate services to address critical incidents that affect Aboriginal individuals, families and communities (including deaths in custody)
- the need for mainstream services to work in partnership with Aboriginal Community Controlled Health organisations.

It also details a number of specific targets and outcomes including:

- Aboriginal clients to receive services from either a non-Aboriginal service provider accompanied by an Aboriginal person or an Aboriginal service provider
- Aboriginal clients to be provided with the option to receive services that involve their families/extended families and/or significant others
- assessment, admission and case management for all Aboriginal clients to incorporate consultation with an Aboriginal health worker
- discharge planning for all Aboriginal inpatients to incorporate consultation with an Aboriginal mental health worker and/or Aboriginal hospital liaison worker and family member and/or significant other
- all case reviews of Aboriginal clients to include an Aboriginal health worker
- Aboriginal appointments to be made to the Mental Health Review Tribunal and official visitor's program.

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Training materials

Introduction

This part of the Guide contains material that can be used to run three, one-hour in-service training sessions on aspects of the *Mental Health Act*.

The first session focuses on the underlying philosophy of the legislation, and the principles of ensuring that the rights, dignity and self-respect of consumers are maintained, even when the restrictive provisions of the *Act* are utilised. The second session provides material for introducing new staff to the overall scope and operation of the *Act*, while the third offers the opportunity to reflect on the use of Community Orders.

As with any training material you may wish to make adaptations to meet the specific needs of your work area. It is hoped, however, that you will find these sessions useful in enabling you to understand and work effectively within the framework established by the *Mental Health Act*.

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Promoting Consumer Rights

The *Mental Health Act* states that those who are mentally ill or disordered are to receive the best possible care and treatment in the least restrictive environment, so that any restriction on their liberty or interference with their rights, dignity and self-respect is kept to a minimum. It is this philosophy which underpins the *Act*, and that should inform the decisions made by mental health workers. The *Act* also confers a number of specific rights on consumers, which are summarised in Section 3 of the *Guide*.

Ensuring that consumers are informed of their rights (often at the point when they are most unwell) and then providing sufficient encouragement and support to enable them to act on those rights can be problematic. This session gives staff the opportunity to consider their own individual and agency practice in relation to consumer rights, and to look at specific ways of promoting them.

Aims and Objectives

By the end of this session participants should have had the opportunity to:

- listen to the views of consumers and carers
- ask questions of consumers and carers
- list the ways in which their ward/agency promotes the exercise of consumer rights
- identify practical ways of enhancing the exercise of those rights.

Before the Session

Invite two or three consumer/carer representatives to participate in the session. Ask two of them to speak for 5–10 minutes about the issue of consumer rights from their experience. For example, one person might speak about rights in the context of involuntary admission, and the other the issue of rights when on a community order. Ask them to consider the following questions:

- were they made aware of their rights
- was this helpful
- did they feel able to ask questions about the process and/or their treatment
- did they know who to turn to with a question or concern
- what could have happened to make the situation less distressing?

Encourage staff to familiarise themselves with Section 3 of the *Guide*.

Activity 1 (40 minutes)

- Facilitator introduces the session and the invited guests
- 2 presentations
- Question and answer period
- Someone to summarise issues/suggestions

Resource

Overhead transparency to introduce the topic.

Activity 2 (5 minutes)

Task

Identify the resources that currently exist in the ward/agency that provide information about consumer rights – these may include posters, pamphlets, Dept of Health forms, as well as specific individuals.

Approach

Brainstorm.

Resource

Whiteboard.

Activity 3 (15 minute)

Task

Develop practical ways of encouraging and supporting consumers to exercise their rights.

Approach

Facilitator to draw out ideas from whole group:

- what are we doing well
- what could we be doing better
- what could we do differently tomorrow (as individuals/group)
- what would we like to see happening in 6 months
- who is taking responsibility for the changes?

Resources

Facilitator and a scribe to keep the discussion focused and ensure that ideas are not lost.

 **Follow up**

Someone to take responsibility for implementing the changes. Review in 6 weeks time. Discuss the changes with the consumer/carer participants where appropriate.

Consumer rights and the Mental Health Act

Those who are mentally ill or disordered are to receive the best possible care and treatment in the least restrictive environment.

Any restriction on their liberty or interference with their rights, dignity and self-respect is to be kept to a minimum.

(s4, Mental Health Act)

Introducing the Mental Health Act

All mental health staff need a basic understanding of the *Mental Health Act*. The following materials provide the structure for an introductory lecture on the *Act*. Depending on whether staff are working in a hospital or community setting, you may wish to exclude or highlight particular sections. In introducing the major concepts of the legislation it is important not to get bogged down in the detail. While this session is aimed primarily at workers new to the system, it may also provide a useful refresher for those who have been working with the *Act*. It provides a basic framework for recognising when the *Act* is important and where further specific information can be located. A 20-question quiz has been developed, which staff can do on their own using the *Guide*.

Aims and Objectives

Introduce staff to:

- the basic philosophy and scope of the *Mental Health Act* 1990
- the use of the *Guide* as a primary reference tool
- where to go for more detailed information the *Act*.

By the end of the session staff should be familiar with:

- the primary aims of the *Act*
- the definitions of a 'mentally ill' and 'mentally disordered' person
- the broad framework for scheduling and involuntary detention
- the broad operation of community orders
- the 2 major avenues of review
- the basic consumer rights outlined by the *Act*
- where to turn for legal advice.

Activity 1

Task

The following overheads provide the basis for a 40-minute structured presentation on the *Mental Health Act*. This presentation can be done by an experienced staff member who has familiarised themselves with the *Guide*. Some additional notes on the overhead transparencies have been included. As with any training, however, you need to make the material your own, and relate the general principles to the specifics of your agency.

Resources

The *Guide*

Overhead transparencies

The quiz

The Mental Health Advocacy Service pamphlet and *The Mental Health Review Tribunal – A brief guide* (copies available from the relevant agencies).

Handout – summary of overhead transparencies.

Notes to accompany the Overheads

1 What is the 1990 Mental Health Act?

2 What is the major aim of the Mental Health Act?

3 To whom does the Mental Health Act apply?

- Overhead transparencies 1–3 are straightforward and require no particular additional information.

4 Key definitions – mentally ill and mentally disordered persons

- It is important to emphasise that these definitions frame many of the decisions made by mental health workers. A precise knowledge of these is vital.

5 Criteria for a mentally ill person

- Introduce all the criteria in summary form and then move on to OHT6.
- Go back to OHT5 and go through the elements of serious harm, continuing condition and least restrictive care.
- Illustrate each of these elements with a short example from your agency or clinical experience.
- Make the point that while these terms appear in the *Act* they have no special legal meaning and are to be understood in their everyday usage.

6 Definition of mental illness

- Emphasise that this is a definition based on symptoms rather than on diagnoses. Conditions like dementia and anorexia are therefore not seen as falling within the *Act's* definition of mental illness.

7 Criteria for a mentally disordered person

- Go through the elements of irrational behaviour, significant physical risk and least restrictive care.
- Illustrate each of these elements with a short example from your agency or clinical experience.
- These terms are to be understood in their everyday usage.

8 Exclusion criteria

- The definitions of the *Act* are incredibly broad. The exclusions are aimed at ensuring that people are not dealt with under the *Mental Health Act* just because they transgress a community norm.

9 Pathways to Involuntary Admission

- The *Act* spells out 6 ways in which involuntary admission can be initiated. 1 & 2 are the most commonly used.
- Medical practitioner – most involuntary admissions are initiated in this way. Medical practitioners are required to fill out a particular form – Schedule 2 of the *Act*.

In country areas there is also provision for certain experienced mental health practitioners to become accredited (and have the same powers as doctors in regard to scheduling).

- Police – have broad powers to take a person to hospital where they appear to be at risk of causing themselves serious bodily harm, or when in the course of investigating a criminal matter the police think the person may be more appropriately dealt with by admission to hospital. There is now a detailed Memorandum of Understanding that provides some clear guidelines on the way that police and mental health staff should work together.
- Request of a relative or friend – this can only be used in remote areas, and a written request to the medical superintendent of the hospital is required.
- Order of the court – this occurs when a person comes before a magistrate and appears to be mentally ill. This allows the magistrate to order that the person be psychiatrically assessed.
- Welfare officer – this is an outmoded category that will gradually be replaced by accredited persons.
- A rarely used provision, but one that enables a magistrate to authorise a doctor with backup from the police to schedule a person.

10 After the person gets to hospital

- Don't get too involved with the detail here. What's important is that people understand there is a procedure to be followed that is set down by the law. Those working in the hospital context will need to work through the detail laid down in the *Guide* once they are familiar with the broad principles.

11 Being detained as a mentally disordered person

12 Being detained as a mentally ill person

- Go through OHTs 11 and 12. The basic difference for staff to understand at this stage is that when a person is detained as 'mentally disordered' the process is handled internally by the hospital, whereas when a person is detained as 'mentally ill' an external process of review applies because the consequences are more serious.

13 Who reviews decisions under the *Mental Health Act*?

- Here it is important to introduce the importance of external review and name the two processes.

14 Magistrate's Inquiry

- At an introductory stage it is important to know that the process exists and that the magistrate can make a variety of decisions. For those who will be directly involved in these hearings, however, a much more thorough knowledge of the process is essential.

15 Mental Health Review Tribunal

- Here it is important to get across the broad outline of the Tribunal's work rather than the detail. Hand out a copy of the MHRT pamphlet.

16 Legal representation under the Act

- Hand out a copy of The Mental Health Advocacy Service pamphlet at this point.

17 What are Community Orders?

- While CCOs are still used, a thorough knowledge of CTOs is more important as these are by far the more commonly issued orders.

18 Finding out more about the *Mental Health Act*

- When complex situations arise these organisations can be contacted for advice.

What is the Mental Health Act?

A law that governs the care and treatment of people in NSW who experience a mental illness or mental disorder.

What is the major aim of the Mental Health Act?

‘Mentally ill’ and ‘mentally disordered’ persons are to receive:

- the best possible care and treatment in the least restrictive environment
- any interference with or restriction of their rights, dignity and self-respect is to be kept to a minimum.

To whom does the Mental Health Act apply?

The Act makes provisions for the care of people who:

- are admitted to hospital voluntarily (informal patient)
- are admitted to or detained in hospital against their wishes (involuntary patient)
- are required to receive treatment in the community
- have committed an offence and are mentally ill (forensic patient)

Definitions

2 key definitions

- A mentally ill person
- A mentally disordered person

Criteria for a mentally ill person

Has a mental illness (definition)

and

risk of serious harm to self or others
(includes physical harm, and harm to reputation, relationships, finances and self neglect)

and

continuing condition, including any likely deterioration, taken into account

and

no other care of a less restrictive kind available.

Definition of mental illness

A condition that seriously impairs, either temporarily or permanently, the mental functioning of a person and is characterised by the presence of any one or more of the following symptoms or signs:

- delusions
- hallucinations
- serious disorder of thought form
- severe disturbance of mood
- sustained or repeated irrational behaviour indicating that the person is having delusions or hallucinations.

Criteria for a mentally disordered person

Displaying irrational behaviour

and

significant physical risk to self or others

and

no other care of a less restrictive kind
available.

Exclusion criteria

A person cannot be regarded as 'mentally ill' or 'mentally disordered' for the purpose of the Act, merely because of the presence or lack of:

- religious beliefs or philosophy
- sexual preference/orientation

or because of past or current involvement in:

- sexual promiscuity
- immoral or illegal conduct

or because the person

- has a developmental disability
- takes or has taken alcohol or any other drug
- engages in antisocial behaviour.

Pathways to involuntary admission

- Certificate of medical practitioner
- After apprehension by police
- Request of relative/friend
- Order of the court
- Information of a welfare officer
- Following order for medical examination

After the person gets to hospital

- Person must be given a form explaining their legal rights
- Examination by doctor within 12 hours
- If neither mentally ill or disordered must be discharged
- If either mentally ill or disordered there must be a second examination
- In some cases a third examination is required

Being detained as a mentally disordered person

- Can be detained for 3 days
- Must be examined every 24 hours by a doctor
- Must be discharged if no longer mentally disordered
- Can be detained for 3 x 3 day periods within a month
- Interpreter provided where appropriate

Being detained as a mentally ill person

- Must be seen by a magistrate
- Legally represented before the magistrate
- Medicated at minimum level until seen by magistrate
- Appear before the magistrate in street clothes
- Interpreter provided where appropriate
- Must be discharged if no longer a mentally ill person

Who reviews decisions under the Mental Health Act?

Two external review processes:

- The Magistrate's Inquiry
- The Mental Health Review Tribunal

Patients can also have decisions about their care and treatment reviewed internally by the medical superintendent.

Magistrate's Inquiry

The magistrate looks at whether those who have been admitted involuntarily:

- are mentally ill under the Act
- require further detention
- whether the correct procedures have been followed

They may:

- make a Temporary Order up to 3 months
- place them on a Community Order
- adjourn the inquiry for up to 14 days
- discharge the person.

Mental Health Review Tribunal

The Tribunal has a wide range of powers to review decisions made under the Mental Health Act.

These include:

- renewing and approving Community Orders
- looking into the care of voluntary patients who have been hospitalised for a year
- authorising applications for ECT
- hearing extensions of TPOs

Legal representation under the Act

- Mental Health Advocacy Service coordinates free legal representation for patients throughout NSW
- Free legal representation is generally only provided in cases of involuntary detention
- Patients can organise a private lawyer if they wish

What are community orders?

Legal orders that require a person to have treatment in the community.

There are two types:

- Community Treatment Order (CTO)
- Community Counselling Order (CCO)

Community Orders can be:

- made for up to 6 months
- renewed with the approval of the Mental Health Review Tribunal.

Finding out more about the Mental Health Act

- Mental Health Review Tribunal
- Mental Health Advocacy Service
- Centre for Mental Health

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The Mental Health Act: 20 Questions

These questions have been designed to help you learn the basics about the *Mental Health Act* and find your way around the *Guide*.

- 1 What section of the *Act* defines 'a mentally ill' person?.
- 2 Bob has been on a spending spree, running up \$60,000 of debt on various credit cards in the last 2 weeks. He has also been making grandiose statements to his friends and family about his ability to predict currency fluctuations. He feels tremendously well and cannot be persuaded to see a doctor. Does Bob come under the *Mental Health Act*? (*Look at the definitions, and consider what other information you would need*.)
- 3 Jane was found last night wandering along the freeway in a highly agitated state. She was shouting at traffic, and attempting to direct all the cars into one lane. She was picked up by the police and taken to hospital.
 - what section of the *Act* did the police use to take her to hospital?
 - what does the hospital need to do in deciding whether to detain Jane?
 - if the hospital decides that Jane can go home, do they need to inform the police?
- 4 How long can a magistrate detain someone under a temporary patient order?
- 5 How can a continued treatment patient apply to be discharged?
- 6 Who does the hospital need to notify once a person has been admitted as an involuntary patient?
- 7 What rights do involuntary patients have in relation to medication?
- 8 What's the criteria for admission for an informal (voluntary) patient?
- 9 Dr Brown completed a Schedule 2 in relation to Wayne on Monday morning. On the way to hospital Wayne ran away, but returned home on Wednesday night. The next morning his father drove him into hospital with the original Schedule. Is it still valid?
- 10 On arrival at the hospital Wayne was seen by Doctor One who found him to be a mentally ill person. Five hours later Doctor Two, a psychiatrist, examined Wayne and found him to be mentally disordered. What happens to Wayne now?

- 11 Cheryl has been on CTOs for the last 14 months. She has started to refuse to take her medication. What do you need to do if you wish to initiate breach proceedings?
- 12 A few weeks later Cheryl was taken to hospital by the police as a result of breaching her CTO? What section(s) of the *Act* allow the police to assist in these cases?
- 13 There is another 4 months to run on Cheryl's current CTO. Can she be detained for this period?
- 14 If the magistrate finds that someone is a 'mentally ill person' what decisions can they make?
- 15 Who sits on the Mental Health Review Tribunal?
- 16 What does the Mental Health Advocacy Service do?
- 17 Who is a 'person responsible'?
- 18 When can an (informal) voluntary patient be given ECT?
- 19 Under what circumstances does an involuntary patient have a right to an interpreter?
- 20 Can a 9-year-old be scheduled?

1 What is the Mental Health Act?

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2 What is the major aim of the Mental Health Act?

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4 Definitions

2 Key Definitions

- A mentally ill person
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5 What are the criteria for a mentally ill person?

- Has a mental illness (definition) and
- Risk of serious harm to self or others (includes physical harm, and harm to reputation, relationships, finances and self neglect) and
- Continuing condition, including any likely deterioration, taken into account and
- No other care of a less restrictive kind available.

6 Definition of mental illness

A condition which seriously impairs, either temporarily or permanently, the mental functioning of a person and is characterised by the presence of any one or more of the following symptoms or signs:

- delusions
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7 Criteria for a mentally disordered person

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- Significant physical risk to self or others and
- No other care of a less restrictive kind available

8 Exclusion criteria

A person cannot be regarded as 'mentally ill' or 'mentally disordered' for the purpose of the Act, merely because of the presence or lack of:

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or because of past or current involvement in:

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- renewed with the approval of the Mental Health Review Tribunal.

18 Finding out more about the Mental Health Act

- Mental Health Review Tribunal
- Mental Health Advocacy Service
- Centre for Mental Health

Working Effectively with Community Orders

Community Orders are now very widely used. While their technical operation is reasonably straightforward, using them as a flexible and effective treatment tool can be more complex. The activities in this session give participants an opportunity to reflect on their work and to develop new approaches. They will take longer than an hour to complete so you may choose to concentrate on a couple.

Aims and Objectives

By the end of this session staff should have had the opportunity to:

- reflect on the use of Community Orders in their agency
- identify situations in which a Community Order has worked well from an agency/ carer/and consumer perspective
- identify situations in which a Community Order has not worked well from an agency/carer/consumer perspective
- develop practical ways of enhancing the effectiveness of Community Orders in the agency.

Activity 1

Task

Develop a list of advantages and disadvantages in using Community Orders for the following groups:

- carers and families
- case managers and professionals
- consumers.

Approach

This could be done as a group or in pairs.

Consumers and/or carers could be invited along to the session.

Resources

Overhead transparencies 1–6 can be used as a discussion trigger.

Activity 2**Task**

Analyse 3 recent cases from the agency:

- a success (the person's mental state improved as a result of the CTO)
- one that has stalled (you're not sure where it's going)
- one where there's been a breach (whether or not the breach has been pursued).

Approach

Select 3 cases beforehand.

Ask 3 staff to prepare a 5 minute presentation covering:

- the consumer's goal – did they have one?/did you ask
- the worker's goal – did you have one
- the strengths and weaknesses of the treatment plan
- how you would know it was effective
- anything you would do differently?

Facilitate a group discussion

- what can be learned from the 3 cases
- what practical conclusions can be drawn
- what changes could occur at an agency level?

Resources

Sufficient time for preparation

Whiteboard/butcher's paper to summarise and focus group discussion.

Activity 3

Task

Develop criteria for the evaluating effectiveness of Community Orders.

Approach

Overhead transparencies can be used as a trigger

People to work in pairs for 10 minutes

Focused group discussion to produce list of 5–10 specific criteria

Resources

Overheads

Whiteboard/butcher's paper to focus discussion and list agreed criteria.

Community orders — advantages for clients

- It helps me take my medication
- It got me out of hospital
- It keeps me mentally well

Community orders — disadvantages for clients

- I don't understand it
- It stinks because I have to take my medication
- Now I can't change doctors – it takes away my free will

Community orders — advantages for case managers

- Reduced hospital admissions
- Increased rapport because client's mental state improved
- Reduced workload

Community orders — disadvantages for case managers

- Destroyed rapport with client – took a long time to rebuild
- Patient constantly in breach which led to police involvement and further stress for the client
- Caregiver shouldn't be the enforcer

Community orders — advantages for carers

- The family feels safe
- We can make some plans for our lives
- Wouldn't be able to cope without it

Community orders — disadvantages for carers

- He was very angry when he was put on the order
- Home visits by the nurse can be inconvenient
- Reinforces the stigma of mental illness

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Mental Health Act Forms

Forms prescribed by regulation

(The content of these forms may not be altered other than to pre-insert recurring information, e.g. the name and address of the hospital).

Form

- 1 Statement of legal rights (to be given to involuntary patient on admission) – s30
- 2 Medical report as to mental state of a detained person – s29, s32
- 3 Notice of proceedings before Magistrate – s38(3)
- 4 Summons - Inquiry under Mental Health Act – s47(1)
- 5 Notification of Tribunal determination – s57
- 6 Appeal by patient against refusal to discharge – s69(1)
- 7 Appeal by a person other than the patient against refusal to discharge a patient – s69(1)
- 8 Rights to apply for review – persons admitted to hospital upon breach of CTO – s142(a)
- 9,10,11 Relate to Psychosurgery – not included.
- 12 Information and consent – ECT – s183, s185, s188
- 13 Notification to relative etc. of application to determine validity of consent to ECT – other than involuntary patients – s185, s190(1)
- 14 Notification to relative etc. of application to administer ECT – involuntary patients – s188, s190(1)
- 15 ECT Register. Available from the Centre for Mental Health
- 16 Notification to relative of intent to seek consent to surgery – s205(3)
- 17 Summons - Mental Health Review Tribunal – s278(1)
- 18 Oath of Assessor (to Supreme Court) – s282(2)(b) – not included
- 19 Psychiatric admissions advice to Mental Health Review Tribunal – s302(2)(m)
19 (A) Involuntary Psychiatric Referrals – s302(2)(m)
19 (B) Magistrates Inquiries – s302(2)(m)
- 20 Order or direction of Magistrate – Inquiry relating to mentally ill person

Forms used by the Centre for Mental Health

- CMH1** Personal application for informal admission to hospital
- CMH2** Application for informal admission to hospital of a person subject to a Guardianship Order
- CMH3** Application for review of decision of medical officer
- CMH4** Your rights after a Magistrate's Inquiry
- CMH5** Notice of discharge of person under guardianship
- CMH6** Application for variation/revocation of order
- CMH7** Request by member of NSW Police Service for admission of an alleged mentally disturbed person
- CMH8** Request by welfare officer for admission
- CMH9** Application for discharge from hospital
- CMH10** Application from relative of friend for patient's discharge from hospital
- CMH11** Breach of CCO – notice to patient
- CMH12** Breach of CTO – notice to patient
- CMH13** Transfer between hospitals of temporary or continued treatment patient
- CMH14** Transfer of an involuntary patient to an interstate mental health facility

Forms prescribed in the Mental Health Act 1990 (NSW)

- Schedule 2** Medical certificate as to examination or observation of person
- Schedule 3** Medical certificate as to examination or observation of person (Corrections Health only)

YOUR RIGHTS

You should read the questions and answers below to find out your rights and what may happen to you after you are brought to a hospital.

WHAT HAPPENS AFTER I ARRIVE AT HOSPITAL?

You must be seen by a hospital doctor not later than 12 hours after you arrive at the hospital.

If you are a person who is already in hospital as an informal patient, and you have been told you are now to be kept in hospital against your will, you must be seen by a hospital doctor not later than 12 hours after it is decided to keep you in hospital.

WHEN CAN I BE KEPT IN HOSPITAL AGAINST MY WILL?

You can be kept in hospital against your will if you are certified by the hospital doctor as a mentally ill person or a mentally disordered person. The doctor will decide whether you are a mentally ill person or a mentally disordered person.

A mentally ill person is someone who has a mental illness and who needs to be kept in hospital for his or her own protection or to protect other people. A mentally disordered person is someone whose behaviour shows that he or she needs to be kept in hospital for a short time for his or her own protection or to protect other people.

The hospital cannot continue to keep you against your will unless at least one other doctor also finds that you are a mentally ill person or a mentally disordered person. At least one of the doctors who sees you must be a psychiatrist.

HOW LONG CAN I BE KEPT IN HOSPITAL AGAINST MY WILL?

If you are found to be a mentally disordered person, you can only be kept in hospital for up to **3 DAYS** (weekends and public holidays are not counted in this time). During this time you must be seen by a doctor at least once every 24 hours. You cannot be detained as a mentally disordered person more than 3 times in any month.

If you are found to be a mentally ill person, you will be kept in hospital until you see a Magistrate who will hold an inquiry to decide what will happen to you.

HOW CAN I GET OUT OF HOSPITAL?

You, or a friend or relative, may at any time ask the medical superintendent to let you out. You must be let out if you are not a mentally ill person or mentally disordered person or if the medical superintendent thinks that there is other appropriate care reasonably available to you.

CAN I BE TREATED AGAINST MY WILL?

The hospital staff may give you appropriate medical treatment, even if you do not want it, for your mental condition or in an emergency to save your life or prevent serious damage to your health. The hospital staff must tell you what your medical treatment is if you ask. You must not be given excessive or inappropriate medication.

CAN I BE GIVEN ECT AGAINST MY WILL?

Yes, but only where the Mental Health Review Tribunal determines, at a hearing that it is necessary or desirable for your safety or welfare. You have a right to attend that hearing.

WHAT OTHER RIGHTS DO I HAVE IN HOSPITAL?

You can receive mail. You must not be ill-treated.

MORE INFORMATION

You should read the questions and answers below to find out about Magistrates' inquiries and when you may be kept in hospital against your will after an inquiry.

WHEN IS A MAGISTRATE'S INQUIRY HELD?

A Magistrate's inquiry must be held as soon as possible after it is decided to keep you in hospital against your will because you are a mentally ill person.

WHAT HAPPENS AT A MAGISTRATE'S INQUIRY?

The Magistrate will decide whether or not you are a mentally ill person.

If the Magistrate decides that you are not a mentally ill person, you must be let out of hospital. The Magistrate may make a Community Counselling Order requiring you to have certain treatment after you are let out.

If the Magistrate decides that you are a mentally ill person, the Magistrate will then decide what will happen to you. Consideration must be given to the least restrictive environment in which care and treatment can be effectively given. The Magistrate may order that you be kept in hospital as a **TEMPORARY PATIENT** for a set time (not more than 3 months) or the Magistrate may order that you be let out of hospital. If you are let out, the Magistrate may make a Community Treatment Order requiring you to have certain treatment after you are let out.

The Magistrate may adjourn the inquiry for up to 14 days where he or she considers that it is in your best interests.

If the Magistrate makes an order that you are to remain in hospital as a Temporary Patient, the Magistrate must also consider whether you are capable of managing your financial affairs. If the Magistrate is not satisfied that you are capable, an order must be made for management of your affairs under the *Protected Estates Act 1983*.

WHAT RIGHTS DO I HAVE AT A MAGISTRATE'S INQUIRY?

You can tell the Magistrate what you want or have your lawyer tell the Magistrate what you want. You can wear street clothes, be helped by an interpreter and have your relatives and friends told about the inquiry. You can apply to see your medical records.

WHAT ARE MY RIGHTS OF APPEAL IF I HAVE BEEN MADE A TEMPORARY PATIENT?

You (or a friend or relative) may at any time ask the medical superintendent to discharge you. If the medical superintendent refuses or does not respond to your request within 3 working days, you (or a friend or relative) may lodge an appeal with the Mental Health Review Tribunal.

You will be given a notice setting out your appeal rights.

WHAT HAPPENS WHEN THE TIME SET BY AN ORDER MAKING ME A TEMPORARY PATIENT HAS NEARLY ENDED?

The hospital medical staff will review your condition before the end of the order and the hospital may either discharge you or apply to the Mental Health Review Tribunal for a further order.

The Tribunal must let you out of hospital if it decides that you are not a mentally ill person or if it feels that other care is more appropriate and reasonably available.

WHO CAN I ASK FOR HELP?

You may ask any hospital staff member, official visitor, chaplain, your own lawyer or the Mental Health Advocacy Service for help. The Mental Health Advocacy Service telephone number is 9745 4277.

MEDICAL REPORT AS TO MENTAL STATE OF A DETAINED PERSON

This report is made as:

a certificate of the opinion of the medical superintendent after examination of a person under section 29 of the Act (initial examination)

OR

advice by a medical practitioner to a medical superintendent under section 33 of the Act (further examination)

(tick whichever is appropriate)

I, the undersigned, a registered medical practitioner, on _____
(date)

personally examined _____
(patient's name)

a person detained at _____
(hospital)

In my opinion, the person named above:

is not a mentally ill or mentally disordered person

OR

is a mentally ill person

OR

is a mentally disordered person

(tick the one box that is appropriate)

The basis for my opinion is as follows:

** (Reported behaviour of the patient)

(Reverse of Medical Report as to Mental State of Detained Person)

(Observations by me of the patient)

(Conclusion)

Name of medical practitioner: _____

Qualifications as a psychiatrist (if applicable): _____

(Signature)

(Date)

Note that this report is for the use of a legal tribunal and therefore should not be written in technical medical language.

INQUIRY-MENTAL HEALTH ACT 1990

Hospital _____

Address _____

NOTICE OF PROCEEDINGS BEFORE MAGISTRATE

Dear _____

I wish to advise you that _____
is at present a patient at this hospital under the provisions of the *Mental Health Act 1990*.

On _____ at approximately _____ a visiting

Magistrate will hold an inquiry at _____ to
consider whether or not further detention for the purpose of treatment is warranted.

You are invited to attend this enquiry. With the permission of the patient and the Magistrate, any person at all may represent the patient. However the patient will be legally represented unless the patient decides that he or she does not want to be. Should it be necessary, a competent interpreter will be available to assist.

If the Magistrate considers further detention is warranted the Magistrate will also consider whether or not the patient is able to manage his or her affairs. If the Magistrate considers that the patient is able to do so, then the patient will continue to do so. If the Magistrate is not satisfied that the patient can manage his or her affairs, then an order will be made that the Protective Commissioner manage the patient's affairs.

If the patient does not agree that his or her affairs should be managed by the Protective Commissioner, the patient may appeal to the Supreme Court.

If you have any questions, please feel free to discuss them with the patient's doctor or social worker. Contact may be made by telephoning _____.

Yours faithfully,

(Medical Superintendent)

(Date)

SUMMONS
Inquiry under Mental Health Act 1990

Hospital _____

Address _____

To: _____

A Magistrate will be holding an inquiry under the *Mental Health Act 1990* in relation to

(patient's name)

The inquiry will be held at approximately _____ on _____

(time)

(date)

at the above address.

You are required:

* to attend the inquiry as a witness

* to attend the inquiry to produce the following documents:

(* delete if inapplicable)

You are entitled to receive reasonable costs, including loss of earnings incurred through compliance with this summons.

Should you fail or refuse to comply with this summons properly served, you may be guilty of an offence under the *Mental Health Act 1990*.

If you are required to attend the hearing only to produce documents, it is sufficient compliance with this summons if those documents are delivered to

_____ at _____

(address)

on or before _____

(signature)

(name)

Included for information only. The Mental Health Review Tribunal will provide such documents as it requires, check with the Tribunal before using. For further information please see the Tribunal website at www.mhrt.nsw.gov.au

FORM 5

(Cl.14)

MENTAL HEALTH ACT 1990
Section 57 (6)

DETERMINATION OF TRIBUNAL

(patient's name)

was brought before the Mental Health Review Tribunal on _____ (Date)

under provisions of section 56 of the Mental Health Act 1990.

The Tribunal determined that the patient:

* be **DISCHARGED** from hospital

* be **DETAINED** as a temporary treatment patient from _____ (Date)

until no later than _____ for further observation or treatment or both
(Date)

* be classified as a continued treatment patient and detained in hospital for further observation or treatment or both.

(* delete whichever is inapplicable)

Signed by the members of the Tribunal on _____ (Date)

(Member)

(Member)

APPEAL BY PATIENT AGAINST REFUSAL TO DISCHARGE

The Registrar
Mental Health Review Tribunal
PO Box 2019
BORONIA PARK NSW 2111

My name is _____ .

I am:

- a temporary patient
- a continued treatment patient

at _____ .
(name of hospital)

I have applied to the medical superintendent for discharge under section 67 (1) of the *Mental Health Act 1990*.

I want to appeal to the Mental Health Review Tribunal against the Medical Superintendent's:

- refusal to discharge me
- failure to make a determination on my application for discharge within 3 working days after I made the application.

(Tick one box only)

Signature _____ Date _____

APPEAL BY A PERSON OTHER THAN THE PATIENT AGAINST REFUSAL TO DISCHARGE A PATIENT

This appeal relates to _____
(patient's name)

who is:

- a temporary patient
- a continued treatment patient

(Tick one box only)

at _____
(name of hospital)

An application was made to the medical superintendent for discharge of the patient under section 67 or 68 of the Mental Health Act 1990.

My name is _____
(name of appellant)

I am:

- the applicant for discharge of the patient
- a person appointed by the patient.

(Tick one box only)

I want to appeal to the Mental Health Review Tribunal against the Medical superintendent's:

- refusal to discharge the patient
- failure to make a determination within 3 working days after the application for discharge of the patient.

(Tick one box only)

Signature _____ Date _____

RIGHTS TO APPLY FOR REVIEW

To _____
(patient's name)

On _____ it was ordered under section 139 of
(date)

the *Mental Health Act 1990* that you be taken to a hospital or health care agency as a result of breaching your Community Treatment Order. You may have been taken directly to the hospital or you may have been taken to the hospital only after you refused treatment at a health care agency.

YOU HAVE THE FOLLOWING RIGHTS

You may discuss your rights of appeal with a social worker, doctor, official visitor or your own lawyer, or with the Mental Health Advocacy Service whose legal advice is free.

1. You may apply to the Mental Health Review Tribunal to have the Community Treatment Order varied or revoked.
2. You may lodge an appeal against the Order with the Supreme Court or, where the order was made by a Magistrate, the Mental Health Review Tribunal.
3. You may ask the Medical Superintendent to discharge you from the hospital.
4. You may get a relative or friend to apply to the Medical Superintendent for your discharge, if the person will give an undertaking that you will be properly taken care of and will be prevented from causing harm to yourself or others. This application may be made orally or in writing. It would be to your advantage to make such an application in writing.

FORMS 9, 10 AND 11 DEAL WITH PSYCHOSURGERY

Form 9 – Information and Consent

Form 10 – Application to Perform Psychosurgery

Form 11 – Summons (for attendance of persons or production of documents)

**INFORMATION AND CONSENT - ELECTRO CONVULSIVE THERAPY
PART 1
INFORMATION TO CONSIDER BEFORE SIGNING**

The treatment is recommended where the alternative forms of treatment have either not had the desired result or would work too slowly to be effective in a particular case.

The treatment will take the following form:

- (a) You will be given a brief general anaesthetic. This involves giving a drug to relax the muscles. The anaesthetist will generally give the anaesthetic by means of intravenous injection.
- (b) While you are anaesthetised, another medical practitioner will use medical apparatus designed to pass a modified electrical current for a few seconds through your brain, with the intention of affecting those parts concerned with emotion and thought.
- (c) While the current is passing, the anaesthetic will prevent you from feeling anything and also your body from moving more than slightly.
- (d) Treatment may be given 2 or 3 times a week.
- (e) A course of treatment will generally involve up to 12 treatments but, on some occasions, more treatments will be required. Any queries you have in relation to the number of treatments you may need can be raised with your doctor.

Possible benefits of treatment:

Benefits depend upon the symptoms of the conditions for which treatment is given. Relief may be obtained from symptoms of depression, agitation and insomnia.

Possible alternative treatments:

Other treatments may also be suitable for your condition. Any queries you have in relation to these can be discussed with your doctor.

A written explanation of the alternative treatments available in relation to your condition is attached.

Possible complications of treatment:

Some patients notice a difficulty with their memory for recent events which almost invariably clears up within a month of receiving the last treatment. Some patients experience a headache or a brief period of confusion, or both, on awakening after the anaesthetic. Otherwise, because the treatment and anaesthetic are very brief and present no significant stress to the body, serious complications are uncommon. All general anaesthetics carry some risk.

Consent for treatment:

This treatment cannot be carried out without your consent (see Part 2 below), unless you are an involuntary patient at the hospital. If you are an involuntary patient, the treatment can be only carried out without your consent after a full hearing before the Mental Health Review Tribunal.

Before giving this consent you may ask your doctor any questions relating to the techniques or procedures to be followed. You may also withdraw your consent and discontinue this treatment AT ANY TIME.

Legal advice:

You also have the right to get legal advice and medical advice before you give your consent.

**DISCLOSURE OF FINANCIAL RELATIONSHIP
Item A**

To be completed by the person proposing the administration of the treatment.

- (a) I declare that there is no financial relationship between me and the hospital or institution in which it is proposed to administer the treatment.

OR

- (b) I declare that the following is a full disclosure of the financial relationship between me and the hospital or institution in which it is proposed to administer the treatment.

Signature _____

Name _____

Item B

To be completed by the medical practitioner who proposes to administer the treatment (unless that medical practitioner is also the person who completed Item A, in which case this item need not be completed).

(a) I declare that there is no financial relationship between me and the hospital or institution in which it is proposed to administer the treatment.

OR

(b) I declare that the following is a full disclosure of the financial relationship between me and the hospital or institution in which it is proposed to administer the treatment.

Signature _____

Name _____

**PART 2
CONSENT TO ELECTRO CONVULSIVE THERAPY**

I, _____
(Name in full)

consent to being treated with a course of electro convulsive therapy.

I *acknowledge* that I have read/have had read to me Part 1 of this form, and that I understand the information it contains.

I *understand* that I am free at any time to change my mind and withdraw from the course of treatment if I so desire.

Signature _____ Date _____

**PART 3
CONSENT TO ELECTRO CONVULSIVE THERAPY (INVOLUNTARY PATIENTS)**

I, _____
(Name in full)

consent to being treated with electro convulsive therapy.

I *acknowledge* that I have read/have had read to me Part 1 of this form, and that I understand the information it contains.

I *understand* that I am free at any time to change my mind and withdraw from the course of treatment if I so desire.

I *understand* that my consent will be reviewed by the Mental Health Review Tribunal.

Signature _____ Date _____

CERTIFICATION OF WITNESS

I certify that all matters dealt with in this Form have been orally explained to the person in respect of whom treatment is proposed and have been so explained in a language with which that person is familiar.

Signature _____ Date _____

**NOTIFICATION OF APPLICATION TO DETERMINE VALIDITY OF
CONSENT TO ELECTRO CONVULSIVE THERAPY- PERSONS OTHER
THAN INVOLUNTARY PATIENTS**

Dear _____

It is my opinion as Medical Superintendent of

(name of the hospital)

that it is desirable and in the best interests of

(full name of person the subject of the application)

for him/her to undergo a course of electro convulsive therapy. He or she has consented.

However, I am unsure whether he or she is capable of giving informed consent to the treatment.

In such cases I am required by law to notify you in writing that an application is being made to the Mental Health Review Tribunal to determine whether he or she is capable of giving informed consent and has given that consent.

He or she has consented to me giving you this notice.

If you wish to discuss this matter further please contact:

_____ on _____

(name)

(telephone number)

Yours faithfully,

(Medical Superintendent)

(Date)

NOTIFICATION OF APPLICATION TO ADMINISTER ELECTRO CONVULSIVE THERAPY – INVOLUNTARY PATIENTS

Dear _____

It is my opinion as Medical Superintendent of

(name of hospital)

that it is desirable and in the best interests of

(patient's full name)

for him/her to undergo a course of electro convulsive therapy.

The patient:

- has consented to the treatment.
- is incapable of giving consent to the treatment.
- is capable of giving consent to the treatment but has refused to do so.
- is capable of giving consent to the treatment but has neither refused nor consented.

(Tick one box only)

In such cases I am required by law to notify you in writing that an application is being made to the Mental Health Review Tribunal to determine:

- (a) whether the patient is capable of giving informed consent to the administration of the treatment and has given that consent; and
- (b) if the patient is incapable of giving informed consent or has not consented – whether the treatment is necessary or desirable for the safety or welfare of the patient.

If you wish to discuss this matter further please contact:

_____ on _____
(name) (telephone number)

Yours faithfully,

(Medical Superintendent)

(Date)

FORM 15 IS THE REGISTER OF ELECTRO CONVULSIVE THERAPY TREATMENTS

This form is unchanged from that in earlier Regulations (except as to the form number). There are remaining stocks of the Registers and it is intended to continue to use those stocks.

ECT Registers can be obtained from the Centre for Mental Health, NSW Health Department, Locked Bag 961, North Sydney 2059 (telephone 9391-9308).

NOTIFICATION TO RELATIVE

Dear _____

It is my opinion as Medical Superintendent of

(Name of Hospital)

that it is desirable and in the best interests of

(Patient's full name)

who is involuntarily detained in the hospital in accordance with the *Mental Health Act 1990*, to undergo a surgical operation or special medical treatment for

(lay description of condition)

This operation or treatment is called _____
(medical name)

To perform the surgery, or carry out the treatment, I am required by law to obtain the patient's consent.

However the patient is:

- incapable of giving that consent
- capable of giving that consent but has refused to do so
- capable of giving that consent but has neither refused nor consented

(Tick one box only)

In such cases I am required by law to notify you in writing that it is my intention to obtain consent on the patient's behalf from the Mental Health Review Tribunal.

If you wish to discuss this matter further please contact

_____ on _____
(Name) (Telephone number)

Yours faithfully,

(Medical superintendent)

(Date)

Included for information only. The Mental Health Review Tribunal will provide such documents as it requires, check with the Tribunal before using. For further information please see the Tribunal website at www.mhrt.nsw.gov.au

FORM 17

(Cl.35)

MENTAL HEALTH ACT 1990
Section 278 (1)

SUMMONS
Mental Health Review Tribunal

To: _____

The Mental Health Tribunal will be hearing matters in relation to

(name of patient)

The hearing will take place on _____ on _____
(time) (date)

at _____
(address)

You are required:

- * to attend the hearing as a witness
- * to attend the hearing and produce the following documents:

(* delete if inapplicable)

You are entitled to receive reasonable costs, including any loss of earnings incurred through compliance with this summons.

Should you fail or refuse to comply with this summons, properly served, you may be guilty of an offence under the Mental Health Act 1990.

If you are required to attend the hearing only to produce documents, it is sufficient compliance with this summons if those documents are delivered to

at _____

on or before _____

Signature _____

President/Deputy President
Mental Health Review Tribunal

FORM 18

This is the oath of office to be taken by persons appointed as Assessors to assist the Supreme Court in any matters coming before it under the Mental Health Act.

Included for information only. The Mental Health Review Tribunal will provide such documents as it requires, check with the Tribunal before using. For further information please see the Tribunal website at www.mhrt.nsw.gov.au

FORM 19

(Cl.40)

MENTAL HEALTH ACT 1990
Section 302 (2) (m)

PSYCHIATRIC ADMISSIONS

Advice to Mental Health Review Tribunal

INSTRUCTIONS

Follow the instructions set out below to fill in this form. Tick the boxes provided or write in the information required.

For patients reclassified from informal patients to involuntary patients

Fill out sections A, B and D *only* of this form.

For other patients (not being forensic patients or informal patients) detained in the hospital

Fill out sections A, C and D *only* of this form.

When to fill out the form

The form should be filled out as soon as practicable after the occurrence of the first of any of the following events in relation to a patient or detained person:

- conclusion of Magistrate's inquiry in respect of a patient
- discharge of a patient
- a temporary patient or continued treatment patient being reclassified as an informal patient
- a person ceasing to be detained in the hospital

Where to send the form

This form is to be sent not later than 21 days after the first event occurs to The Registrar of the Mental Health Review Tribunal.

Should you have any questions about the form contact the Registrar or Deputy Registrar of the Tribunal by telephone.

SECTION A. INVOLUNTARY

To be completed for all **involuntary** patients.

Q1. Hospital_____

Q2. Medical Record Number_____

Q3. Date of Birth_____

Q4. Sex_____

Q5. Country of Birth_____

Q6. Interpreter required Yes [] No [] Language_____

SECTION B. RECLASSIFICATION

To be completed for all Patients **reclassified** from informal to involuntary and for all patients presenting voluntarily but who are scheduled at the admission office.

Q7. If the patient was reclassified to involuntary, when was this done?

SECTION C. INITIAL ADMISSION

To be completed for patients taken to hospitals only.

Q8. Date taken to hospital _____

Q9. **Method of referral** (*Tick one box*)

- | | |
|---|--------------|
| <input type="checkbox"/> Certificate of medical practitioner | sec.21 |
| <input type="checkbox"/> Request by relative/friend | sec.23 |
| <input type="checkbox"/> Apprehension by police | sec.24 |
| <input type="checkbox"/> Order under sec. 33 Mental Health
(Criminal Procedure Act) 1990 | sec.25 |
| <input type="checkbox"/> Welfare officer or welfare officer with police assistance | sec.26 |
| <input type="checkbox"/> Authorised medical practitioner's certificate | secs. 21, 27 |
| <input type="checkbox"/> Breach of Community Treatment Order | sec.142 |

Q10. After examination was the patient admitted?

Yes No

Q11. On admission was the patient classified as

- Informal
 Involuntary, mentally ill
 Involuntary, mentally disordered

Q12. Was the patient discharged by hospital before Magistrate's inquiry?

Yes No

If yes, when _____

SECTION D. INVOLUNTARY

To be completed for all **involuntary** patients.

Q13. Was the patient presented to a Magistrate?

Yes No

Q14. If yes to Q13, what was the date of the inquiry _____

(*If inquiry completed, proceed with Q16.*)

Q15. Was the case adjourned?

Yes No If yes, until when? _____

(*Note: If the patient was then presented again at a resumed hearing, proceed with Q16*)

Q16. At the first or resumed hearing, what was the Magistrate's decision?

- Discharge
 Defer discharge. For how long _____
 Classify patient as Temporary Patient
Until when? _____
 Make a Community Treatment Order
 Make a Community Counselling Order
 Any other order (please specify)
-

ORDER OR DIRECTION OF MAGISTRATE - INQUIRY RELATING TO MENTALLY ILL PERSON

Hospital _____

Address _____

Date _____

(Complete Part 1 or Part 2 only)

Part 1 – Order or Direction

I have today ordered or directed that _____
(patient's name)

(who was brought before me under section 38 of the *Mental Health Act 1990*):

- must be discharged from hospital
- must be discharged from hospital into the care of

(name)

- must be detained as a temporary patient until no later than _____
(date)
for further observation or treatment, or both

- must be made subject to a community treatment order
- must be made subject to a community counselling order

(Tick one box only)

The reasons for my order or direction (as required by section 53 of the Act) are annexed to this form.

(OR)

Part 2 Order for adjournment

I have today ordered the adjournment of the inquiry in relation to _____

_____ (who was brought before me under section 38 of the
Mental Health Act 1990) for a period of _____ days.

The reasons for my order (as required by section 53 of the Act) are annexed to this form.

Signature of Magistrate _____

Name of Magistrate _____

MENTAL HEALTH ACT 1990
Section 12(1)

PERSONAL APPLICATION FOR INFORMAL ADMISSION TO HOSPITAL

I, _____ request admission to
(Name in full)

_____, for treatment as an Informal Patient.
(Name of Hospital)

Intending patient's signature: _____

Date: ___/___/___

VERIFICATION

The above application was made apparently freely and voluntarily, in my presence.

Signature of Witness: _____

Date: ___/___/___

or, in the case of a person who needs the assistance of an interpreter, -

I have interpreted the content of this form to the intending patient, who has signed above. The above application was made apparently freely and voluntarily, in my presence.

Signature of Interpreter: _____

Date: ___/___/___

MENTAL HEALTH ACT 1990
Section 12(2)

**APPLICATION FOR INFORMAL ADMISSION TO HOSPITAL
OF A PERSON SUBJECT TO A GUARDIANSHIP ORDER
UNDER THE GUARDIANSHIP ACT 1987**

I, _____
(Name of Guardian in full)

being the appointed Guardian under section 14 of the Guardianship Act 1987 of

(Name of intended patient in full)

request that he/she be admitted to _____,
(Name of Hospital),
for treatment as an Informal Patient.

This application is made:

- * with the approval of the Guardianship Tribunal as required by section 12(2) of the *Mental Health Act 1990* (copy of approval to be provided)

OR

- * subject to the approval of the Guardianship Tribunal,
which was/will be sought on _____.
(Date application was made or is to be made)

* delete whichever is inapplicable

Guardian's signature: _____

Date: ___/___/___

I have interpreted the content of this form to the Guardian.

Signature of Interpreter: _____

Date: ___/___/___

NSW DEPARTMENT OF HEALTH

MENTAL HEALTH ACT 1990
Section 19(1)

APPLICATION FOR REVIEW OF DECISION OF MEDICAL OFFICER

To, The Medical Superintendent,

(Name of Hospital)

I, _____ request review of the decision:
(Name in full)

* not admit me as an informal patient

* not to admit _____
(Name in full)

for whom I am the appointed Guardian under section 14 of the
Guardianship Act 1987

* to discharge me as an informal patient

* to discharge _____
(Name in full)

for whom I am the appointed Guardian under section 14 of the
Guardianship Act 1987

** delete whichever is inapplicable*

Signature: _____

Date: ___/___/___

NSW DEPARTMENT OF HEALTH

MENTAL HEALTH ACT 1990

Section 55

YOUR RIGHTS AFTER THE MAGISTRATE'S INQUIRY

On _____ you went to the Magistrate's Inquiry at
(date)

_____ and the Magistrate ordered that -
(Name of Hospital)

- * You be detained as a Temporary Patient for further observation and/or treatment until _____.
(date)
- * You be discharged subject to a Community Treatment Order or Community Counselling Order.
- * Your estate be managed, on your behalf, by the Protective Commissioner.
- * *delete where inapplicable*

YOU HAVE THE FOLLOWING RIGHTS OF APPEAL AGAINST THESE ORDERS

If you are ordered to remain in Hospital as a Temporary Patient:

- You may ask the Medical Superintendent to discharge you.
- You may ask the Medical Superintendent to reclassify you as an Informal (voluntary) Patient. The Medical Superintendent would only do this if satisfied that you would benefit from treatment as an Informal Patient.
- A relative or friend may apply in writing asking the Medical Superintendent to discharge you. The application must satisfy the Medical Superintendent that you will be properly taken care of and be prevented from causing harm to yourself or other people.
- If the Medical Superintendent refuses an application for your discharge, or fails to decide within three working days, you or your relative or friend may appeal to the Mental Health Review Tribunal.
- If the Mental Health Review Tribunal disallows your appeal, you may further appeal to the Supreme Court. This is expensive and may take some time. Some free legal advice may be available from the Mental Health Advocacy Service.

(Reverse of CMH 4)

- Any person may take a case to the Supreme Court to seek the discharge of a person, where there is evidence the person is not a mentally ill or mentally disordered person or where other care of a less restrictive kind is appropriate and reasonably available.

If you are discharged on a Community Treatment Order or Community Counselling Order:

- You may appeal to the Mental Health Review Tribunal.

If an order is made that your estate be managed by the Protective Commissioner:

- You may appeal to the Supreme Court. To do this you will need legal advice. Some free legal advice may be available from the Mental Health Advocacy Service.
- Once you have ceased to be a patient in the hospital, you may appeal to the Mental Health Review Tribunal.

WHILST YOU ARE AWAITING CONSIDERATION OF AN APPEAL YOU MUST COMPLY WITH ALL LEGAL ORDERS WHICH HAVE BEEN MADE.

These telephone numbers may be of some assistance to you:

- Mental Health Advocacy Service 9745-4277
- Mental Health Review Tribunal 9816-5955
- Office of the Protective Commissioner 9265-3131

NSW DEPARTMENT OF HEALTH

MENTAL HEALTH ACT 1990
Section 65(3)

NOTICE OF DISCHARGE OF PERSON UNDER GUARDIANSHIP

(Name of Hospital)

(Address of Hospital)

To _____
(Full name of guardian)

Notice is hereby given that _____,
(Full name of patient)

an Informal Patient at _____,
(Name of Hospital)

will be discharged from this facility on _____.
(Date)

Signature: _____
(Medical Superintendent)

Name: _____

Date: ___/___/___

NSW DEPARTMENT OF HEALTH

MENTAL HEALTH ACT 1990
Section 148(5)

APPLICATION FOR VARIATION/REVOCAION OF ORDER

To: The Registrar
Mental Health Review Tribunal
PO Box 2019
BORONIA PARK NSW 2111

On _____, * a Community Treatment Order
(Date) * a Community Counselling Order

was made in relation to _____,
(Patient's full name)

by * a Magistrate
* the Mental Health Review Tribunal.

I, _____, being
(Full name of applicant)

- * the person for whom the order was made
- * the psychiatric case manager implementing the order
- * an authorised applicant under Schedule 1 of the Act,

do hereby apply for the order to be * revoked
* varied, as follows

** delete where inapplicable*

Applicants signature _____

Applicant's contact information _____

(address and telephone number)

Date: ___/___/___

MENTAL HEALTH ACT 1990
Section 24

**REQUEST BY MEMBER OF THE NSW POLICE SERVICE
FOR ADMISSION OF AN ALLEGED MENTALLY DISTURBED
PERSON INTO A PSYCHIATRIC HOSPITAL**

I, the undersigned, _____, a Police Officer
(Name in full)

at present attached to _____ Police Station,

inform you, the Medical Superintendent of _____

Psychiatric Hospital that it appears to me that _____,
(Name in full, if available)

is mentally disturbed, and further that I have reason to believe when apprehended

he/she: * was committing or had recently committed
an offence, and would benefit from being
dealt with under the Mental Health Act,
rather than otherwise in accordance with
law.

 * has recently attempted to kill himself/herself
or that it is probable he/she will attempt to
kill himself/herself or attempt to cause
serious bodily harm to himself/herself.

** delete where inapplicable*

Further details of the circumstances leading to this request for admission appear
over page.

Dated: ___ / ___ / _____

At: _____

Signature: _____

Rank: _____

Address: _____

MENTAL HEALTH ACT 1990
Section 26

**REQUEST BY A WELFARE OFFICER FOR THE
ADMISSION OF PERSON INTO A PSYCHIATRIC HOSPITAL**

I, the undersigned, _____, a Welfare Officer
(Name in full)

appointed under the *Mental Health Act 1990*, inform you, the Medical

Superintendent of _____ Psychiatric Hospital

that I believe _____,
(Name in full, if available)

to be * a mentally ill person
 * a mentally disordered person.

** delete where inapplicable*

Further details of the relevant circumstances leading to this request for admission appear over page.

Dated: ___/___/___

At: _____

Signature: _____

Address: _____

NSW DEPARTMENT OF HEALTH

MENTAL HEALTH ACT 1990
Section 67

APPLICATION FOR DISCHARGE FROM HOSPITAL

To, The Medical Superintendent

I, _____, being a Temporary
(Name in full)

or Continued Treatment Patient at _____,
(Name of Hospital)

request to be discharged from the Hospital.

Date: ___/___/___

Signature: _____

Address: _____

INFORMATION

This application should be given to the Medical Superintendent or to another member of the Hospital's medical staff.

If the Medical Superintendent refuses your application or fails to make a decision within three working days, you, or a relative or friend, may appeal to the Mental Health Review Tribunal.

NSW DEPARTMENT OF HEALTH

MENTAL HEALTH ACT 1990
Section 68

**APPLICATION FROM RELATIVE OR FRIEND
FOR PATIENTS DISCHARGE FROM HOSPITAL**

To, The Medical Superintendent

I, _____, being a relative or
(Full name of Applicant)

friend of _____, who is a
(Full name of patient)

Temporary or Continued Treatment Patient at _____,
(Name of Hospital)

request that he/she be discharged from the Hospital.

Date: ___/___/___

Signature: _____

Address: _____

INFORMATION

This application should be given to the Medical Superintendent or to another member of the Hospitals medical staff.

If the Medical Superintendent refuses your application or fails to make a decision within three working days, you, the patient or another person appointed by the patient, may appeal to the Mental Health Review Tribunal.

MENTAL HEALTH ACT 1990
Section 128

BREACH OF COMMUNITY COUNSELLING ORDER
NOTICE TO PATIENT

(Name of Health Care Agency)

(Address)

To _____
(Patient's name)

(Address)

Notice is hereby given that as a result of:

1. Your refusal to comply with your community counselling order;
2. Your further refusal to comply after intervention of your psychiatric case manager as required by section 127 of the Mental Health Act 1990; and
3. You being informed that such further refusal will result in an order to attend the Health Care Agency,

YOU ARE NOW REQUIRED under section 128 of the Mental Health Act 1990 to attend the Health Care Agency at the address given above for counselling/assessment/administration of medication *.

* (delete where inapplicable)

Under section 128 of the Mental Health Act 1990, I am required to warn you that the assistance of the NSW Police Service may be obtained to ensure your attendance as set out above.

Signature: _____

Name: _____
(Director of Health Care Agency)

Date: ____/____/____

MENTAL HEALTH ACT 1990
Section 138

BREACH OF COMMUNITY TREATMENT ORDER
NOTICE TO PATIENT

(Name of Health Care Agency)

(Address)

To _____
(Patient's name)

(Address)

Notice is hereby given that as a result of:

1. Your refusal to comply with your community treatment order (copy attached);
2. Your further refusal to comply after intervention of your psychiatric case manager as required by section 137 of the Mental Health Act 1990; and
3. You being informed that such further refusal will result in an order to attend the Health Care Agency,

YOU ARE NOW REQUIRED under section 138 of the Mental Health Act 1990 to attend the Health Care Agency at the address given above for counselling/ assessment/administration of medication *.

* (delete where inapplicable)

Under section 138 of the Mental Health Act 1990, I am required to warn you that the assistance of the NSW Police Service may be obtained to ensure your attendance as set out above.

Signature: _____

Name: _____
(Director of Health Care Agency)

Date: ____/____/____

NSW DEPARTMENT OF HEALTH

MENTAL HEALTH ACT 1990
Section 78

**TRANSFER BETWEEN HOSPITALS
OF INVOLUNTARY PATIENT**

Name of patient being transferred _____

from _____ Hospital

to _____ Hospital.

The abovementioned transfer in terms of section 78 of the Mental Health Act 1990
has been arranged, with your concurrence, to take effect on ____/____/____.

- * As required by section 78(3), I have done all such things as are reasonably practicable to give notice of this transfer, and the reasons therefore, to the patient's nearest relative/a relative nominated by the patient/a person said by the patient to be a close friend.
- * As this transfer arises from circumstances constituting, in my opinion, an emergency, I will, after the patient is transferred, do all such things as are reasonably practicable to give an emergency notice of this transfer, and the reasons therefore, to the patient's nearest relative/a relative nominated by the patient/a person said by the patient to be a close friend.

** delete whichever is inapplicable*

Signature of Medical Superintendent: _____

Name: _____

To, the Medical Superintendent,

_____ Hospital

Mental Health Act 1990

Section 286

U/R No.

Unit Record No

Ward

Family Name

Given Names

D.O.B. Sex

Alias.....

TRANSFER OF AN INVOLUNTARY PATIENT TO AN INTERSTATE MENTAL HEALTH FACILITY

TO BE COMPLETED BY *MEDICAL SUPERINTENDENT/DELEGATE:

I,
GIVEN NAME/S FAMILY NAME (BLOCK LETTERS) *Medical Superintendent/ Delegate

ORDER THAT
GIVEN NAME/S FAMILY NAME (BLOCK LETTERS) of involuntary patient

an involuntary patient at
gazetted hospital/premises pursuant to section 208 Mental Health Act 1990 (NSW)

be transferred from the abovenamed hospital to
Name and address of admitting interstate mental health facility**

on: the day of 20.....

I am satisfied that:

the patient will benefit from the transfer; **and/or**

the transfer is necessary for the patient's treatment;

and

the patient could continue to be detained in an approved mental health service; **and**

the interstate authority for the interstate mental health facility has agreed in writing to the transfer (attached).

(tick whichever applies)

signed dated/...../.....

*Medical Superintendent/ Delegate

CMH 14

**SCHEDULE 2 – MEDICAL CERTIFICATE AS TO EXAMINATION OR
OBSERVATION OF PERSON**

(Secs. 21, 22)

MENTAL HEALTH ACT 1990

PART 1

1, (Medical Practitioner/accredited person)
(name in full - use block letters)

of certify that

on 19 immediately before or shortly before completing

this certificate, at
(state place where examination/observation took place)

I personally examined/personally observed
(name of person in full)

for a period of
(state length of examination/observation)

I certify the following matters:

1. I am of the opinion that the person examined/observed by me is a mentally ill person suffering from mental illness/or a mentally disordered person and that there are reasonable grounds for believing the person's behaviour for the time being is so irrational as to justify a conclusion on reasonable grounds that temporary care, treatment or control of the person is necessary:

*(a) in the case of a mentally ill person:

- (i) for the person's own protection from serious harm; or
- (ii) for the protection of others from serious harm; or

*(b) in the case of a mentally disordered person:

- (i) for the person's own protection from serious physical harm; or
- (ii) for the protection of others from serious physical harm.

2. I have satisfied myself, by such inquiry as is reasonable having regard to the circumstances of the case, that the person's involuntary admission to and detention in a hospital are necessary and that no other care of a less restrictive kind is appropriate and reasonably available to the person.

3. Incidents and/or abnormalities of behaviour and conduct (a) observed by myself and (b) communicated to me by others (state name, relationship and address of each informant) are:

(a)

.....

.....

.....

** delete whichever is not applicable*

**SCHEDULE 2 – MEDICAL CERTIFICATE AS TO EXAMINATION OR
OBSERVATION OF PERSON – continued**

(b)

.....

.....

.....

4. The general medical and/or surgical condition of the person is as follows:

.....

.....

.....

5. The following medication (if any) has been administered for purposes of psychiatric therapy or sedation:

.....

.....

.....

6. I am not a near relative of the person.

7. I have/do not have a pecuniary interest, directly or indirectly, in an authorised hospital.
I have/do not have a near relative/partner/assistant who has such an interest.
Particulars of the interest are as follows:

.....

.....

.....

Made and signed this day of 20.....

Signature:

**SCHEDULE 2 – MEDICAL CERTIFICATE AS TO EXAMINATION OR
OBSERVATION OF PERSON – continued**

PART 2

If the assistance of a Police Officer is required, this part of the Form should be completed.

YOU SHOULD NOT REQUEST THIS ASSISTANCE UNLESS IT IS NECESSARY AND THERE ARE NO OTHER MEANS OF TAKING THE PERSON TO HOSPITAL REASONABLY AVAILABLE.

I am of the opinion, in relation to
(name of person in full)

- (a) that the condition of the person is such that the assistance of a Police Officer is required in order to take the person to a hospital; and
- (b) that no other means of taking the person to a hospital are reasonably available.

Made and signed this day of 20

Signature:

NOTES:

1. Chapter 3 of the Mental Health Act 1990 states:

**8. Criteria for involuntary admission etc. as mentally ill person or mentally
disordered person**

A person is a mentally ill person or a mentally disordered person for the purpose of:

- (a) the involuntary admission of the person to a hospital or the detention of the person in a hospital under this Act; or
- (b) determining whether the person should be subject to a community treatment order or be detained or continue to be detained involuntarily in a hospital, if, and only if, the person satisfies the relevant criteria set out in this Chapter.

9. Mentally ill persons

(1) A person is a mentally ill person if the person is suffering from mental illness and, owing to that illness, there are reasonable grounds for believing that care, treatment or control of the person is necessary:

- (a) for the person's own protection from serious harm; or
- (b) for the protection of others from serious harm.

(2) In considering whether a person is a mentally ill person, the continuing condition of the person, including any likely deterioration in the person's condition and the likely effects of any such deterioration, are to be taken into account.

10. Mentally disordered persons

A person (whether or not the person is suffering from mental illness) is a mentally disordered person if the person's behaviour for the time being is so irrational as to justify a conclusion on reasonable grounds that temporary care, treatment or control of the person is necessary:

- (a) for the person's own protection from serious physical harm; or
- (b) for the protection of others from serious physical harm.

SCHEDULE 2 - MEDICAL CERTIFICATE AS TO EXAMINATION OR OBSERVATION OF PERSON - continued

11. Certain words or conduct may not indicate mental illness or disorder

(1) A person is not a mentally ill person or a mentally disordered person merely because of any one or more of the following:

- (a) that the person expresses or refuses or fails to express or has expressed or refused or failed to express a particular political opinion or belief;
- (b) that the person expresses or refuses or fails to express or has expressed or refused or failed to express a particular religious opinion or belief;
- (c) that the person expresses or refuses or fails to express or has expressed or refused or failed to express a particular philosophy;
- (d) that the person expresses or refuses or fails to express or has expressed or refused or failed to express a particular sexual preference or sexual orientation;
- (e) that the person engages in or refuses or fails to engage in, or has engaged in or refused or failed to engage in, a particular political activity
- (f) that the person engages in or refuses or fails to engage in, or has engaged in or refused or failed to engage in, a particular religious activity;
- (g) that the person engages in or has engaged in sexual promiscuity;
- (h) that the person engages in or has engaged in immoral conduct;
- (i) that the person engages in or has engaged in illegal conduct;
- (j) that the person has developmental disability of mind;
- (k) that the person takes or has taken alcohol or any other drug;
- (l) that the person engages in or has engaged in anti-social behaviour.

(2) Nothing in this Chapter prevents, in relation to a person who takes or has taken alcohol or any other drug, the serious or permanent physiological, biochemical or psychological effects of drug taking from being regarded as an indication that a person is suffering from mental illness or other condition of disability of mind.

2. In addition to matters ascertained as a consequence of personally examining or observing the person, account may be taken of other matters not so ascertained where those matters:

- (a) arise from a previous personal examination of the person; or
- (b) are communicated by a reasonably credible informant.

3. In the Mental Health Act 1990 "mental illness" is defined as follows:

mental illness means a condition which seriously impairs, either temporarily or permanently, the mental functioning of a person and is characterised by the presence in the person of any one or more of the following symptoms:

- (a) delusions;
- (b) hallucinations;
- (c) serious disorder of thought form;
- (d) a severe disturbance of mood;
- (e) sustained or repeated irrational behaviour indicating the presence of any one or more of the symptoms referred to in paragraphs (a)-(d).

4. In the Mental Health Act 1990 "near relative" is defined as follows:

near relative, in relation to a **person**, means a parent, brother, sister or child or the spouse of the person and such other person or persons as may be prescribed as a near relative of the person.

5. For admission purposes, this certificate is valid only for a period of 5 days, in the case of a person who is a mentally ill person, or 1 day, in the case of a person who is a mentally disordered person, after the date on which the certificate is given.

MENTAL HEALTH ACT 1990
SCHEDULE 3 – MEDICAL CERTIFICATE AS TO EXAMINATION OF INMATE

(sections 97 and 98)

I, _____ (Psychiatrist, Medical Practitioner)
(Name in full – use block letters) *(delete one)*

of the Corrections Health Service do hereby certify that on the _____ day of

_____ 20____, at _____
(state name of correctional centre where examination took place)

separately from any other medical practitioner, I personally examined

(Name of inmate in full)

_____ and I am of the opinion
(MIN) *(Date of birth)*

that he/she is *(delete one)* * a mentally ill person within the meaning of the Act
* suffering from a mental condition for which
treatment is available in a hospital.

I have formed this opinion on the following grounds:

(1) Facts indicating mental illness/mental condition observed by myself

(2) Other relevant information (if any) communicated to me by others (state name and address of each informant)

Made and signed this _____ day of _____ 20____.

Signature _____

Mental Health Review Tribunal Material

- 1 Supporting documentation requested by the Tribunal
- 2 Application for hearing
- 3 Sample application for Community Order
- 4 Sample treatment Plan
- 5 Checklists for those appearing before the Tribunal
- 6 Sample reports
 - Application for temporary patient order
 - Application for CTO

SUPPORTING DOCUMENTATION REQUESTED BY THE TRIBUNAL

<i>Order</i>	<i>Documentation Required</i>
Extension of Temporary Patient Order (TPO)	<ul style="list-style-type: none"> • Copy of current Temporary Patient Order • Report from treating doctor • Report from hospital social worker if possible • Report from community case manager if relevant
Community Treatment Order (CTO)	<ul style="list-style-type: none"> • Copy of current order – TPO or CTO • Application for Community Order • Report from applicant on reason for order • Treatment Plan • Report on efficacy of previous Treatment Plan if patient is on a community order which is expiring
Community Counselling Order (CCO)	<ul style="list-style-type: none"> • Application for Community Order • Report from applicant on reason for order • Treatment Plan • Report on efficacy of any previous Treatment Plan
Consent for ECT	<ul style="list-style-type: none"> • Information and Consent: Form 12 if appropriate • Certificates from 2 medical practitioners of whom at least one should be a psychiatrist, that ECT is a reasonable, and proper treatment for the patient and is necessary or desirable to be administered to the patient.
Consent for surgery where no relatives or relatives refuse to consent in writing (for details of procedure in other circumstances check with Tribunal)	<ul style="list-style-type: none"> • Application from the medical superintendent of the hospital • Written report from medical superintendent about why the patient cannot give or refuses, or is unable to give informed consent • Written report from a medical practitioner, explaining the reasons for, benefits of and contra-indications of surgery • Evidence of attempt to, or giving of, notice to relatives and get their views: Form 16.
Consent for special medical treatment	<ul style="list-style-type: none"> • Refer Mental Health Review Tribunal
Protected Estates application	<ul style="list-style-type: none"> • Report from treating doctor and/or social worker regarding the patient's capacity to manage his/her own affairs, stating the reasons for coming to this view.
Continued Treatment Order	<ul style="list-style-type: none"> • Copy of current order • Report from treating doctor • Report from hospital social worker
<i>Appeal</i>	<i>Documentation Required</i>
Against refusal to discharge	<ul style="list-style-type: none"> • Report from medical superintendent (or nominee) about refusal to discharge: Form MHRT 6A/91
Against Protected Estates Order	<ul style="list-style-type: none"> • Report from health professional, i.e. social worker, medical practitioner, etc. regarding your appeal • Report from Estate Manager
To vary or revoke Community Order	<ul style="list-style-type: none"> • Report from case manager and/or psychiatrist

APPLICATION FOR HEARING

FOR FACSIMILE TRANSMISSION ONLY

APPLICATION FOR HEARING BY MENTAL HEALTH REVIEW TRIBUNAL

FROM: HOSPITAL/HEALTH CENTRE:
 PROPOSED VENUE:
 HOSPITAL/HEALTH CENTRE CONTACT PERSON:
 Tel: Fax:

TO: SENIOR TRIBUNAL CLERK, MHRT, Tel: (02) 9816 5955 Fax: (02) 9817 4543

CLIENT DETAILS	CLIENT 1	CLIENT 2
Surname		
Given Names		
Date of Birth		
Country of Birth		
Hospital (<i>not Health Centre</i>) Medical Record Number		
Private Address (for clients currently living in the community)		
Nature of Current Order		
Expiry Date of Current Order (<i>if applicable</i>)		

REASON(S) FOR REQUESTING TRIBUNAL HEARING (please tick box)

ORDERS:

	<i>Patient 1</i>	<i>Patient 2</i>
Extend temporary order	<input type="checkbox"/>	<input type="checkbox"/>
* Community treatment order	<input type="checkbox"/>	<input type="checkbox"/>
* Community counselling order	<input type="checkbox"/>	<input type="checkbox"/>
Consent for ECT	<input type="checkbox"/>	<input type="checkbox"/>
Consent for surgery	<input type="checkbox"/>	<input type="checkbox"/>
Consent for special medical treatment	<input type="checkbox"/>	<input type="checkbox"/>
Protected estates application	<input type="checkbox"/>	<input type="checkbox"/>
Continued treatment order	<input type="checkbox"/>	<input type="checkbox"/>

APPEALS:

Against refusal to discharge (after magistrate's order)	<input type="checkbox"/>	<input type="checkbox"/>
Against Protected Estates order	<input type="checkbox"/>	<input type="checkbox"/>
Against CTO made by magistrate	<input type="checkbox"/>	<input type="checkbox"/>

*PLEASE PROVIDE AT LEAST TWO WEEKS' NOTICE FOR CTO OR CCO APPLICATIONS.

- Please ensure that copies of all relevant reports and treatment plans are provided to the Tribunal prior to the hearing.*
- If seeking an extension of an order, please allow sufficient time prior to the expiry date to enable the patient to seek legal advice if required and (for community orders) to enable the Tribunal officially to notify the patient concerning hearing arrangements and his or her rights under the Mental Health Act 1990.*

5. CLINICAL, MANAGEMENT, REHABILITATION, PLANNING ETC

Brief history of patient or client and diagnosis

Effectiveness of previous treatment in ameliorating condition, effecting recovery, or preventing deterioration; History of non-compliance, subsequent relapse, and consequences; Effect of any current CTO:

Duration of order requested (maximum 6 months)

Advantages of community order for safe, effective, and least restrictive possible care

Rationale for treatment plan

Attitude of patient/client, and relations/friends (if applicable) to application

Evidence from psychiatrist of likely relapse, so that client will become a “mentally ill person” within three months (on application for CCO) if CCO not made

Attempts by health care agency to maintain contact and gain consent to treatment (on application for CCO)

Applicant’s signature: Date:

Client's given name(s):

Surname:

Client's address:

.....

Health care agency:

.....

Director:

Address of health care agency:

.....

Case Manager:

Treating Psychiatrist:

Order sought: *please tick box*

CCO

FIRST CTO

SECOND OR SEBSEQUENT CTO

1. The TREATMENT PLAN should set out the following particulars if relevant:

1.1 Any obligations on the client to make contact with other person, eg treating psychiatrist, case manager:

.....

• person(s) to be contacted

.....

• contact times (eg weekly, monthly, etc)

.....

• place of contact

.....

• medium of contact (eg by telephone, or by personal attendance at a particular place, etc)

.....

.....

This information should be presented on Community Health Centre letterhead, or prepared on this form and accompanied by a covering letter on agency letterhead.

Name of Person affected by order:

1.2 MEDICATION: who is to prescribe and administer; how, when and where:

.....
.....
.....
.....
.....

1.3 Requirements as to attendance at the health care agency, and/or other rehabilitation services; and frequency of attendance.

.....
.....
.....
.....
.....

1.4 Other services to be provided to the patient (e.g. support services, educational facilities, family counselling and education, etc.)

.....
.....
.....
.....

2. To the extent that they are not subsumed under the above headings, the treatment plan should set out the duties and undertakings of both parties (client, health care agency).

.....
.....
.....
.....
.....

Signed:
(Director)

Signed:
(Case Manager)

Checklists for those attending Tribunal Hearings

These have been prepared by the MHRT.

Consultant psychiatrists and psychiatric registrars

- clinical history
- current mental condition
- treatment provided – current medication and dosage
- proposed and alternative treatments
- other therapy provided
- person's responses to treatment, therapy and treatment plan
- outlook for future management and rehabilitation
- past compliance with treatments
- consequences of compliance/non-compliance

Case managers and social workers

- social history
- treatment plan
- current accommodation and future options
- rehabilitation programs planned or undertaken
- additional activities
- practicalities of day to day management
- patient's views about treatment plan
- patient's support network
- patient's financial management skills
- views of relatives/friends
- opinion on whether this is the least restrictive alternative
- patient's progress under order.

Nurses

- current mental condition
- behaviour on the ward, including sleeping, eating
- relationships with visitors and others on the ward
- response to in ward/out of ward programs
- response to medication.

Consumers

- views about proposed plan, hospitalisation or treatment
- information about available support
- views on medication
- views on leaving hospital
- views on ability to manage mental illness.

Family members and friends

- general experience with the patient in the past/at home
- ability to cope if the patient leaves or stays in hospital
- views on the treatment, treatment plan or hospitalisation
- concerns about the proposed plan, hospitalisation or treatment.

Sample Report

Application for Temporary Patient Order (or Extension)

Mr A is a 42 year old man with a diagnosis of Schizophrenia. He lives in his own Housing Department accommodation. He has had 4 previous admissions to this hospital and is a registered client of the community mental health service.

Mr A was brought in to hospital on a Schedule 2. The community team reports a six week deterioration in his mental state. Mr A's father recently died and since this time Mr A reports an increase in auditory hallucinations and persecutory ideas revolving around fears that he is being poisoned. Subsequently Mr A has stopped eating with marked deterioration in his physical health. At the time of admission Mr A was refusing any treatment and would not consider admission to hospital.

At present Mr A is being treated with the following medications:

.....

This medication has produced a slight improvement in his mental state. However, Mr A has continued to report hearing voices telling him to stop eating, and remains reluctant to eat any of the food provided for him. In the past it has taken up to two months to see a significant improvement in his mental state.

It is evident then that Mr A is currently a mentally ill person as defined by the Mental Health Act with the presence of auditory hallucinations and delusions, and the risk of serious harm he presents to himself.

I therefore request that Mr A be detained as a Temporary Patient for a period of up to four weeks.

Signed: _____

Sample Report for CTO

1. THIS IS AN APPLICATION FOR A: *please tick box*

- CCO
- CTO FIRST APPLICATION
- CTO SECOND OR SUBSEQUENT APPLICATION

2. ATTACHED REPORTS:

- (A) CCO (s122)
 - 1. Attach section 136 report on efficacy of any recently expired CTO
 - 2. Attach section 126 report on efficacy of any previous CCO
- (B) CTO (s134)
 - 1. Attach section 136 reports on efficacy of any current CTO
 - 2. Attach section 126 report on efficacy of any recently CCO

3. APPLICANT DETAILS:

Agency Name:

Address:

4. CLIENT DETAILS:

Hospital or residential address:

Given name(s): Ms B.....

Surname:

Date of birth:

Medical Record Number if hospital patient:

5. CLINICAL, MANAGEMENT, REHABILITATION, PLANNING, ETC.

Brief history of client and diagnosis:

Ms B is a 35 year old woman with a diagnosis of Schizophrenia. She currently lives alone in Housing Department accommodation. Ms B is working in a supported employment programme. She also receives Disability Support Pension. Ms B has limited contact with her family who live interstate.

Effectiveness of previous treatment in ameliorating condition, effecting recovery, or preventing deterioration; history of non-compliance, subsequent relapse and consequences; effect of any current CTO:

Ms B has an excellent response to anti psychosis medication. When Ms B is on medication she only experiences symptoms during times of extreme stress (eg losing her job). Ms B however does not like to take medication and will cease this shortly after discharge from hospital. This has happened after the previous three admissions and has resulted in involuntary hospitalisations due to delusional ideas which lead to behaviour presenting a risk to others.

Duration of order requested (maximum 6 months for CTO and CCO):

A CTO of 6 month duration is requested.

Advantages of Community Order for safe, least restrictive possible care:

A CTO would ensure that Ms B maintains regular contact with her case manager and is in receipt of effective medication. This would therefore work toward preventing involuntary hospitalisations and is therefore the least restrictive form of care.

Rationale for Treatment Plan:

The Treatment Plan proposed aims to promote the following:

- regular contact with the case manager with the aim of working toward increasing rapport and a positive working relationship;
- regular review of medication and mental state to ensure the prescribed medication is the most suitable for Ms B's needs;
- cooperation with medication regime to assist with maintaining optimal mental health.

Attitude of patient/client, and relation/friends (if applicable) to application:

The application and Treatment Plan have been explained to Ms B and she is not in agreement with the application.

Applicant's signature:

Date:

Advice on the Mental Health Act

Centre for Mental Health

(02) 9391 9308

Mental Health Review Tribunal

(02) 9816 5955

Toll free: 1800 815 511

Mental Health Advocacy Service

(02) 9745 4277

Complaints and Concerns

Official Visitors' Program

(02) 9620 8218

NSW Health Care Complaints Commission

(02) 9219 7444

Toll free: 1800 043 159

Patient Support Office

Northern Sydney

(02) 9926 8184

South Eastern Sydney

(02) 9382 8129

Central Sydney

(02) 9767 8300

Western Sydney

(02) 9839 1506

Penrith/Blue Mountains

(02) 4724 3870

South Western Sydney

(02) 9828 5710

Hunter

(02) 4921 4943

Consumer and Carer Organisations

ARAFMI

(02) 9887 5897

NSW Association for Mental Health

(02) 9816 1611

NSW Consumer Advisory Group

(02) 9556 9219

Schizophrenia Fellowship of NSW

(02) 9878 2053

Guardianship

Guardianship Tribunal

(02) 9555 8500

Toll free: 1800 463 928

Public Guardian

(02) 9265 3184

Toll free: 1800 451 510

Protective Commissioner

(02) 9265 3131

Toll free: 1800 451 510

Cultural Issues

Transcultural Mental Health Centre

(02) 9840 3800

Toll free: 1800 648 911

