

## 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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