



# **REVIEW OF THE MENTAL HEALTH ACT 1990**

## **REPORT**

August 2006

## INTRODUCTION

The Review of the Mental Health Act 1990 commenced in February 2004 and has been conducted through calls for submissions on two discussion papers, Carers and Information Sharing (DP 1) released in February 2004 and The Mental Health Act 1990 (DP 2) released in August 2004.

The Review has also considered work done by the NSW Parliamentary Select Committee on Mental Health which reported to Parliament in December 2002 and Reports of the Sentinel Events Review Committee. In addition, throughout 2005 the Minister Assisting the Minister for Health (Mental Health) Cherie Burton conducted visits to the State's mental health facilities and a series of public meetings to discuss the issues raised in the Review. These meetings included key stakeholders in mental health, including NGOs, carers, consumers, and staff.

The Department of Health has received more than 300 letters, submissions and comments on the two papers from a broad range of groups and individuals, including patients, carers, clinicians, stakeholder groups and interested members of the community.

This Report is in 3 Parts:

- *Part One:* Outline of the Review and summary of issues arising;
- *Part Two:* Summary of key changes in the Exposure Draft Bill;
- *Part Three:* The Exposure Draft Mental Health Bill 2006.

## 1. PART ONE – THE REVIEW

### 1.1 The Submissions

Generally, the submissions reflected broad support for the overall content of the current Act. This extended to key aspects of the legislation, including the definitions of “mental illness”, “mentally ill person” and “mentally disordered person” and the reliance on both Magistrates and the Mental Health Review Tribunal to oversee and review involuntary admission and treatment.

In relation to the areas for change canvassed in the two discussion papers, there was strong support for recognition of the role of carers and the need for them to have information, provided the process adopted also provided the patient with an opportunity to identify an appropriate contact. There was also support for changes to provisions providing for treatment in the community, and for additional restrictions to be imposed on some mental health treatments such as psychosurgery and ECT.

Many submissions to the Review also observed that the Mental Health Act itself forms only part of a bigger picture of mental health services in NSW, and that a range of non-legislative and resourcing issues are also critical to improving care and improving services in this area. The Government recognises this broader canvas, and, on the 1<sup>st</sup> of June announced a \$939 million package over the next five years for new mental health initiatives including services for forensic patients, new inpatient beds and expanded community mental health initiatives.

The role of this Review is to ensure the legislative structure keeps pace with and supports these improvements.

## 1.2 Themes for Change

While the submissions were supportive of much of the current content of the law, some clearly identified “themes for change” also arose, and these have informed the development of the Exposure Draft Bill:

*First*, recognising and supporting greater participation for carers and patients by revising the language of the Act into plainer english, overhauling and enhancing the recognition of patient rights and expectations and enhancing information sharing between clinicians, carers and patients.

*Secondly*, by making the 1990 Act more operationally relevant to current service models and needs, by recognising the role of service providers such as ambulance services, and improving the means by which persons with mental illnesses can obtain general and specialist medical care.

*Thirdly*, by ensuring there is sufficient flexibility in the legislative scheme to accommodate future changes and additions in service delivery by revising the way services are recognised by the legislation.

## 1.3 The Next Steps

The current Exposure Draft Bill will be released for a period of three months consultation, after which the Bill will be reviewed and revised to take account of the consultations, and finalised for introduction into Parliament.

The Government has also announced two further reviews to be conducted by the President of the Mental Health Review Tribunal. These Reviews will run for 12 months and will cover the following issues:

### *Review of Administration of the Mental Health Review Tribunal*

This review will examine current administrative practices and procedures of the Mental Health Review Tribunal with a view to enhancing the quality of decision-making and the efficient and economic operation of the Tribunal. It will consider the administration of the Mental Health Tribunal Registry, the procedures and procedural guidelines relied on in Tribunal hearings and staffing issues. The Review will also look at the role of the Tribunal within the broader forensics system.

### *Review of the legislation relating to forensic and security patients*

The provisions relating to the oversight, review and release of forensic patients are contained in Chapter 5 of the 1990 Mental Health Act, and were subject to review in Discussion Paper 2. During the consultation process, a range of options arose on reform in this area. The Government therefore decided to request the President of the Tribunal to convene a Taskforce to examine these options further, with a view to making final recommendations in this area.

The Review will examine these options in detail and in particular look at the appropriate authority or person to make decisions about care, treatment and control of forensic patients, mechanisms for ensuring issues of public safety are properly considered and the role of victims of crime and the means by which their views and concerns can be addressed.

A copy of the terms of reference on both Reviews is attached in Annexure 1 to this Report.

#### **1.4 Consultation on the Bill**

The terms of the Bill in Part 3 of this Report are still under development, and the Government is seeking the views of the community in relation to both the provisions of the Bill and the underpinning policy conclusions arising from the Review. Submissions are encouraged, and should be provided to:

**Legal Branch**  
**Department of Health**  
**LMB 961 NORTH SYDNEY 2059**  
**e-mail: [legal@doh.health.nsw.gov.au](mailto:legal@doh.health.nsw.gov.au).**

Comments and submissions should be provided by 3 November 2006.

## **PART TWO – THE EXPOSURE DRAFT BILL: KEY CHANGES**

### **2.1 A “plain English” Act**

While the issue was not directly raised in the Discussion Papers, many submissions suggested the 1990 Act was difficult to understand and suggested the new legislation be drafted in a more “plain English” style. Given the range of laypersons who are affected by or work with the Act, making its language as accessible as possible should improve understanding of the legislation and how it affects the community. The Exposure Draft Mental Health Bill 2006 has therefore been drafted with these principles in mind.

### **2.2 Rights and Objects**

Part of the restructure of the Act has involved establishing a new Part (Part 1 of Chapter 4) which focuses in one place a range of provisions protecting or affecting the rights of patients and carers. While this new section draws together some existing rights from the 1990 Act, it also expands them, adding a number of new provisions.

#### *Principles for Care and Treatment*

These principles identify a range of matters which should be considered in care and treatment, including assisting people with mental illnesses or disorders to live, work and participate in the community, ensuring the prescription of medicine is for therapeutic purposes alone, recognising age, religious and cultural needs of people with mental illnesses, and involving patients and carers in decisions about treatment (see section 68).

#### *Information Sharing and Primary Carers*

One of the main proposals in Discussion Paper 1, was to ensure greater involvement of people who have primary responsibility for providing care and support for a patient while in the community. Recognition that carers and family members need greater access to patient information was one of the key issues arising from the Parliamentary Select Committee on Mental Health Services.

The submissions received in the course of the Review largely supported carers (including family members) being able to have access to relevant information which would assist them in providing care, as well as involving them in care decisions. A second strong theme also arose however – to ensure the patient is involved in those care decisions, and to give them some capacity to control who is given information. The key issue is to balance and manage what may sometimes be the competing interests of carers and the person they provide care to.

The Government has accepted the proposals in Discussion Paper 1, and new provisions have been drafted which for the first time in NSW include the notion of a “primary carer”, as opposed to a relative or friend. These provisions:

- Allow a person to nominate a primary carer to receive information (see section 72);
- Allow a person to identify persons who they do *not* wish to have identified as the primary carer (see section 72);

- Provide for a primary carer where there has been no nomination. Where there is no nomination, the Bill establishes a process for identifying an appropriate carer, starting with the person's guardian and moving down a list of person's who may provide care or support to a patient. This list has been drawn from the concept of "person responsible" used under the Guardianship Act (see section 71);
- identify what sort of information should be provided to the identified primary carer (see section 75 and 78);
- provide for health service providers to take reasonable steps to involve the primary carer in discharge planning discussions (see section 79).

#### *Additional Recognition of Patient Rights*

The Review identified that, as the role of carers needs to be recognised, so too the provisions which provide for patients to be kept informed and involved in care and treatment decisions, needed further consideration. To this end, Chapter 4 also includes provisions which:

- provide for information to be given to a person who is detained under the Act (see section 74) and incorporates the "Statement of Rights" into the Act (see Schedule 2);
- identify what sort of information should be provided to a patient (see sections 74, 76 and 77);
- provide for health service providers to take reasonable steps to involve the patient in discharge planning (see section 79);
- through the Principles for Care and Treatment, establish people with a mental illness should, as far as is reasonably practicable, be involved in decisions about their care (see section 68);

#### *Enhancement of protective provisions*

The submissions to the Review were also very strongly supportive of section 11 of the current Act, which prevents certain conduct or behaviour being deemed as "mental illness". Section 11 has therefore been retained and expanded to make it clear that the fact a person has a particular economic or social status or is a member of a particular cultural or racial group cannot of itself be used to deem them mentally ill (see section 16).

## **2.4 Co-operation and Co-ordination**

People who have a mental illness or disorder do not obtain services exclusively from the health system, and will often have service needs involving other government agencies. The quality and relevance of these services can be improved if agencies work co-operatively, not only with the patient and any community carer they identify, but also with each other. While this sort of co-operation must be developed by interagency liaison and cannot be legislated for, the Exposure Draft Bill contains some provisions to designed to support and enhance co-operation between agencies, including:

- providing for health service providers to take reasonable steps to involve agencies who may provide ongoing care or other services to a patient, or their carer, child or other dependent in discharge planning (see section 79)
- expanding the administrative functions of the Director General of the Department of Health to include assisting and promoting co-operation between different agencies involved in the provision of ongoing care or other services (see section 106).

## **2.5 Review of involuntary care**

The main mechanisms for review available under the 1990 Act involve Magistrates (review of initial detention, community treatment orders), the Mental Health Review Tribunal (ongoing detention and community treatment orders) and the Supreme Court (special appeal rights in relation to decisions under the Act). Discussion Paper 2 asked for comment on these processes.

Submissions received strongly supported the high levels of judicial oversight provided by the 1990 Act, and as a result, each of the three levels of review will be retained, as follows:

- role of the Magistrates retained (see sections 34 to 38 and Schedule 2);
- role of the Tribunal in both review of detention, community treatment orders and ECT to be retained (see sections 37 to 45, 50 to 56, 87 to 97); and
- special right to appeal to the Supreme Court to be retained (see Chapter 7).

The main changes adopted in the exposure draft are simply structural, with the Act to be simplified by placing the procedural provisions for Magistrates and Tribunal hearings and meetings in schedules and regulations under the Act, and provision to streamline the initial review of detention by the Tribunal. Placing procedural matters in the regulations is in line with courts and other similar bodies, whose procedural provisions are generally dealt with via delegated legislation.

As noted in paragraph 1.3, the Mental Health Review Tribunal is also presently conducting an administrative review of tribunal processes, the results of which will also feed into the final draft of the Bill.

## **2.6 Restrictions on treatments for mental illness**

Discussion Paper 2 also looked at the provisions in the 1990 Act dealing with mental health treatments, including prohibited treatments and those such as psychosurgery and ECT, which are subject to additional review and restriction. The submissions strongly supported additional limitations on these types of treatment, and were almost unanimous in calling for a formalisation of the current embargo on psychosurgery. In response to these submissions, the Bill:

- includes psychosurgery in the list of treatments that are prohibited under the Act (see section 83);

- imposes limits on the number of ECT treatments which can be approved for involuntary patients by the Mental Health Review Tribunal at any one time, without provision of additional evidence of effectiveness. The Tribunal will be entitled to approve up to 8 treatments in the same manner as under the current Act. Additional treatments will only be approved where there is additional cogent evidence presented (relating for example, to past history and use or clinical need) to justify further procedures (see section 96).

## 2.7 Official Visitors

The changes being made to the Official Visitors (OV) program are designed to improve and enhance the operation of the program, and also reflect the views of the majority of submissions. They involve:

- Revision of the functions of the Official Visitors and the Principal Official Visitor to cover matters such as provision of advocacy on behalf of consumers of mental health care, ensuring that issues of importance to their welfare are addressed properly in the hospital and health systems, and to referring of matters raising significant issues of public health or safety, or raising a significant question as to the appropriate care or treatment of a client to appropriate authorities (such as for example, the Health Care Complaints Commission) (see section 129);
- The Principal Official Visitor will advise and assist Official Visitors in the exercise of their functions, oversee the operation of the Official Visitors' Program as well as report to the Minister (see section 128);
- A new provision also explicitly recognises the right of carers to contact an OV to raise issues of concern for their family member or friend (see section 134);
- The requirement that at least one OV conducting each visit be a medical practitioner OV has been varied to provide for a clinical OV, who can have qualifications in nursing, psychology or other relevant areas as determined by the regulations (see section 129). This reflects the fact that a range of other professional groups will be equally capable of identifying health issues which may arise in a visit, and also reflects the difficulty the program has faced for some time in attracting medical practitioners.

## 2.8 Admission and Transportation

Discussion Paper 2 raised a number of issues involving the initial admission of patients to involuntary care and how there are transported. The changes proposed generally involved clarifying and identifying who can admit, transport and restrain a person being transported. The key proposals to be adopted in the Bill include:

### *A Role for NSW Ambulance Service Officers*

The Bill adds ambulance officers to the categories of persons who are entitled to take a person to hospital for involuntary care and treatment. There was very strong support from submissions to this proposal, which recognises that Ambulance Officers are likely to encounter persons who may need treatment for a mental illness. Adding them to the categories of people who can authorise involuntary admission also brings NSW into line with other states.

The power will not be open ended, but will be limited to where the Ambulance Officer

- is treating a person and providing ambulance services;
- has reasonable grounds to suspect the person is mentally ill or mentally disturbed and in need of involuntary care;
- has been authorised to make detention decisions

This last point reflects the fact that training and support for Ambulance Officers will be critical to ensure they can safely and effectively perform this role. As such, the necessary training required prior to authorisation will be considered further as implementation of the legislation progresses.

Ambulance Officers will also be able to request Police assistance, if they have serious concerns about the safety of transporting violent or distressed individuals.

### *Enhanced Transportation Provisions*

In line with proposals in Discussion Paper 2 new, express transportation provisions have been developed for the new Bill. The new provisions aim to emphasise that NSW Health will take primary responsibility for patient transports, with requests for Police involvement to be limited to where there are serious concerns about patient and/or staff safety.

The transport provisions also ensure there is clear guidance to allow people to be transported safely, by allowing for restraint and for them to have articles with which they may harm themselves or others removed prior to transportation occurring. The revised provisions in the Bill therefore provide for:

- Revised “police assistance” provisions to balance law enforcement and mental health priorities and to allow health professionals to identify any safety risks (see section 21 and Schedule 1);
- Inclusion of provisions that expressly provide for the use of restraint for involuntary patients and detainees (see section 81);
- Identification of who is authorised to transport a detainee to hospital or transport involuntary patients between hospitals (see section 81).

## **2.9 Authorisation of mental health facilities**

As noted in Discussion Paper 2, over the last 15 years, the way mental health services are provided has increasingly moved away from the system of care reflected in the 1990 legislative structure. The 1990 Act envisages a system where persons will only be provided involuntary care and treatment (both for their psychiatric illness and any medical condition) in large stand alone “gazetted units”, or through separately authorised health care agencies, which administer Community Treatment Orders.

At an operational level however, mental health services are increasingly being mainstreamed into the general health system, with services provided through a range of differing institutional and community settings. In addition, given the specialist mental health treatment units do not have general medical facilities, many patients now arrive via general hospital emergency departments, due to presentations involving a range of medical and psychiatric issues.

The process under the 1990 Act for “gazetting” mental health facilities is however limited both in the recognition it can give to differing care models, and in supporting the development of new models in the future. The Exposure Draft Bill therefore proposes overhaul of this process, making it flexible enough to recognise and support these developments in service provision, while retaining a mechanism for accountability and oversight of involuntary care and detention. The revised provisions in section 109 involve:

- Retention of the process for the Director General of Health to approve facilities at which or through which care or treatment can be provided on an involuntary basis, and for publication of this approval in the Government Gazette;
- Recognition of all such facilities as “declared mental health facilities”, with provision for the Director General to establish classes of facilities, which may include classes designed to provide ongoing in-patient care and treatment (as per current inpatient units) classes providing community treatment (as per current health care agencies) or new classes (which may, for example, include Psychiatric Emergency Centres, or short term assessment centres);
- The authorisation of classes of facilities will also allow for provision of other matters, such as for example, whether it is community care or admission, the length of time a person may be held and the regularity of visits by official visitors to be designed and determined in a way that best reflects the purpose of that particular class of facilities.

## 2.10 Community Treatment Orders

### *A single type of order*

The main reform in this area involves the consolidation of the current Community Counselling Orders and Community Treatment Orders into a single order which can be issued while a person is in a mental health facility or while living in the community.

As outlined in Discussion Paper 2 while the counselling order was originally intended to be the main form of community treatment, over the years they have rarely been used, due to the fact they are difficult to obtain, easily avoided and have insufficient enforcement powers to be effective. The limited use of counselling orders was further confirmed in the submissions. While some of these argued the counselling order should be retained as a “least restrictive alternative” for community treatment, the practical experience over 15 years is that they are simply not being used and there appears little basis to suggest this will change if the orders are retained.

The main concern expressed by submissions on the idea of a single order was assurance that appropriate criteria were used and to ensure the person subject to the order would have a reasonable and proper opportunity to challenge it. To this end, the Bill provides for people in the community to be given 14 days notice of an application for an order (see section 52).

The test for issuing an order will be the same, whether a person is in the community or detained in a facility, although their personal circumstances will of course be relevant to the order. Legal representation will be available (as with a current processes) but a

failure to attend on the notified date will allow an order to be issued in the persons absence. Orders will be able to be made by the Tribunal or by a Magistrate.

*Length of the order*

It is also proposed to extend the maximum length of time an order can run for from 6 to 12 months. When the Act was first introduced in 1990, community treatment orders were only allowed for a period of up to 3 months. Clinical advice during the implementation review suggested that a maximum of 12 months was a more reasonable figure. Changes made in 1997 ultimately extended the orders to 6 months. While the submissions to the current Review were mixed on this point, clinical advice and experience after more than 15 years remains that orders of 12 months are more appropriate. This is also the maximum period adopted in Victoria. As such, the Exposure Draft Bill extends the maximum possible length of a CTO from 6 to 12 months (see section 53 and 56) and makes consequential provision for an appeal where an order is made for more than 6 months (see section 67).

*Review after detention on breach*

Currently if a person is involuntarily admitted to a hospital via the “scheduling” process, their community treatment order automatically ends. As a result, the person may then remain detained until arrangements are made for another order, often in the exact terms of the old order. This means the person may spend extended periods of time in hospital while this process occurs, when they could otherwise have simply been released on their existing order. The change proposed therefore allows the authorised medical officer to overturn the presumption that detention ends the CTO. The change was generally supported by the submissions received by the Review

The submissions also identified that while a person who is scheduled is required to be reviewed within 12 hours of arrival at a mental health facility, there is no similar time requirement for a person who has been detained due to a breached of a CTO. The Exposure Draft Bill addresses this, imposing an equivalent 12 hour timeframe for review (see section 61).

## ANNEXURE 1

### ADMINISTRATIVE REVIEW

- (1) Review and make recommendations in relation to the administrative practices and procedures of the Mental Health Review Tribunal with a view to enhancing the quality of decision making and the efficient and economic operation of the Tribunal, and in particular to consider:
  - (a) the administration of the Mental Health Tribunal Registry;
  - (b) the procedures and procedural guidelines relied on in Tribunal hearings;
  - (c) the adequacy of current staffing levels and gradings of staff of the Tribunal;
  - (d) the processes for appointment of and qualifications of Tribunal members;
- (2) Develop and provide to the Minister an implementation plan to put into operation the administrative recommendations of the Review
- (3) Make such recommendations for amendment to NSW mental health legislation as may be necessary to support implementation of the administrative recommendations of the Review
- (4) Review and make recommendations in relation to the role of the Mental Health Review Tribunal within the broader forensic system in co-ordination with the recommendations identified by the taskforce on the forensic system as set by this Cabinet.
- (5) Report to the Minister within twelve months of the Cabinet decision.

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### REVIEW OF FORENSIC PROVISIONS

- (1) Review and make recommendations in relation to the legislative provisions of Chapter 5 of the Mental Health Act 1990 relating to forensic patients, and in particular to consider:
  - (a) the appropriate authority or person to make decisions in relation to the terms and conditions of detention, release and conditional release of forensic patients;
  - (b) mechanisms for ensuring issues of public safety are properly considered and addressed in reviews of forensic patients;
  - (c) the role of victims of crime, and in particular means by which their views and concerns can be addressed in the forensic review process;
  - (d) the appropriate structure for review and decision making process;
  - (e) the current definition of forensic patient, and in particular whether there should be two categories of patients, namely “forensic patients” and “security patients”, the latter to cover persons who are transferees from a Correctional Centre;

- (f) the ability of the Mental Health Review Tribunal to make Community Treatment Orders for people who are in prison and who are mentally ill; and
  - (g) how those recommendations relate to the work of the review of the administrative practices and procedures and its role within the forensic system.
- (2) Review and make recommendations on the provisions of the Mental Health (Criminal Procedure) Act 1990 as may arise out of clause (1);
- (3) Report to the Minister within twelve months of the Cabinet decision.