



# Discussion Paper : September 2012

*Issues arising under the Mental Health Act 2007*



Health

Mental Health & Drug and Alcohol Office

## *Acknowledgement*

Image: Sandra, *Mood*, 2011

This image was part of the *See Me Hear Me* exhibition held in the Fairfield City Museum and Gallery in 2011. The exhibition consisted of works of art created by people who experience mental illness. The art works provide the viewer with a small window into the lives of the artists and their individual stories. It also aims to encourage reflection and challenge stereotypes to break down the stigma surrounding mental illness.



# MINISTERIAL FOREWORD

The NSW Government came into office with a powerful mandate from the community to address the health needs of the people of NSW. The Government's reform agenda is about getting the right structures to deliver better health and mental health care and we are committed to the development of a world-class health service that meets the needs of the community. The newly established NSW Mental Health Commission will drive a more accountable, effective, and efficient mental health system and, most importantly, enhance the mental health and well-being of the people of NSW.

The review of the New South Wales *Mental Health Act 2007* (the **Act**) is another vital step forward in the NSW Government's plan to improve mental health services and delivery for every person in the state. This review will examine whether the current Act provides a contemporary, evidence-based, legislative framework for the treatment and care of New South Wales consumers with a mental illness.

Since the current legislation was enacted in 2007, there have been a number of reviews to Mental Health Acts in other jurisdictions, including the review of the UK legislation and the recent and extensive reviews of the Mental Health Acts in Victoria and Western Australia.

The review provides an opportunity for widespread comment, debate and input from mental health consumers, carers, practitioners, other stakeholder groups and the broader community about how the Act might be improved.

Mr Sebastian Rosenberg, the Hon Rob Knowles and the NSW Mental Health Commissioner Mr John Feneley have been appointed to an independent Community Consultation Panel to lead public consultation on this review. An Expert Reference Group has also been established to provide legal and mental health expertise on matters that arise from the community consultation forums and submissions to the review. I am pleased to release this paper for public consultation.

This paper explores some of the legislative issues raised by stakeholders, including (where relevant) discussion of possible advantages and disadvantages of any amendments that have been suggested. The discussion paper does not put forward a proposed position but instead asks a number of questions, and interested parties are encouraged to provide feedback about the extent of each issue and the likely consequences of suggested changes. It is designed to stimulate discussion and I encourage all interested members of the NSW Community to provide their views on the future shape of the Act.

We will also be holding eight Community Consultation Forums around NSW during October and I encourage you to participate.

## **HON. KEVIN HUMPHRIES MP**

Minister for Mental Health

Minister for Healthy Lifestyles

Minister for Western New South Wales

# GLOSSARY OF TERMS

## Accredited person (AP)

An accredited person is a suitably qualified and experienced mental health practitioner, such as a nurse, psychologist or social worker, who is appointed by the Director-General of the Ministry of Health to write Schedule 1 certificates (s136).

## The Act

The current NSW Mental Health Act 2007.

## Assessable person

An assessable person is someone who has been detained in a declared mental health facility and who is awaiting a mental health inquiry by the Mental Health Review Tribunal (s17).

## Authorised medical officer (AMO)

An authorised medical officer is either the medical superintendent of a declared mental health facility, or a medical practitioner attached to the facility who has been nominated by the medical superintendent to fulfil certain responsibilities and make various decisions under the Act (s4).

## Community treatment order (CTO)

A Community Treatment Order is a legal order made by the Mental Health Review Tribunal or by a Magistrate (s50-67). It sets out the terms under which a person must accept such things as medication and therapy, counselling, management, rehabilitation and other services while living in the community. It is implemented by a community declared mental health facility that has developed an appropriate treatment plan for the individual person. A Community Treatment Order authorises compulsory care for a person living in the community. Community Treatment Orders can be made for any period of time up to twelve months. It is possible for a person to have more than one consecutive Community Treatment Order.

## Consumer

A person who has the experience of using mental health services or the experience of mental illness.

## Declared mental health facilities (DMHF)

Declared mental health facilities are premises subject to an order in force under s109. These premises are declared by the Director-General to fulfil certain functions under the Act.

The three current classes of declared mental health facilities are:

- a mental health emergency assessment class that deals with short term detention for initial assessment and treatment
- a mental health assessment and inpatient treatment class that deals with the full range of inpatient functions under the Act
- a community or health care agency class to administer community treatment orders.

## Form 1

A certificate completed by an authorised medical officer, psychiatrist, or other medical practitioner that allows for a person's continued detention and examination at a declared mental health facility (s27).

### Involuntary patient

An involuntary patient is someone who is ordered to be detained following a mental health inquiry or following a review by the Mental Health Review Tribunal (s35 & 38).

### Medical superintendent

The medical superintendent of a declared mental health facility is the senior medical practitioner, appointed in writing by the Director-General (or delegate), who holds a range of administrative responsibilities under of the Act. The medical superintendent is also an "authorised medical officer", and may be appointed as the medical superintendent of more than one declared mental health facility (s111).

### Mental health inquiry

A mental health inquiry must be held to decide whether a person, who has been detained in hospital following Form 1 assessments, should continue to be detained for treatment, be treated within the community or be discharged. If the inquiry determines that the person should continue to be detained for treatment, they become an *involuntary patient* (s34 & 35).

### Mental Health Review Tribunal (MHRT)

The Mental Health Review Tribunal is a specialist quasi-judicial body constituted under the Mental Health Act 2007 (s140). It has a wide range of powers that enable it to conduct mental health inquiries, make and review orders, and to hear some appeals, about the detention, treatment and care of people with a mental illness.

### Mental illness

Mental illness for the purposes of the Act (s4) 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 presence of any one or more of the symptoms mentioned above.



## Mentally disordered person

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 (s15).

## Mentally ill person

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 and the likely effects of any such deterioration, are to be taken into account.

## Official Visitor (OV)

Official Visitors are appointed by the Minister to inspect mental health facilities in NSW and are available to assist consumers who are detained or on community treatment orders (s128-135). Official Visitors come from the community from a range of cultural, professional and personal backgrounds. They aim to safeguard standards of treatment and care, and advocate for the rights and dignity of people being treated under the Act.

## Primary carer

A primary carer is someone who is either appointed by an authorised medical officer or is nominated by a consumer who is receiving involuntary or voluntary treatment under the Mental Health Act (s71 & 72). Generally, a primary carer is someone who has a close personal relationship with the consumer and has an interest in their welfare. Primary carers are entitled to receive certain information about a consumer's care and treatment, and to be notified of certain events. A consumer may nominate persons (including the primary carer) who are excluded from being given notice or information about the person.

## Schedule 1 certificate

A Schedule 1 certificate (or mental health certificate) provides one of the legal foundations for involuntary admission to declared mental health facilities in NSW. The Schedule 1 certificate allows for the person to be taken to and initially detained in a declared mental health facility for care and treatment if the practitioner/accredited person is of the view that (s19):

- the person is a mentally ill or mentally disordered person;
- the person is at serious risk of harm to themselves or others;
- there are no other appropriate means available for dealing with the person; and
- it is the least restrictive environment in which the person can receive care and treatment.



## Scheduling

The process of involuntary admission to a mental health facility (see 'Schedule 1 certificate').

## Serious harm

This is not defined in the Act but could potentially include such things as:

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

## Voluntary patient

A voluntary patient is a person who has been admitted voluntarily to a mental health facility under the Act (s4).



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# 1. Review of the Mental Health Act 2007

New South Wales (NSW) has had a long history of reform and review of mental health laws. From the first reforms in 1983, to the major changes with the introduction of the 1990 *Mental Health Act* and more recent revisions in 2007, the aim has been to examine the laws in conjunction with those they primarily impact on: consumers, their carers and the health professionals who provide treatment.

Much of the focus of the reviews has been on the terms and conditions of involuntary care, compulsory treatment and the oversight and accountability imposed on the use of such coercive measures. More recently, there has been renewed focus on empowering consumers and ensuring appropriate information sharing with carers. This has been in the context of the law ensuring that a person receives care for their mental illness in an environment that respects their rights and wishes as far as possible.

The *NSW Mental Health Act 2007* requires the Minister to review the Act five years after it has been assented to (s 201). A report on the outcome of the review must then be tabled in each House of Parliament within 12 months of the review commencing.

## 1.1. Terms of Reference

This review will consider whether the policy objectives of the Mental Health Act remain valid and whether the terms of the Act remain appropriate for securing those objectives.

It is important that the Act supports contemporary, evidence based best practice and provides confidence to mental health consumers, carers, the workforce and the broader community. This review will highlight the changes that may be required to the Act to secure these and other policy objectives, while taking account of:

- NSW Government priorities
- The evidentiary basis for reform
- The NSW legal framework
- Australian and international models for mental health legislation
- Regulatory principles
- The impacts of proposed reforms and associated implementation issues.

It is also expected that the review may highlight some inadequacies in the Act in need of legislative amendment and establish broad principles agreed by stakeholders, the Government and the community on broader reform in mental health. Due to time constraints, these may need to be pursued after the statutory review period ends.



## 1.2. Discussion Paper

This discussion paper has been prepared to introduce some of the issues that have been raised by stakeholders, and to stimulate discussion and comment about areas of the legislation which might require review or amendment.

The discussion paper is not intended to capture all areas of the legislation which might require review or amendment. Comments and feedback are however being sought on any issues related to the legislation, and this consultation process is not restricted by the content in the discussion paper.

In March 2012, key stakeholders were invited to provide their views about some of the issues that should be covered in the discussion paper for the review of the Act. Some of the issues raised by stakeholders related to policy or process rather than the legislation itself, and will therefore be considered and addressed outside this review of the Act. The legislative issues raised were considered, and those issues where further discussion is required to clarify the extent of the issue, the breadth of perspectives on the issue, or the possible consequences of any proposed amendments have been included in this discussion paper.

A number of the issues raised in the discussion paper are complex and not easily resolved. Nonetheless, the paper has been prepared and released for public consultation in order to obtain the community's views and to encourage debate and discussions on these important issues.

## 1.3. Consultation Process

The discussion paper will be released for public consultation for a period of **12** weeks and submissions can be made in writing, as detailed in *section 1.5* below.

### *Community Consultation Forums*

In addition to releasing the discussion paper, the Ministry of Health will be hosting eight Community Consultation Forums across New South Wales.

Further details about the Forums, including how to register to attend a Forum, are available at: [http://www.health.nsw.gov.au/mhdao/review\\_nsw\\_mh\\_act\\_2007.asp](http://www.health.nsw.gov.au/mhdao/review_nsw_mh_act_2007.asp).

### *Community Consultation Panel and Expert Reference Group*

The Community Consultation Panel will lead the public consultation process on behalf of the NSW Ministry of Health.

The individuals listed below have been invited to sit on this panel. These highly skilled individuals have a wealth of knowledge and expertise in mental health care and treatment and policy formulation and are well respected in their fields.

- Mr Sebastian Rosenberg (Facilitator, Academic in Mental Health Policy)
- Mr John Feneley (NSW Mental Health Commissioner)
- Hon Rob Knowles (National Mental Health Commissioner)

The Expert Reference Group, comprised of key mental health stakeholder groups and individuals with legal expertise, will support the Independent Community Consultation Panel as well as the Ministry of Health by providing advice and feedback.

## *Process and Timeline*

A report which summarises the issues raised, discussion and feedback provided, and options/recommendations for any further work on reviewing and/or amending the Act will be provided to Parliament in June 2013.

Following the report to Parliament, further discussion and consultation may be required with specific stakeholders and/or the broader community before any amendments are made to the legislation.

Updates on the consultation process will be provided on the Ministry of Health's dedicated webpage as required ([http://www.health.nsw.gov.au/mhdao/review\\_nsw\\_mh\\_act\\_2007.asp](http://www.health.nsw.gov.au/mhdao/review_nsw_mh_act_2007.asp)).

## *Submissions*

Submissions on the issues raised in this paper, or any other matter relating to the Act can be made by completing the submission template in Appendix One or by writing a letter detailing any issues, with rationales and examples, and comments on how to address the issues.

Please send consultation responses to:

Email address: mhactreview@doh.health.nsw.gov.au

Postal Address: Mental Health Act Review  
Mental Health and Drug & Alcohol Office  
Ministry of Health  
Locked Bag 961  
North Sydney NSW 2059

### **Submissions must be received by 5pm on Monday 10<sup>th</sup> December**

Individuals and organisations should be aware that submissions might be made available under the *Government Information (Public Access) Act 2009*. The Ministry may also decide to circulate some or all submissions for further comment to other interested parties.



# INTRODUCTION

## 2. Purpose of the Act

The aims and objectives of the *NSW Mental Health Act 2007* (the **Act**) focus on ensuring that provision is made for the care, treatment, control and rehabilitation of consumers who are mentally ill or mentally disordered, in the least restrictive way possible.

The objects of the NSW Mental Health Act 2007 are:

- (a) to provide for the care, treatment and control of persons who are mentally ill or mentally disordered, and*
- (b) to facilitate the care, treatment and control of those persons through community care facilities, and*
- (c) to facilitate the provision of hospital care for those persons on a voluntary basis where appropriate and, in a limited number of situations, on an involuntary basis, and*
- (d) while protecting the civil rights of those persons, to give an opportunity for those persons to have access to appropriate care, and*
- (e) to facilitate the involvement of those persons, and persons caring for them, in decisions involving appropriate care, treatment and control.*

The aim of this review is to consider whether the above objects continue to be valid. This must be kept in mind throughout the review process.

## 3. Principles for care and treatment

Under the Act, the following principles are, as far as practicable, to be given effect to with respect to the care and treatment of people with a mental illness or mental disorder:

- (f) people with a mental illness or mental disorder should receive the best possible care and treatment in the least restrictive environment enabling the care and treatment to be effectively given,*
- (g) people with a mental illness or mental disorder should be provided with timely and high quality treatment and care in accordance with professionally accepted standards,*
- (h) the provision of care and treatment should be designed to assist people with a mental illness or mental disorder, wherever possible, to live, work and participate in the community,*
- (i) the prescription of medicine to a person with a mental illness or mental disorder should meet the health needs of the person and should be given only for therapeutic or diagnostic needs and not as a punishment or for the convenience of others,*

- (j) people with a mental illness or mental disorder should be provided with appropriate information about treatment, treatment alternatives and the effects of treatment,*
- (k) any restriction on the liberty of patients and other people with a mental illness or mental disorder and any interference with their rights, dignity and self-respect is to be kept to the minimum necessary in the circumstances,*
- (l) the age-related, gender-related, religious, cultural, language and other special needs of people with a mental illness or mental disorder should be recognised,*
- (m) every effort that is reasonably practicable should be made to involve persons with a mental illness or mental disorder in the development of treatment plans and plans for ongoing care,*
- (n) people with a mental illness or mental disorder should be informed of their legal rights and other entitlements under this Act and all reasonable efforts should be made to ensure the information is given in the language, mode of communication or terms that they are most likely to understand,*
- (o) the role of carers for people with a mental illness or mental disorder and their rights to be kept informed should be given effect.*



# CRITERIA FOR DETENTION AND TREATMENT

## 4. Principles that Underpin Intervention

A fundamental principle of the healthcare system is that persons have the right to choose if, when and how they wish to receive treatment for any medical condition they may have. This is also a right at law – treatment without consent is assault, unless legislation provides differently. This principle applies equally to persons with a mental illness.

Coercive or involuntary treatment should only be used as a last resort, and wherever possible, a person should retain the right to make informed decisions about their own lives, including their healthcare.

It is recognised that there are times when a mental health consumer poses risk of serious harm to themselves or another person and at this point, an intervention by the state may be justified.

The Act aims to clearly articulate the point at which the benefit for the mental health consumer and the community outweighs the restriction placed on the consumer's rights by the use of involuntary treatment.

As part of this review of the Act, it is necessary to consider where the balance between a consumer's rights and the responsibilities of the state to intervene should lie.

### 4.1. Current criteria for involuntary admission to and discharge from Declared Mental Health Facilities

Information is provided below about the processes in the Act that allow for a person to be taken to and involuntarily admitted to a declared mental health facility (**DMHF**) and that require an involuntary patient to be discharged from a DMHF. In addition, an outline is provided of the provisions in the Act that identify the types of information medical officers may consider when determining whether to continue detaining a person, and that direct the involvement of primary carers in the discharge process.

A person can be initially detained in a DMHF (s18):

- on the basis of a Schedule 1 mental health certificate stating that the person is mentally ill or mentally disordered (further information is provided below about 'Scheduling');
- after being brought to the facility by an ambulance officer;
- after being apprehended by a police officer;
- after an order for examination (and after that examination or observation takes place) by a medical practitioner or accredited person;
- on the order of a Magistrate or bail officer;

- after a transfer from another health facility;
- on a written request made to the Authorised Medical Officer (**AMO**) of the facility by a primary carer, relative or friend of the person.

‘Scheduling’ is a process whereby a medical practitioner or accredited person completes a Schedule 1 certificate, which allows the person to be taken to and initially detained in a DMHF for care and treatment if the practitioner/accredited person is of the view that (s19):

- the person is a mentally ill or mentally disordered person; and
- the person is at serious risk of harm to themselves or others; and
- there are no other appropriate means available for dealing with the person; and
- it is the least restrictive environment in which the person can receive care and treatment.

Once a person has been brought to a DMHF through one of the mechanisms set out above, and depending on circumstances outlined in s27 of the Act, between 1-3 medical practitioners are involved in decision making about whether a person needs to continue to be involuntarily detained or can be discharged to the community. Section 27 provides that some of the assessing medical practitioners must be psychiatrists.

These medical practitioners complete forms (known as ‘Form 1’s) which indicate whether they are of the view that the person requires ongoing detention and involuntary treatment. This is based on the same criteria used in completing a Schedule 1 certificate.

The first Form 1 needs to be completed within 12 hours of the person being brought involuntarily to the DMHF, and subsequent Form 1’s must be completed as soon as possible after the first Form 1.

Depending on the view of the assessing medical practitioner(s), the person:

- must either be discharged (although the person can be immediately re-admitted as a voluntary patient if they agree); or
- can be detained for up to three working days, if they were found to be a mentally disordered person; or
- can be detained pending a mental health inquiry hearing by the Mental Health Review Tribunal ( the **MHRT**) to determine if the person should continue to be detained (these hearings usually occur 2-3 weeks after the person’s initial detention in the DMHF).

In relation to the latter two dot points, the AMO must discharge the person at any time if the AMO is of the view that the person no longer meets the Act’s requirements for detention (s12).

In making their determination about whether a person needs to be detained, the assessing medical officers *“may take into account his or her observations and any other available evidence that he or she considers reliable and relevant in forming an opinion as to whether the person is a mentally ill person or a mentally disordered person”* (s28(1)). This may include information provided by carers, family members, and ambulance and police officers.

As outlined above, the Act currently relies on medical practitioners to make decisions about the need for a mentally ill or disordered person to be detained and involuntarily treated in a DMHF, based on the person’s risk of harm to themselves or others.



## 4.2. Managing Risk

The majority of mental health consumers are not violent or aggressive, and do not cause serious harm to themselves or others; however, when they do, it can cause significant distress and may affect many people. Historically, the way that mental health systems have tried to reduce and avoid the risk of serious harm can lead to considerable restrictions on people's lives and opportunities.

As a consequence, there *“is a growing move in England and elsewhere to reframe risk through the lens of safety. At a time of increasing choice and control for those receiving services, clinicians, the public and politicians have to feel confident that the risks are mitigated. Through a new, more inclusive and more holistic approach, the responsibility for achieving safe outcomes is beginning to be shared by the person who is ill, their family/close friends, and the psychiatrist and other professionals involved. These more inclusive processes move away from the fantasy that all risks can be prevented and seek to develop a more mature approach to managing it.”*<sup>1</sup>

## 4.3. Convention on the Rights of Persons with Disabilities

The United Nations *Convention on the Rights of Persons with Disabilities* (the **Convention**) was ratified by the Australian Government on 17 July 2008. Countries that have ratified the Convention are required to adopt strategies to pursue these general obligations, and ensure the full realisation of all human rights for all people with disabilities.

Article 1 of the Convention states:

*“The purpose of the present Convention is to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity.*

*Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.”*

Article 12 of the Convention recognises the legal capacity of persons with disabilities, and has been interpreted by some legal academics as saying that people with disabilities, including mental illness, are capable of making their own decisions and that any other form of decision-making must be seen as a measure of last resort, and shifts the focus from substituted decision-making to supported decision-making<sup>2</sup>.

The proposed changes to the Victorian and Western Australian Mental Health Acts reflect this move from the substituted decision making model, where psychiatrists provide substituted consent to treatment for a person who is unable or refusing to consent, towards a supported decision making model.

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<sup>1</sup> Gregor Henderson Limited, *Informing the Development of a Quality Assurance Framework for Mental Health in Western Australia, Interim Report May/June 2011*. Gregor Henderson Limited, 2011, p. 11, viewed on 18 August 2012 <[http://www.mentalhealth.wa.gov.au/Libraries/pdf\\_docs/WA\\_QA\\_Interim\\_Report\\_FINAL\\_DRAFT\\_12\\_June\\_2011\\_2.sflb.a.shx](http://www.mentalhealth.wa.gov.au/Libraries/pdf_docs/WA_QA_Interim_Report_FINAL_DRAFT_12_June_2011_2.sflb.a.shx)>

<sup>2</sup> Wolstenholme M, *Current Trends in Mental Health Legislation, Government of Western Australia, Mental Health Commission*, (undated), viewed on 18 August 2012 <[http://www.mentalhealth.wa.gov.au/Libraries/pdf\\_docs/Current\\_Trends\\_in\\_Mental\\_Health\\_Legislation.sflb.ashx](http://www.mentalhealth.wa.gov.au/Libraries/pdf_docs/Current_Trends_in_Mental_Health_Legislation.sflb.ashx)>

The principles of a supported decision making model described in the Victorian Draft Bill state that a person with a mental illness must, as far as is reasonably possible in the circumstances, be:

- consulted about decisions relating to their mental illness
- supported to make decisions, including in developing a treatment plan
- provided with information and support to exercise their rights.

Comment is sought from interested parties on this issue, along with submissions outlining whether the amendments to the Act should be made to focus more on supported decision making rather than substituted decision making.

### Questions:

1. **Is supported decision making a principle that should be further explored in NSW?**
2. **What are the key issues that need to be considered?**

## 5. Treatment for conditions other than a mental illness

As well as setting out the criteria for involuntary detention and allowing for involuntary mental health treatment to be provided to patients, the Mental Health Act also provides for general medical treatment to be given to patients who are subject to the Mental Health Act. However, the provisions in the Mental Health Act relating to the provision of non mental health treatment are complicated and establish different processes for authorising treatment than those applied under other laws. This review presents a timely opportunity to review these provisions and ask whether the provisions relating to non mental health treatment meet the objectives of the Act.

At common law, every competent adult has the right to self determination, including the right to control one's own body and make decisions as to what, if any, medical or dental treatment should be administered<sup>3</sup>. As has been made clear in recent cases, a competent adult can refuse medical or dental treatment even if a failure to treat the person will result in the person's death.<sup>4</sup>

The common law also presumes that every adult is competent but this presumption can be overturned. In terms of making a medical decision, a person will not have the capacity to consent, or refuse to consent, to a medical decision, if the person:

- (1) is unable to comprehend and retain the information which is material to the decision, in particular as to the consequences of the decision; or*

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<sup>3</sup> See for example: *Rogers v Whitaker* (1992) 175 CLR 479; *Department of Health & Community Services v JWB & SMB ("Marion's Case")* (1992) 175 CLR 218; *Hunter and New England Area Health Service v A* [2009] NSWSC 761; *Brightwater Care Group (INC) v Rossiter* [2009] WASC 229.

<sup>4</sup> *Hunter and New England Area Health Service v A* [2009] NSWSC 761.

(2) *is unable to use and weigh the information as part of the process of making the decision.*<sup>5</sup>

Determining capacity requires a scaled assessment, with higher threshold when the consequences of a decision are more serious and a lower threshold when the consequences are lower<sup>6</sup>. For example, a decision on medical treatment likely to have a serious and permanent impact on a person is likely to require greater certainty that the person can comprehend the consequences of the decision than a decision regarding a simple medical procedure.

In NSW, there are two main legal avenues for testing capacity and applying a substitute decision making framework, where these issues arise across the community.

At common law, if a person lacks capacity, the Supreme Court's inherent *parens patriae* jurisdiction<sup>7</sup> could be invoked if the person lacks capacity and the Court could consent on the person's behalf. The *NSW Guardianship Act 1987* (the **Guardianship Act**) also provides a more accessible framework for substituted decision that aims to ensure persons who lack capacity can be treated appropriately.

In providing a substituted decision making regime, the Guardianship Act comprehensively sets out the information that must be provided to the substituted decision maker and lists the factors that must be considered by the substituted decision maker before determining whether or not to give consent to a medical or dental procedure. The Guardianship Act also places limits on the circumstances in which a substituted decision maker can consent to treatment over the objection of the patient. This can only occur by order of the Guardianship Tribunal, or where a guardian has been given specific power to consent to treatment over the objection of the patient, and that person consents to the treatment<sup>8</sup>. However, a patient's objection can also be disregarded if the patient has minimal or no understanding of what the treatment entails and the treatment will cause the patient no distress or, if it will cause the patient some distress, the distress is likely to be reasonably tolerable and only transitory<sup>9</sup>.

As noted above however, the Mental Health Act also provides a further separate regime, with specific provisions that relate to providing substituted consent for surgical procedures which vary depending on the status of the patient. That is, whether the patient is a voluntary patient, an assessable person, an involuntary patient or a forensic or correctional patient.

Where an involuntary patient or a forensic or correctional patient with a mental illness requires surgery, the Mental Health Act allows the Director-General of the Ministry of Health or the MHRT to consent to surgery even over the objections of a competent patient. However, if the patient is a voluntary patient or an assessable person, or a forensic or correctional patient who does not suffer from a mental illness, the Mental Health Act does not allow the Director-General or the Tribunal to override a competent patient's objection and impose treatment on the patient. Unlike the Guardianship Act, the provisions in the Mental Health Act do not currently provide for relevant information, such information on the effects of the treatment or alternative course of treatment, to be provided to the Director General or the Tribunal. The Mental Health Act does not even require the Director General or the Tribunal to consider the views of the patient before

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<sup>5</sup> *Re MB* [1997] Fam Law 542, cited with approval in *Hunter and New England Area Health Service v A* [2009] NSWSC 761.

<sup>6</sup> *Hunter and New England Area Health Service v A* [2009] NSWSC 761.

<sup>7</sup> The *parens patriae* jurisdiction refers to the power of the Supreme Court to make orders with respect to the welfare of children and others incapable of making decisions on their behalf. Such a power must be exercised for the benefit of the person.

<sup>8</sup> Section 46A, *Guardianship Act 1987*.

<sup>9</sup> Section 46(4), *Guardianship Act 1987*

deciding whether or not to consent to surgery as would be the case if substituted consent was given in accordance with the Guardianship Act.

The differences between the substituted consent regimes, as they apply to the general community and those who are being treated under the Mental Health Act for general medical conditions, arguably represents, on a broader scale, an outdated understanding of mental illness. The Mental Health Act provisions focus on a person's status under the Act, rather than a direct assessment of their legal capacity to make decisions. This can be contrasted with the provisions of the Guardianship Act which focus on capacity and not status. On a wider scale, the Mental Health Act also arguably fails to properly recognise or provide guidance as to the rights of an individual to participate in making decisions on their general medical treatment when they have capacity to make such decisions and to apply their decision making into the future, including through advance care directives.

The Paper is calling for submissions on the question of whether or not the current provisions in the Mental Health Act relating to non mental health treatment are appropriate and whether this is an area in need of reform.

### Questions:

3. Are the provisions in the Mental Health Act relating to the provision of non mental health treatment appropriate?
4. Should the provisions relating to non mental health treatment be better aligned with the Guardianship Act?

## 6. Definition of Mental Illness

### 6.1. How is mental illness defined in the NSW Act?

Currently, mental illness is defined in the Act as a condition that 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).



A mentally disordered person (s15) is someone whose 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.

Persons detained as mentally disordered under the Act can be detained for up to three continuous days, not including weekends and public holidays (s31).

The Act also specifies exclusions for determining whether a person has a mental illness or disorder (s16). These exclusions are certain words or behaviours that on their own may not indicate mental illness or disorder. A person is not a [mentally ill person](#) or a [mentally disordered person](#) merely because of any one or more of the following:

- a) 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) 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) the person expresses or refuses or fails to express or has expressed or refused or failed to express a particular philosophy,
- d) 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) 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) 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) the person engages in or has engaged in a particular sexual activity or sexual promiscuity,
- h) the person engages in or has engaged in immoral conduct,
- i) the person engages in or has engaged in illegal conduct,
- j) the person has developmental disability of mind,
- k) the person takes or has taken alcohol or any other drug,
- l) the person engages in or has engaged in anti-social behaviour,
- m) the person has a particular economic or social status or is a member of a particular cultural or racial group.

Nothing in this part 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.

There is some debate about whether Personality disorders (PD) are, or should be, covered under the definition of mental illness. Personality disorders (PD) are complex conditions and people with a PD may present with a range of mental health, physical and social problems including drug and alcohol issues,



suicidality, self-harm, housing instability, and for a sub-group, potentially high levels of aggression and violence (UK Department of Health, 2009). People with PD are a client group for whom there can be diagnostic ambiguity and a lack of evidence-based clinical interventions, however recent evidence suggests that for some people, psychological interventions can lead to significant changes in mood states and functioning (Fonagy & Bateman, 2006).<sup>10</sup>

There is considerable debate as to whether PD is a treatable condition, particularly for Antisocial Personality Disorder which is most prevalent in the criminal justice system, and whether mental health services are equipped to provide adequate services to this client group.<sup>11</sup>

People with PD are often in a state of crisis and can be difficult to manage and engage in treatment or rehabilitation.<sup>12</sup> They can experience significant psychosocial impairment, and for patients with Borderline Personality Disorder, a high mortality rate due to suicide.<sup>13</sup> However, responding effectively to PD is a growing concern for public services including mental health, forensic and correctional services.

### *How is mental illness/disorder/ condition defined in other jurisdictions and countries?*

The *UK Mental Health Act 2007* (the **UK Act**) has a single definition of mental disorder: ‘mental disorder’ means any disorder or disability of the mind (s1).

The UK Act further provides that a person shall not be considered to be suffering from a mental disorder simply as a result of having a learning disability, unless that disability is associated with “abnormally aggressive or seriously irresponsible conduct” on the part of the person concerned (s2).

Section 328 of the *Mental Health (Care and Treatment) (Scotland) Act 2003* (the **Scottish Act**) provides that "mental disorder" means any mental illness; personality disorder; or learning disability, however caused or manifested.

In Australia, the *Victorian Mental Health Bill Exposure Draft 2010* (the **Victorian Draft Bill**) proposed to define mental illness as *a medical condition that is characterised by a significant disturbance of thought, mood, perception or memory*.

The *Western Australia Mental Health Bill 2011* (the **WA Bill**) proposed to define mental illness as *“a condition that is characterised by a disturbance of thought, mood, volition, perception, orientation or memory; and significantly impairs (temporarily or permanently) the person’s judgment or behaviour”*. The WA Bill also states that a person does not have a mental illness merely because a number of behaviours or beliefs apply, such as *the person engages in indecent, immoral or illegal conduct; the person has an intellectual disability; the person uses alcohol or other drugs; or the person engages in anti-social behaviour*.

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<sup>10</sup> Fonagy P, Bateman A, *Mechanism of change in mentalization based treatment of borderline personality disorder*, Journal of Clinical Psychology, Vol. 62, Issue:4, 2006, pp: 411-430.

<sup>11</sup> Gibbon S, Duggan C, Stoffers J, Huband N, Vollm BA, Ferriter M, Lieb K., *Psychological treatments for people with antisocial personality disorder (Review)*, JohnWiley & Sons, Ltd, The Cochrane Library, 2010, Issue: 6; UK Department of Health, *Recognising Complexity: Commissioning guidance for personality disorder services*, July 2009, viewed on 18 August 2012 <[http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/documents/digitalasset/dh\\_101789.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_101789.pdf) >

<sup>12</sup> Lieb K, Zanarini MC, Schmahl C, Linehan MM, Bohus, M, *Borderline personality disorder*, The Lancet, 2004, Vol:364, Number: 9432, pp.453-461

<sup>13</sup> *ibid*; UK Department of Health, op. cit, 2009

## 6.2. Should the definition of mental illness change?

Stakeholders have suggested that the review consider whether to include definitions of mental conditions that exhibit transient but chronic irrational behaviours, such as PD or Dementia, in the Act, so that treatment may be authorised in appropriate circumstances.

This is important as the definition of mental illness or disorder within the Act limits who can be detained and treated involuntarily and, to some extent, determines the service landscape.

In some jurisdictions, the definition of mental illness is cast wide enough to include the conditions listed above and allows for services provided under their Acts to be available to people who need them (see below). However, a person with a mental disorder will only be subject to involuntary measures under their Acts if they meet the specific criteria for those measures.

One must take into consideration the local environment and not just the definition in legislation when determining the appropriateness or otherwise of changing the definition of mental illness in the Act. For example, broadening the definition of mental illness may have significant operational and resource implications. Further, expanding the definition would impact on the liberty of persons for whom there can be diagnostic ambiguity and a consequent lack of clarity around evidence-based clinical interventions.

It should also be noted that the current symptomatic definition of mental illness came about due to the previous difficulties with relying on a specific clinical based diagnosis definition of mental illness as a basis for legal detention. To date, the symptomatic definition appears to have captured an appropriate range of medical conditions.

## 6.3. Dementia

Stakeholders have raised concern about a lack of clarity by some clinicians regarding the application of the Act to individuals with dementia, and how this interfaces with the *NSW Guardianship Act 1987* (the **Guardianship Act**) with advice suggesting:

- a) circumstances in which clinicians are unclear how to appropriately obtain consent for patients with dementia, and
- b) significant variation in practice.

These problems are particularly prominent for people with dementia because of the frequency with which they are managed both within, and outside of, mental health settings. Therefore, people with dementia and their carers are at risk of different approaches to consent being taken in relation to their care. It is claimed that this is both confusing for the patient and carer, and a source of potential confusions for NSW Health staff regarding consent-related issues, with potential legal implications.

Anecdotal evidence suggests that there is a significant minority of clinicians who believe that the term 'mentally ill' cannot, or should not be applied to a person with dementia, and that the 'mentally disordered' provision of the Act must be utilised. This variation in interpretation has the potential to significantly impact upon a person's access to, and experience of, mental health inpatient care.

Where an individual with dementia requires voluntary admission to a Mental Health Facility, the question of consent often arises. The issue of consent will be influenced by the stage of dementia a person is at, other factors influencing their mental state and cognitive capacity, and the degree of support they receive in making decisions.

Both the Guardianship Act and [NSW Capacity Toolkit](#) emphasise supporting the individual to be able to make a decision themselves wherever possible, and utilising informal decision support, through the 'Person Responsible'. This contrasts with the Act, which is silent on the role of such support and informal mechanisms.

This review seeks clarity on the definition of mental illness and, if and how conditions such as personality disorder and dementia should be covered in the Act.

## Questions

5. **How should mental illness be defined in the Act?**
6. **Are personality disorders currently adequately addressed in the Act?**
7. **Is dementia currently adequately addressed in the Act?**
8. **Should any conditions be explicitly excluded from the definition of mental illness?**
9. **Are there any other comments you wish to make concerning the definition of mental illness?**

## 7. Mental Health Review Tribunal Hearings

A number of issues have been identified in relation to MHRT hearings for consideration as to whether amendments to the *Mental Health Act 2007* (Act) are appropriate. These issues are:

- Whether the MHRT should be able to make a community treatment order (**CTO**) or an order delaying the discharge of a person for up to 14 days at hearings to consider appeals against a refusal by an AMO to discharge a person from involuntary inpatient treatment.
- Whether the MHRT should be able to make a CTO for an involuntary patient which would not require that the patient be discharged immediately.
- Whether patients whose involuntary/voluntary status has changed during their time in a DMHF should have to be reviewed by the MHRT at least once in a 12 month period.
- Whether mental health services should be able to commence involuntary treatment of a person in the community without a CTO approved by the MHRT.

### 7.1. Orders delaying discharge of persons

When a person or their primary carer makes a request for their discharge from a DMHF and the AMO does not approve this request, the matter can be appealed to the MHRT.

When considering an appeal, the MHRT can either order that the person continue to be detained or order that the person be discharged. However, the MHRT is not able to make a CTO, nor can it delay a person's discharge under the current wording in the Act (s 44(4)).

At a mental health inquiry or review of an involuntary patient, however, the MHRT does have the power to make a CTO and to defer a person's discharge for up to 14 days. This has been raised as an inconsistency by stakeholders, and it has been proposed that the Act be amended to bring the MHRT's powers at such appeal hearings into line with its powers at other reviews of detained mental health consumers.

## Questions

10. Do you believe that the MHRT should be able to make CTOs and/or defer the discharge of a detained person for up to 14 days at an appeal hearing against a refusal to discharge the person? Why/why not?
11. Are there any other comments you wish to make concerning this issue?

## 7.2. Discharge after making a CTO

Under the Act, the MHRT is required to review each person who has been detained in a DMHF to determine whether their ongoing detention is warranted. If the MHRT determines that the person is a mentally ill person but there is other care of a less restrictive kind that is appropriate and reasonably available to the person, then the MHRT must make an order that the person be discharged. At this point, the MHRT can also make a CTO, if appropriate.

When the MHRT discharges someone, it has the power to delay the person's discharge for up to 14 days. This normally occurs where appropriate accommodation or services for the person are still being arranged by health staff. However, if a CTO is made, the AMO must discharge the patient (unless the patient agrees to stay as a voluntary patient). There is no power under the Act to delay discharge when a CTO is made if the patient does not agree to stay as a voluntary patient (s41).

Some stakeholders have proposed that the Act be amended to allow the MHRT to make a CTO for a person who is being detained in a DMHF and defer their discharge until appropriate accommodation or other relevant services are arranged for the person. The rationale for this is that it would negate the need for the MHRT to adjourn hearings until accommodation and other relevant matters are worked out, potentially allowing person's to be discharged when appropriate (rather than having to wait for the MHRT to adjourn or reschedule a hearing to consider making a CTO).

Concerns with such a proposal include the potential for persons placed on CTOs to be detained for relatively long periods without access to the MHRT reviews that occur for persons detained under the Act. However, as with normal delayed discharge, a time limit of 14 days could be set. In addition, the Act could clarify that the patient, as with all other persons detained under the Act, would continue to be able to seek discharge from the AMO and seek review from the MHRT if the discharge was refused.

## Questions

12. Do you believe that the Act should be amended to allow the MHRT, when undertaking a mental health inquiry, or a review of an involuntary patient, to make a CTO and delay the person's discharge until appropriate accommodation and other arrangements are in place? Why/why not?
13. If you do believe such an amendment is appropriate, do you think that any restrictions should be placed on such orders? (e.g. should there be a maximum period that a person can be detained pending discharge or further review by the MHRT if they have not been discharged by the end of that period? Should the person be able to still seek discharge and appeal if it is refused, as other persons detained involuntarily can do?)
14. Are there any other comments you wish to make concerning this issue?

### 7.3. Review by MHRT at least once every 12 months

Under s9 of the Act, a voluntary patient must be reviewed by the MHRT at least once every 12 months. There may, however, be circumstances where a voluntary patient has resided in MHFs continuously for more than 12 months without a MHRT review.

An example of this is where a person is admitted as a voluntary patient and after nine months they are scheduled and detained as an assessable person, awaiting a mental health inquiry by the MHRT. Two weeks after being detained, and prior to the inquiry taking place, they are discharged from their involuntary status and made a voluntary patient again. They are then reviewed by the MHRT 12 months following their current voluntary admission (i.e. 12 months after they were discharged from their involuntary status). In such a case, the person could potentially not be reviewed by the MHRT for over 21 months, despite the person having resided in MHFs continuously during this period.

It has been proposed by stakeholders that section 9 of the Act be amended so that a voluntary patient must be reviewed at least once every 12 months of continuous residence voluntarily or involuntarily in MHFs.

## Questions

15. Do you believe that the Act should be amended so that voluntary patients must be reviewed at least once every 12 months of continuous residence voluntarily or involuntarily in MHFs? Why/why not?
16. Are there any other comments you wish to make concerning this issue?



## 7.4. Initial involuntary treatment in the community

### *Nature of the issue*

Under the Act, involuntary treatment in the community, in the form of CTOs, can only be authorised by the MHRT. This means that persons in the community cannot be treated against their will until and unless the MHRT has made a CTO. In the case of persons living in the community who are not currently on a CTO, a MHRT hearing cannot occur for at least 14 days after a CTO application is made (s52(3)). Such persons cannot be involuntarily treated in the community while awaiting a CTO application to be heard.

In some circumstances, such as where a person in the community has refused to take medication and, as a result, remains or becomes mentally unwell, this may mean that such persons end up being detained and involuntarily treated in inpatient DMHFs since this is the least restrictive form of treatment that is reasonably available to the person. For a person who is detained in a DMHF, but where the treating team has determined that they could be appropriately discharged and treated on a CTO, their discharge may have to be delayed until a MHRT hearing can be organised to consider a CTO application.

An argument has been put forward that, if such persons could be treated immediately in the community, this would reduce the need for them to receive involuntary treatment and detention in an inpatient DMHF, and may allow persons to be discharged earlier from such facilities into the community, where appropriate.

It has therefore been proposed by stakeholders that the Act be amended to allow community DMHFs to provide initial involuntary treatment of persons in the community without a CTO approved by the MHRT.

### *Relevant legislation*

In order for a CTO to be granted, an application needs to be made to the MHRT that includes a proposed treatment plan for the person from the community DMHF that will manage the CTO, if it is granted (section 53(2)).

The treatment plan must set out:

- *“in general terms, an outline of the proposed treatment, counselling, management, rehabilitation or other services to be provided to implement the”* CTO, and
- *“in specific terms, the method by which, the frequency with which, and the place at which the services would be provided for that purpose”* (s54).

The MHRT may only make a CTO if it determines that:

- *“no other care of a less restrictive kind, that is consistent with safe and effective care, is appropriate and reasonably available to the person and that the affected person would benefit from the order as the least restrictive alternative consistent with safe and effective care”,* and
- *“a declared mental health facility has an appropriate treatment plan for the affected person and is capable of implementing it”,* and
- *“if the affected person has been previously diagnosed as suffering from a mental illness, the affected person has a previous history of refusing to accept appropriate treatment”,* unless the person has been a forensic patient or subject to a CTO in the previous 12 months. In such cases, the MHRT need

only be “satisfied that the person is likely to continue in or to relapse into an active phase of mental illness if the order is not granted” (s53(3) & (3A)).

Under the Act, persons can be initially detained and involuntarily treated in an inpatient DMHF without the approval of the MHRT (s18 & s27). The MHRT holds an inquiry to determine the appropriateness of a person’s detention “as soon as practicable” after a person is detained. This is normally 2-3 weeks following the person’s involuntary admission. This means that, in most cases, persons are detained and involuntarily treated for 2-3 weeks on the agreement of two medical practitioners, at least one of whom must be a psychiatrist (s27).

## Other jurisdictions

A broad outline is provided in this section about the processes for making CTOs and for independently reviewing CTOs in some other relevant jurisdictions, with particular focus on jurisdictions which have recently updated, or are in the process of reviewing, their mental health legislation.

The *Victorian Mental Health Act 1986* allows for CTOs to be made by ‘authorised psychiatrists’ (roughly the equivalent of the medical superintendent under the NSW Act) for up to 12 months. The authorised psychiatrist can then extend the CTO for another 12 months an indefinite number of times. The Victorian Mental Health Review Board (which is the equivalent of the NSW MHRT) only reviews CTOs if they are extended, with the review occurring within eight weeks of a CTO being extended. Persons subject to CTOs can appeal to the Board.

The Victorian Act is currently under review and the proposed changes include that the authorised psychiatrist can only make a CTO for up to three months. A “review officer” (roughly the equivalent of an Official Visitor under the NSW Act) would, within seven days of a CTO being made, assess whether the CTO had been made in accordance with the Act and inform the affected person of their rights. It is proposed that for extensions of a CTO beyond three months, the authorised psychiatrist must apply to the Tribunal for an ‘Extended Treatment Order’.

The *South Australia Mental Health Act 2009* (the **SA Act**) allows for a CTO to be made by a medical practitioner or an “authorised health professional” (roughly the equivalent of an accredited person under the NSW Act), for up to 28 days. If the CTO is not made by a psychiatrist or an “authorised medical professional” (AMP) (roughly the equivalent of an AMO under the NSW Act), then a psychiatrist or AMP must assess the affected person within 24 hours of the CTO being made and determine whether the CTO is required. The Guardianship Board (the equivalent of the NSW MHRT) must review the CTO as soon as practicable after the CTO has been made, and can, if certain criteria are met, make a further CTO.

The *Western Australian Mental Health Act 1996* (the **WA Act**) allows for a psychiatrist to make a CTO for a person in the community for up to three months, as long as it is confirmed within 72 hours by another psychiatrist or medical practitioner. The supervising psychiatrist can then make a continuation order for up to three months, if appropriate, an indefinite number of times. The Mental Health Board is responsible for reviewing each CTO as soon as practicable after it is made, but not later than eight weeks after it is made.

The WA Act is currently under review and, under the proposed amendments, a psychiatrist would be allowed to make a CTO for a person in the community for up to three months. The supervising psychiatrist can then make a continuation order for up to three months, if appropriate, an indefinite number of times. It is proposed that a Mental Health Tribunal be established, and its responsibilities would include reviewing

each CTO as soon as practicable after it is made, but not later than 35 days after it is made in the case of an adult or 10 days in the case of a child.

### *Analysis of proposal to allow for 'initial involuntary community treatment' (IICT)*

As stated above, it has been proposed that consideration be given to amending the Act to allow community DMHFs (also known as community mental health services or health care agencies) to provide initial involuntary community treatment (IICT) of mentally ill persons in the community pending consideration of a CTO application by the MHRT.

Part of the rationale for this proposal is that, currently persons can be initially detained and involuntarily treated in an inpatient DMHF on the basis of an assessment by at least two medical officers, at least one of whom must be a psychiatrist, and that the person meets the criteria under the Act for such detention. However, persons who are in the community or who are discharged from an inpatient DMHF into the community cannot receive initial involuntary treatment without the approval of the MHRT.

Currently, in relation to persons who are in the community and not on a CTO, at least 14 days are required between notifying the person that a CTO application is being made to the MHRT, and a hearing taking place (section 52(3)). According to Section 4 of the MHRT's Civil Hearing Kit, if the person is notified by post, an additional 4 working days must be allowed for before a hearing can occur (i.e. at least 18 days must elapse between a CTO application being made and the hearing taking place if the person is notified by post).

As a result of these restrictions, a person can remain untreated in the community for at least 14 days after a DMHF has decided that, in its view, a CTO is required for the person. In some cases, this may result in a person becoming unwell and requiring involuntary treatment in an inpatient DMHF, or may mean that a person must be detained in a DMHF while awaiting the CTO hearing because this is the least restrictive option available for the person at that time (since they cannot receive involuntary treatment in the community while awaiting a CTO hearing). If the IICT proposal was implemented, it could potentially allow for some of these persons to remain in the community or be discharged earlier from inpatient DMHFs into the community, where appropriate.

The IICT proposal would therefore arguably bring initial community involuntary treatment more in line with initial involuntary treatment in an inpatient setting. As outlined above, IICT could potentially allow for more timely treatment of persons with a mental illness in the community, which may reduce the number of persons requiring involuntary inpatient treatment and allow for earlier discharge of persons from detention into the community, where appropriate.

The IICT proposal would, if implemented, bring NSW in line with a number of other jurisdictions in Australia where CTOs can be made by qualified health professionals, and are then reviewed at a later date by their MHRT or equivalent.

Potential concerns with the creation of an IICT system include the possible increase in workload of, and resultant increase in financial costs to, community mental health services of taking on additional caseloads; increased costs for the MHRT of potentially more appeal hearings; and the possible impact on the rights and liberty of persons (as it would create an additional means by which administrative involuntary orders could be made). In addition, it should be noted that there is no requirement under the CTO provisions in the Act that the person must be a mentally ill or mentally disordered person for the CTO to be made. There are

therefore no specific clinical criteria that must be met before an application for a CTO can be made, or before a CTO can be imposed on a person. This could potentially create difficulties in terms of implementation and reviews of decisions to make an initial CTO by a person other than the MHRT. It may create potential avenues of improper infringements of individual's rights.

If there is broad stakeholder and community support for the IICT proposal, then further consideration could be given to exactly how IICT would work in practice and how the Act would need to be amended to ensure that appropriate checks and balances are put in place to make sure that IICT is only used where clinically indicated. This would need to involve substantial stakeholder and community consultation to ensure that any IICT system substantively addressed any stakeholder concerns and was consistent with the principles of the Act.

Issues that would need to be considered to ensure appropriate development of an IICT system include:

- What assessment of the person would be required before they could be subject to IICT, and by whom should it be conducted?
- What criteria would need to be met, as a minimum, for a person to be subject to IICT?
- How would the affected person and any primary carer be notified of the intention to place them under the IICT regime? Would they have a right to respond and argue against the IICT?
- Should there be appeal mechanisms for persons subject to IICT, and if so, what type of mechanisms?
- What information and conditions would an IICT treatment plan need to include and what restrictions would need to be placed on the conditions that can be placed in such a treatment plan to ensure that inappropriate plans are not developed?
- Are current inspection mechanisms (such as the Official Visitors (OVs)) adequate to ensure proper oversight of IICT?
- How soon after a person is subject to IICT should a MHRT review be held to consider a CTO application?
- What provisions should be in place to deal with persons who breach IICT conditions?
- Is there a need to strengthen community MHS resources to ensure that IICT can be effectively implemented?
- How could an IICT 'order' be varied or revoked?

## Questions

- 17. Do you believe that the Act should be amended to allow for initial involuntary treatment of persons in the community? Why/why not?**
- 18. What restrictions, if any, do you believe should be placed on initial involuntary treatment in the community, and why?**
- 19. Are there any other comments you wish to make concerning this issue?**

## 8. Detention on order of a Magistrate or police officer

This is an issue where the *Mental Health Act 2007* intersects with the *Mental Health (Forensic Provisions) Act 1990*. Any review or amendment of the *Mental Health (Forensic Provisions) Act 1990* is outside the scope of this current review process.

Where a person has been referred to a DMHF for assessment on the order of a Magistrate or an *authorised officer*, under section 33 of the *Mental Health (Forensic Provisions) Act 1990*, or by a police officer after being apprehended because the officer believed the person to be committing or to have recently committed an offence (under section 32 of the *Mental Health Act 2007*), the court or police officer will specify whether or not the person is to be returned to the court or the police officer if they are found not to meet the criteria for involuntary admission.

Where the person was brought to the MHF because the police officer believed they had committed an offence, and the DMHF does not consider that the person meets the criteria for involuntary treatments, the MHF must:

- *release the person into the custody of any police officer who is present, or*
- *notify the appropriate police station of the decision not to further detain the person and ascertain whether the police intend to apprehend them*

According to section 32(4) of the Act, at this stage, the MHF may:

- detain the person for a period not exceeding one hour pending the person's apprehension by a police officer,*
- admit the person in accordance with this Act as a voluntary patient,*
- discharge the person, in so far as it may be possible to do so, into the care of the person's primary carer,*
- discharge the person.*

Stakeholders have raised a concern that being able to detain a person for one hour while awaiting police attendance may not allow sufficient time to enable police to attend and apprehend the person, particularly in rural and remote areas of NSW. It has been suggested that the time be extended to four hours.

### *Issues to consider*

In the situation described above, where a person is no longer being detained by the DMHF for assessment or treatment, the person is being held to assist the police with their processes.

Where the DMHF detains a person while waiting for the police to attend, for an hour in the current Act or longer if the proposed extension was accepted, health resources (physical resources such as beds and staff, and funding) are required to ensure that the person does not leave the facility and to ensure the safety of that person and other people in the facility.

Had there not been any query about the mental wellbeing of a person, they would have remained within the police or judicial system. Where police wish to speak to or apprehend a person in relation to an alleged

crime, or the Court orders that the person be returned to Court, it might be argued that it could be in the public interest for that person to be detained for sufficient time to allow the police to attend.

This issue is likely to arise more frequently in rural and remote parts of NSW, where there are often limited numbers of police officers covering a large geographical area. Consequently, it may not be possible for police to attend and apprehend a person who is being held at a DMHF within an hour. In particular, if a large, high priority incident has occurred in rural NSW and requires all available police resources it is unlikely that police would be able to attend the facility within an hour.

It is a key human rights' principle that people have a right to freedom, and therefore they should not be detained longer than necessary. It is important that police attend and apprehend people being held on their behalf by a DMHF as quickly as possible.

## Questions

20. Where the police officer has requested that the person be returned to their custody following a mental health assessment, how long should mental health facilities be able/required to detain a person to enable officers to attend and take custody of that person?
21. Are there any other comments you wish to make concerning this issue?

## 9. Detention of Voluntary inpatients

A voluntary patient may discharge himself or herself from a MHF at any time. On occasions, a voluntary patient may wish to discharge themselves prior to a planned medical discharge. Under s 10(1) of the Act, an AMO may detain a voluntary patient if the officer considers the person to be a mentally ill person or a mentally disordered person. If such detention occurs, the examination processes in s27 of the Act will have to take place.

There may be circumstances when an AMO is not immediately available to examine and form an opinion as to whether the patient should be detained. The Act does not make any provisions for holding the voluntary patient pending the AMO's arrival.

### *Other legislation*

The Scottish Act states that when a patient being treated on a voluntary basis decides to discharge themselves against medical advice, a nurse can hold the patient for up to two hours to allow a doctor to attend and assess the patient. A further one hour extension is possible once the doctor arrives.

The Western Australian Draft Mental Health Bill 2011 proposes that, where a voluntary inpatient wants to leave against medical advice, and the person in charge of the ward suspects that the patient is in need of involuntary treatment, the person in charge has the authority to detain the voluntary inpatient for up to 6 hours to allow them to be medically assessed.

The Act empowers an accredited person (who may be a nurse, psychologist, social worker) or medical practitioner to schedule a voluntary patient under s19.

## Questions

22. Does the *NSW Mental Health Act* need to include a provision that allows a nurse employed by the mental health facility to hold a voluntary patient wanting to discharge themselves against medical advice? Why/why not?
23. Under what circumstances, if any, would it be reasonable to hold a voluntary patient who wanted to discharge themselves before an authorised medical officer could undertake a review?
24. If allowed, what would be an appropriate time period for the mental health nursing staff to hold a voluntary patient pending a review by the authorised medical officer?
25. If mental health nursing staff were to have such authority:
  - (a) what skills and experience would be required?
  - (b) should a specific staff position (or positions) in the facility be nominated?
26. Are there any other comments you wish to make concerning this issue?

## 10. Initial Assessment for Involuntary Detention

Under section 19 of the Act, a medical practitioner or accredited person who is of the opinion that a person is a mentally ill person or a mentally disordered person can complete a schedule 1 certificate allowing the person to be taken to, and initially detained in a DMHF for assessment.

Accredited persons are experienced, and specially trained and appointed health practitioners who may be nurses, psychologists or social workers. They usually work in rural/regional community settings and emergency departments to supplement the numbers of doctors.

At present, only medical practitioners (including AMOs and psychiatrists) in declared mental health facilities can complete the certificate (Form 1) which allows for a person's continued detention and involuntary treatment at a DMHF (pending a mental health inquiry) (s27). As a further safeguard, where the first Form 1 examiner proposes to continue detaining the person, they must then be examined by at least one, and in some cases two, additional medical practitioners, both of whom must be psychiatrists if the first assessor was not a psychiatrist.

Access to medical practitioners with sufficient working knowledge of the Act and of mental health may be problematic in some DMHF emergency departments that undertake Form 1 assessments.

It has been proposed by some stakeholders that accredited persons also be authorised to undertake Form 1 examinations.

Although no evidence has been put forward to support this proposal, anecdotal stakeholder comments suggest that some accredited persons may have more mental health expertise and a better working knowledge of the provisions of the Act than some AMOs working in emergency departments that are DMHFs. In addition, it has been argued by some stakeholders that empowering accredited persons to undertake a Form 1 examination may allow, in some circumstances, for more timely access to such examinations.

There are, however, concerns about accredited persons being provided with the authority to complete the initial Form 1 examination. This is because if an accredited person formed the view that the person subject to the examination did not require further detention and treatment then the person must be released without a second examination by a psychiatrist (s27(a)). This may lead to situations where a person is discharged on the sole opinion of an accredited person even though a psychiatrist may have formed the view that the person required ongoing involuntary mental health treatment.

## Questions

27. **Where medical or psychiatric resources are limited, are there other mechanisms for enhancing the quality and access to Form 1 assessments?**
28. **Should accredited persons have a role in completion of Form 1's and under what conditions?**
29. **Are there any other comments you wish to make concerning this issue?**

# 11. Transport of persons for assessments

## *Nature of the issue*

In some rural and remote areas of NSW, a person is sometimes transported involuntarily under the Act over long distances to the nearest DMHF for an assessment to determine whether the person is a mentally ill or mentally disordered person and requires involuntary inpatient care. This assessment, a "Form 1", is done by an AMO of the DMHF (s27). In some cases, the AMO at the DMHF does not think the person requires involuntary inpatient care. In effect, in these cases the person has been unnecessarily transported over long distances to be informed that they do not meet the criteria in the Act for involuntary treatment and detention and cannot continue to be detained (and must also potentially be returned to their place of residence).



This has implications for the person being transported, in that they have had their liberty taken away and been transported involuntarily, possibly with the use of restraints and sedation. This situation could potentially be avoided if it was possible for the Form 1 assessment to occur at a place closer to where the transport commenced. In addition, transport over such distances is costly and time consuming for scarce police and ambulance resources. This may have an adverse impact on rural and remote communities as it means that police and ambulance resources are unavailable to that community for the period that they are away undertaking the transport.

Currently, under the Act, Form 1 assessments can only occur in a DMHF. As a result, it is necessary for police and ambulance to take the person to a DMHF for assessment, even if the nearest DMHF is located a very long distance from where the transport commenced.

Some stakeholders have argued that the requirement for Form 1 assessments to be conducted in DMHFs may cause, in some cases, unnecessarily long transports in rural and remote areas, with resultant impacts on the liberty of the person being transported. It is also argued that there are significant financial and staffing impacts on the services that provide these transports, and a resultant reduction in the level of these services in affected communities.

It has been proposed that the Act be amended to allow the first Form 1 assessment to be conducted by video-link by an AMO in a DMHF, to a health facility that is not a DMHF but that has suitable infrastructure and resources in place to support such assessments, and that is located closer to where the transport commenced.

## *Current relevant legislation*

The Act currently allows for persons to be involuntarily transported to DMHFs by police and ambulance officers, and by members of staff of the NSW Health Service (s18-26, s81).

Section 81 allows authorised persons undertaking such transports to:

- use reasonable force,
- restrain the person in any way that is reasonably necessary in the circumstances,
- sedate the person (if they are authorised by law to administer the sedative) if it is necessary to do so to enable the person to be taken safely to the facility.

Once a person has been brought to a DMHF, between 1-3 medical practitioners are involved in decision making about whether the person needs to continue to be detained or can be discharged to the community.

These medical practitioners complete forms (known as 'Form 1's) which indicate whether they are of the view that the person is, or is not, a mentally ill or mentally disordered person, and whether or not they require ongoing detention and involuntary treatment. A person can only continue to be detained if at least two of the assessing medical practitioners are of the view that:

- the person is a mentally ill or mentally disordered person;
- there are no other appropriate means available for dealing with the person; and
- it is the least restrictive environment in which the person can receive care and treatment.

The first Form 1 needs to be completed within 12 hours of the person being brought involuntarily to the DMHF and must be completed by an AMO, who is either the medical superintendent of the DMHF, or a



medical officer appointed by the medical superintendent. Subsequent Form 1's must be completed as soon as possible after the first Form 1.

Depending on the view of the assessing medical practitioner(s), the person:

- either be discharged; or
- can be detained for up to three working days, if they are found to be a mentally disordered person; or
- can be detained pending a mental health inquiry hearing by the MHRT to determine if the person should continue to be detained (these hearings usually occur 2-3 weeks after the person's initial detention in the DMHF).

In relation to the latter two dot points, the AMO must discharge the person at any time if the AMO is of the view that the person no longer meets the Act's requirements for detention (s12).

Under the Act, Form 1s can only be completed at DMHFs (s27).

## *Analysis of proposal*

As outlined above, it has been proposed that ambulance and police officers, as well as staff of NSW Health, be allowed to transport persons to certain health facilities (that are not DMHFs) for the purposes of a mental health assessment. At such a facility, an AMO from an appropriate DMHF would undertake the first Form 1 assessment by video-link. If the AMO was of the view that the person did not meet the criteria for involuntary admission under the Act, the person could not continue to be detained (although they could still be admitted as a voluntary patient). If the person is assessed as requiring ongoing detention and involuntary treatment, then they would need to be transported to the DMHF.

The rationale for the proposal is that it could potentially significantly reduce the number of unnecessary long distance transports and the amount of time taken to transport a person for assessment in rural and remote areas. This would mean that persons who are assessed as not meeting the criteria for involuntary admission would not be deprived of their liberty for lengthy periods of time as currently occurs. Such transports may require the person to be restrained and/or sedated for part or all of the journey, which currently may take several hours, in the worst case scenario. The proposal could potentially reduce the length and intensity of such measures. Currently, if the person is assessed at the DMHF as not meeting the criteria for involuntary admission, then the person also potentially has a long journey back to their place of residence. The proposal potentially reduces or negates the need for the person to find a way to get home over long distances.

An additional rationale for the proposal is that it could substantially reduce the amount of time that police, ambulance and NSW Health staff spend transporting persons to DMHFs for assessment in rural and remote areas, especially where the person is then assessed as not meeting the requirements for involuntary or voluntary admission.

Consideration needs to be given to both the appropriateness of the proposal, including whether alternative options might effectively deal with the issue, and, if appropriate, what practical issues there might be with its implementation.

In terms of the proposal's appropriateness, it should be noted that, if the proposal was to go ahead, the Form 1 assessment conducted at such facilities would always be conducted by video-link, whereas at present such assessments at DMHFs are conducted either face-to-face or by video-link. In addition, OV's would not

be able to inspect the affected facilities as they would not be DMHFs, unless the OV inspection powers were amended in the Act to allow such inspections to occur. It needs to be recognised that if such inspections were allowed, this would likely have substantial additional financial costs for the OV program.

An alternative option to the above proposal, and one that has also been suggested by some stakeholders, would be to “gazette” certain health facilities as DMHFs of a specific class for the purposes of undertaking Form 1 assessments only. The Director-General of the Ministry of Health has the power under s109 of the Act to declare facilities to be DMHFs and may establish classes of facilities that have certain restrictions placed on their operation.

Gazetting such facilities as DMHFs would allow Form 1s to be conducted and would mean that an amendment to the Act would not be required. Such a proposal may result in significant transport concerns, particularly in relation to which agency would be responsible for transport and possible resourcing issues.

However, gazetting such facilities as DMHFs would also mean that at least two OVs would be required under the Act to inspect each facility once a month (see s131 as well as clause 20 of the Mental Health Regulation) which could have a substantial financial impost for the OV Program, given that such facilities would likely be in smaller and more remote centres.

In terms of the practicalities of implementing the proposal, consideration should be given to what infrastructure, security and staffing would need to be put in place to ensure that a health facility could accommodate Form 1 assessments. Such requirements could include sufficiently trained staff to manage the person, having a safe assessment room with video-conferencing facilities and having adequate security available. Consideration should also be given to the maximum timeframes that a person could be detained at such a facility pending a Form 1 assessment.

In addition, thought needs to be given to what should happen if a person who has been assessed as not requiring involuntary admission then becomes more unwell and requires another assessment under the Act – does it occur at the health facility again or should they be taken to the DMHF? Should the second Form 1 (and, if relevant, the third Form 1) be allowed to be completed at the health facility (since this may further reduce the need for unnecessary transport to the DMHF)?

## Questions

30. Do you believe that the Act should be amended to allow for Form 1 assessments by video-link at certain prescribed health facilities in rural and remote areas of NSW? Why/ why not?
31. Are there any other potential methods of addressing this issue which you believe may provide the same or similar benefits to that of the proposal?
32. What practical issues do you think need to be addressed in implementing such a proposal and how do you think they should be addressed?
33. Are there any other comments you wish to make concerning transport of persons for assessment?

# RIGHTS AND RESPONSIBILITIES

## 12. Review of Treatment Planning and Medication

Stakeholders have suggested that a provision could be inserted in the Act to empower consumers to apply to the MHRT for a review or change in medication, or to access a second opinion from a psychiatrist outside the hospital in relation to appropriate or alternative treatment.

Under the Act, an involuntary patient or person detained in a MHF, the person's lawyer and their primary carer, have the right to information about their treatment, including side effects and dosages (s73). The consumer does not have the right however to refuse appropriately prescribed treatment although they have the right to express their objection<sup>14</sup>.

In prescribing medication, the MHF must:

- *prescribe medication to meet the health needs of the person and should be given only for therapeutic or diagnostic needs and not as a punishment or for the convenience of others (s68(d))*
- *ensure that people with a mental illness or mental disorder be provided with appropriate information about treatment, treatment alternatives and the effects of treatment (s68(e))*
- *monitor and review the prescription and use of drugs (s86)*

The MHRT must:

- *inquire into the medication of the consumer*
- *take into account the effect of the medication on the consumer's ability to communicate at the hearing<sup>15</sup>*

The principles for care and treatment in the Act provide that every effort that is reasonably practicable should be made to involve persons with a mental illness or mental disorder in the development of treatment plans and plans for ongoing care (s68(h)).

Currently, consumers can pursue a number of avenues if they are unhappy with the medication or treatment they receive or response from their service provider, such as contacting OVs or the NSW Health Care Complaints Commission (the **HCCC**).

OVs are appointed by the Minister (s129) and can advocate on behalf of people being treated under the Act. OVs can speak with health care professionals on behalf of consumers and can help them resolve issues arising in their care and treatment.

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<sup>14</sup> NSW Department of Health, Mental Health & Drug & Alcohol Office, *Mental Health Act (2007) Guide Book* (4<sup>th</sup> ed.), NSW Institute of Psychiatry, August 2011

<sup>15</sup> *ibid*

The HCCC is an independent body with responsibility for dealing with complaints about health services or healthcare providers. A person who is subject to the Act can make a complaint to the HCCC about:

- lack of information about their condition, treatment or treatment plan
- wrong medication for their condition
- medication causing side effects
- mistakes in medication
- lack of information about medication
- problems in communication with their treating team, doctor or case manager
- rights to have a second opinion<sup>16</sup>

In addition, the majority of Local Health Districts (LHD) employ consumer workers who can provide peer support and advocacy to consumers, and support them when seeing their case manager or psychiatrist, or appearing before the MHRT.

Introduction of a mechanism for consumers to apply to the MHRT for a review of their treatment, including a change in medication, or to seek a second opinion from an independent psychiatrist, would require careful management and clear guidelines to ensure that every treatment recommended or prescribed is not reviewed. Any review by someone external to the facility would require an assessment as to the availability of funding and resources.

A possible option for addressing consumer concerns about medication and treatment, which is not excluded under the current legislation, could be to allow the consumer to request that the Medical Superintendent undertake a treatment review, or if the Medical Superintendent is the treating psychiatrist, then another psychiatrist of the facility undertake the review. Comment is sought during the review process on whether a formal review mechanism should be included in the Act as a consumer right.

## Questions

- 34. Should the Act be amended to include provision for patients to apply for a treatment review and if so, what limits should be placed around this?**
- 35. Should patients on a Community Treatment Order also be able to apply for a treatment review?**
- 36. Should the treatment review be undertaken by the Mental Health Review Tribunal or another party? What would be the role of the Medical Superintendent?**
- 37. Are there any other comments you wish to make concerning treatment reviews?**

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<sup>16</sup> See: <http://www.hccc.nsw.gov.au/Information/Information-For-Health-Consumers/Complaints-about-mental-health-care/default.aspx>

# 13. Electroconvulsive Therapy

Electroconvulsive therapy (ECT) has been used for more than 70 years in the treatment of psychiatric disorders. The most common indication for ECT in Australia is major depressive episodes.<sup>17</sup>

The administration of ECT in NSW is governed by the Act and Regulations. In addition, the Ministry of Health has published a [Policy Directive and a Minimum Standards Guidelines](#).

Only medical practitioners are permitted to provide ECT, and it must be performed in a hospital approved for this purpose, whether public or private. A minimum of two medical practitioners must be present, of whom one is experienced in the administration of ECT and another is experienced in anaesthesia.

ECT administered other than in accordance with the Act is unlawful, and penalties apply.

## 13.1. Electroconvulsive Therapy for Children and Adolescents

ECT in young people was first reported in the early 1940s. It became a popular treatment for mental illness in this age group, largely because few other effective treatments were available, but its use then diminished to become a controversial treatment of last resort in most countries.<sup>18</sup>

In the 1990s, there were renewed efforts to delineate the indications for ECT in young people and the way the treatment should be administered.<sup>19</sup> The use of ECT in these younger age groups is uncommon but at times it may be the most appropriate treatment option.

Currently, under the Act, the same rules for consent to ECT treatment apply to children under the age of 18 as they do to adults. This means that if the child is a voluntary patient, the child must give informed consent before the ECT can be performed. If the child lacks the capacity to consent and is a voluntary patient, ECT cannot be administered while the child is a voluntary patient. If the child is an involuntary patient, ECT can only be administered in accordance with an ECT determination made by the MHRT following an ECT Administration Inquiry. Parents cannot consent to ECT being performed on their child.

The current Victorian and Western Australian Acts do not differentiate between adults and children/adolescents; however, both States have recently consulted on draft Bills which propose additional requirements for who can recommend treatment of children with ECT, and a minimum age requirement. These proposed amendments respond to public submissions seeking additional safeguards and regulation of the use of ECT to treat children.

Both draft Bills propose that, when ECT is to be used on a child aged less than 18 years, there is a requirement that the treatment recommendation be supported by a registered psychiatrist who specialises in the area of child or adolescent mental health.

In addition, the draft Bills include consent requirements specifically for treatment of children. In the WA draft Bill, voluntary patients aged 12-18 years must give informed consent (if they are deemed to have

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<sup>17</sup> NSW Department of Health, Mental Health and Drug and Alcohol Office, *Guidelines: ECT Minimum Standards of Practice in NSW*, Better Health Centre, November 2010, p.8

<sup>18</sup> *ibid*, p.38

<sup>19</sup> *ibid*, p.38

capacity) for ECT themselves. Approval is required from the Mental Health Tribunal for involuntary or 'mentally impaired accused' patients aged 12-18 years.

In the Victorian Draft Bill, an application must be made to the Mental Health Tribunal for all patients aged 13 – 18 years, irrespective of whether the child is considered to have capacity to consent. However, both the recommending medical practitioner and the Mental Health Tribunal must have regard to the views of the patient and, if applicable, the nominated person and parent or guardian.

The Queensland *Mental Health Act* (2000) does not include any specific regulations for treatment of children with ECT.

## Questions

38. Should the legislation include any specifications regarding treatment of children with ECT? If YES, please provide details.
39. Are there any other comments you wish to make concerning ECT?

## 14. Psychosurgery

The Act currently states that a person must not administer or perform deep sleep therapy, insulin coma therapy, or psychosurgery. NSW is currently the only Australian state where the legislation specifically prohibits the use of psychosurgery.

Psychosurgery is defined in section 83(2) of the Act as:

- (a) *the creation of 1 or more lesions, whether made on the same or separate occasions, in the brain of a person by any surgical technique or procedure, when it is done primarily for the purpose of altering the thoughts, emotions or behaviour of the person, or*
  - (b) *the use for such a purpose of intracerebral electrodes to produce such a lesion or lesions, whether on the same or separate occasions, or*
  - (c) *the use on 1 or more occasions of intracerebral electrodes primarily for the purpose of influencing or altering the thoughts, emotions or behaviour of a person by stimulation through the electrodes without the production of a lesion in the brain of the person,*
- but does not include a technique or procedure carried out for the treatment of a condition or an illness prescribed by the regulations for the purposes of this definition.*

In line with this definition of psychosurgery, deep brain stimulation cannot be performed on patients in NSW. This prohibition extends to the use of psychosurgery and deep brain stimulation for the treatment of any health conditions; however, Regulation 12 states:

For the purposes of section 83 of the Act, **psychosurgery** does not include a neurological procedure carried out for the relief of symptoms of the following:

- (a) Parkinson's disease,
- (b) Gilles de la Tourette syndrome,
- (c) Chronic tic disorder,
- (d) Tremor,
- (e) Dystonia.

There are ongoing clinical trials internationally investigating the use of deep brain stimulation for the treatment of a number of conditions, including some mental health conditions.

As part of this review of the Act, it is appropriate to consider whether psychosurgery, or perhaps deep brain stimulation specifically, should continue to be prohibited in NSW. Given that prior to its prohibition there were strict statutory requirements and guidelines on psychosurgery, views are also sought on this issue.

## Questions

- 40. **Should the legislation be amended to permit the use of psychosurgery, including deep brain stimulation? If YES what sort of restriction or limitations should be imposed? Please provide details.**
- 41. **Are there any other comments you wish to make concerning psychosurgery or deep brain stimulation?**

# 15. Declaration of financial interest

## Legislation

Specific requirements in the Act govern the information that must be provided to a patient for informed consent before ECT can be administered.

The Act requires that a 'fair explanation' be provided of the techniques or procedures to be followed. Among other provisions, the Act also requires that:

Section 91.2 (g)

*A full disclosure must be made to the person of any financial relationship between the person proposing the administration of the treatment or the administering medical practitioner, or both, and the facility in which it is proposed to administer the treatment.*

Section 91.3

*The regulations are to prescribe forms setting out the steps to be taken before obtaining informed consent to electroconvulsive therapy.*



It is also required that this should occur **prior** to ECT consent as set out in [Regulation 13](#) and as defined in [Form 6](#).

The informed consent requirements for ECT described in section 91 of the Act (including the provisions quoted above) apply to voluntary and involuntary patients who are considered to have capacity or where the treating clinician is uncertain whether the patient has capacity (in which case the MHRT is then required to adjudicate).

## *Professional Codes*

The Australian Medical Council (AMC) has developed a national code of professional conduct for medical practitioners on behalf of all state and territory medical boards – ‘*Good Medical Practice: A Code of Conduct for Doctors in Australia*’ (the **Code**)<sup>20</sup>.

In relation to conflicts of interest, the Code states that good medical practice involves a number of provisions, including:

- *Not allowing any financial or commercial interest in a hospital, other health care organisation, or company providing health care services or products to adversely affect the way in which you treat patients. When you or your immediate family have such an interest and that interest could be perceived to influence the care you provide, you must inform your patient.*

In relation to financial and commercial dealings, the Code states that ‘*doctors must be honest and transparent in financial arrangements with patients*’, including:

- *Being transparent in financial and commercial matters relating to your work, including in your dealings with employers, insurers and other organisations or individuals. In particular:*
  - *declaring any relevant and material financial or commercial interest that you or your family might have in any aspect of the patient’s care*
  - *declaring to your patients your professional and financial interest in any product you might endorse or sell from your practice, and not making an unjustifiable profit from the sale or endorsement.*

It is expected that all medical practitioners (including those proposing and/or administering ECT) declare any conflict of interest, particularly any possible financial gain for the medical practitioner. There may be greater likelihood of a financial or commercial interest for medical practitioners who are working in private facilities.

## *Practical issues*

Stakeholders have identified some practical challenges with completion of Form 6 in line with the current legislation. While there is no suggestion that medical practitioners should cease to declare any financial interests, it may be appropriate to review the process outlined in the Act and consider whether there is added value in legislating for declaration of financial interests specifically when undertaking ECT, in addition to the expectations for all medical practitioners irrespective of specialty, treatment or patient population.

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<sup>20</sup> See: <http://www.amc.org.au/index.php/about/good-medical-practice> (accessed on 30 August 2012)

A course of ECT treatment will generally involve a number of sessions of ECT (often 8 - 12 sessions). Consent is sought and given for the full course of treatment prior to the first ECT session being administered. Patients who give consent may withdraw their consent and discontinue treatment at any time.

Where the medical practitioner who will administer the treatment is the same person who proposed that ECT be administered, it is straightforward for any financial relationship to be disclosed prior to consent being sought from the patient. In such a case, the medical practitioner will only be required to complete Item A of Form 6.

In practice, the medical practitioner proposing the treatment is frequently not the medical practitioner(s) who will administer the treatment. Different medical practitioners may administer the sessions of ECT over a course of treatment. In addition, the Act requires that at least two medical practitioners must be present during the administration of ECT. At the time that consent is being sought from the patient, it is usually not possible to predict which medical practitioner(s) within the service might administer ECT for that patient. Therefore, under the current legislation, all potential administering medical practitioners would need to declare their financial relationships and complete Item B of Form 6 prior to the patient receiving ECT.

### *Consistency issues*

The current wording of the Act requires that any financial relationship between the medical practitioner proposing and administering ECT and the facility be disclosed. However, it is appropriate to consider if and how such disclosures should be made for all mental health interventions, and whether this should be specified in the legislation.

As all medical practitioners are paid for their work, they will all have a financial relationship to disclose. Being paid for undertaking their role as medical practitioners does not necessarily constitute a conflict of interest; however, a large proportion of mental health treatment in NSW is proposed and administered in private mental health facilities. It is not uncommon for medical practitioners working in a private setting to also have a financial or commercial interest in the facility (e.g. as a shareholder or (part) owner), and there is also more scope for performance payments. It is therefore vital that such financial relationships are disclosed to patients and their carers so that they make a fully informed decision about whether to consent to the treatment. Under the AMC's Code of Conduct, all medical practitioners should disclose any conflicts of interest, including financial or commercial interests, for all treatments that they prescribe or provide.

### Questions

- 42. Should medical practitioners who propose or administer ECT be required to disclose any financial or commercial relationship with the facility in which it is proposed to administer the treatment (other than being an employee)?**

## 16. Consumer engagement in the development of treatment plans

Some stakeholders have suggested that the review consider formally recognising advance health care directives in legislation which would allow consumers to specify while well, the treatment they wish or do not wish to be given in circumstances where they lose decision making capacity due to mental illness. Advance care directives usually refer to written statements of wishes often in the context of ‘end of life’ decision making rather than ongoing treatment decisions and may not be generally relevant to treatment in a MHF. However, the process of engaging consumers in the development of treatment plans more generally can empower consumers, promote opportunities for therapeutic communication and promote consistency in the management approach.

The paper therefore asks whether the Act currently does give consumers enough opportunities to develop ongoing treatment plans on whether there needs to be specific provisions to ensure a dialogue between clinician and consumers regarding the development and implementation of a treatment plan. Further, consideration should also be given to whether treatment plans developed by a clinician and a consumer, if pursued in the legislation, should be followed if a consumer becomes acutely unwell and requires involuntary detention and treatment.

### Questions

43. Should treatment plans developed with consumer input be formally recognised in the Act, and if so, how?
44. In what circumstances should such treatment plans be allowed to be overridden?

## 17. Non-admission and discharge of persons brought involuntarily to a declared mental health facility

### *Nature of the issue*

All persons in NSW have a right to seek mental health treatment; however, the decision to admit a person for treatment is a clinical judgement made at the time of presentation.

Please refer to section 4.1 in this paper for information about the current criteria and process for involuntary admission of mental health consumers to, and discharge from, DMHFs.



Some stakeholders have raised concerns that, on occasion, there are poor outcomes for persons who are taken to DMHFs and not involuntarily admitted, or who are discharged into the community too early. Such poor outcomes may include serious harm to the person, their carers, family, and/or other members of the community.

Their specific concern is that the views of others (such as carers, family, and police and ambulance officers) are not always adequately taken into account by the assessing medical practitioners at DMHFs when practitioners decide whether to involuntarily admit or discharge a person under the Act. The concern is that this may represent a flaw in the decision making process around the admission and discharge of persons detained under the Act.

Accordingly, some stakeholders have requested that consideration be given to establishing a formal process through which relevant parties, for example carers or service providers, can seek a review of clinical decisions relating to the detention of a person for inpatient treatment.

### *Scope of the Issue*

At present, there is no mechanism for reviewing decisions made by medical practitioners not to detain persons under the Act. The Act does, however, allow for persons seeking *voluntary* admission to a DMHF to request that the medical superintendent of the facility review a decision by an AMO not to admit them voluntarily (s11). There is also no right under the current Act to appeal a decision to discharge a person detained in a DMHF.

In relation to the discharge of a patient or other detained person, s79 of the Act requires AMOs to take all reasonably practicable steps to ensure that:

- the patient,
- their primary carer,
- any dependent children or other dependents of the patient, and
- any agencies involved in providing relevant services to the patient,

are consulted in relation to planning the patient's discharge and any subsequent treatment.

The AMO must also take all reasonably practicable steps to provide the patient and their primary carer with appropriate information about follow-up care.

### *Extent of the issue*

The 2010-2011 MHRT Annual Report contains the most recent data on involuntary presentations to DMHFs, and states that 16,449 persons were taken to a DMHF involuntarily over the 2010/11 financial year. Of these persons, 11,915 (72.4%) were admitted involuntarily to a DMHF and 1, 112 (6.8%) were admitted as voluntary patients. That is, more than 79% of persons taken involuntarily to a DMHF were admitted for mental health treatment.

Detention and involuntary treatment places significant restrictions on a person's liberty and opportunities; therefore, it is vital that only persons who are assessed as being a serious risk are detained, and that strict and rigorous processes are put in place to minimise the risk of persons being detained and treated inappropriately.



Assessing clinicians are required to make a decision about whether a person is mentally ill or disordered as well as a prediction of the person's level of risk of harm to themselves or others based on the assessors own observations and the information available at the time of the assessment.

The review of the Act, therefore, is considering whether there should be a mechanism for the review of decisions not to involuntarily admit a person, or to discharge a detained person from a DMHF. A mechanism for reviewing clinical decisions may give consumers, their families, and the community greater reassurance that consumers who are at serious and immediate risk of harm to themselves and others are receiving appropriate and timely treatment.

There are a range of options for such a mechanism and the review seeks views on the most appropriate approach.

### *Potential methods of addressing any such issue*

The review of the Act will consider whether there should be a mechanism for the review of decisions not to involuntarily admit a person, or to discharge a detained person from a DMHF. There are a range of options for such a mechanism, including:

- Consideration of *legislative amendments*, such as:
  - amending the Act to allow relevant persons (e.g. primary carer, service providers) to request that the medical superintendent review a decision by medical practitioners not to involuntarily admit a person to, or to discharge a detained person from, a DMHF (this would potentially be similar to s11 in the Act, which allows a person to request that the medical superintendent review a decision by an AMO not to admit them as a voluntary patient or to discharge them as a voluntary patient);
  - amending the detention and discharge from involuntary care processes and requirements in the Act in such a way that would reduce barriers or impediments to appropriate detention and involuntary treatment of persons;
  - whether the assessing medical officers should be specifically required under the Act to seek and consider the views of carers, relatives, and service providers, where practicable, in determining whether a person should be detained or discharged;
  - whether the s27 assessment provisions in the Act should be amended such that an AMO must have certain qualifications or experience if undertaking the first Form 1 assessment (since if the AMO decides that the person does not meet the criteria for ongoing detention, the person must be discharged, and a second assessment of the person does not occur); or that if an AMO is not a psychiatrist, they must consult with a psychiatrist if they are proposing to discharge the person; or that a second Form 1 assessment must be conducted by a psychiatrist even if the AMO is of the view that the person must not be detained;
  - amending the CTO provisions to allow a community DMHF to involuntarily treat a person in the community while awaiting the development of a CTO application to the MHRT; and
  - amending the Act to allow certain classes of person a right of appeal to the MHRT against a decision by medical officers not to involuntarily admit a person to a DMHF, and a right of appeal to the MHRT against a decision to discharge a detained person into the community.

- Consideration of whether the issue might be addressed in a *non-legal manner*, for example:
  - By increasing the role and input of family and carers in the mental health assessment on persons presented to DMHFs (and also in discharge planning);
  - through improving and augmenting inpatient and community mental health resources;
  - through greater availability of expert psychiatric advice on such assessments; and
  - through amending and strengthening relevant existing policies or developing new policies if required.
- A combination of the above legislative and non-legislative methods, or an escalation process through a number of the above methods ending with an appeal to the MHRT.

### *Potential unintended consequences*

Consideration needs to be given to the potential for unintended consequences of the proposed changes:

- Holding a person pending a review or appeal outcome following a decision not to admit or discharge, may place significant restrictions on the person’s liberty, particularly if the outcome of the review confirms that the person does not meet the criteria for continued detention.
- Requiring a DMHF to hold a person pending a review or appeal outcome may have implications for bed availability and patient flow. It may result in other consumers (who may be viewed by treating clinicians as posing a higher risk of harm to themselves or others and therefore having a greater clinical need for inpatient treatment) not gaining access to, or being discharged prematurely from, the DMHF in order to accommodate a person subject to an appeal.
- In addition, there is a concern that such changes could result in unequal access for consumers to, and detention in, inpatient DMHFs based on the level of involvement and views of carers, family and other service providers in the person’s presentation at a DMHF. Such changes may result in increased detention of consumers with carers/family/service providers who are actively involved in their care, as these consumers may be more likely to be detained as a result of this appeal right than persons without such carers or who are brought in through other means (e.g. Schedule 1s). This may distort admissions and mean that persons who have a greater requirement for inpatient care are not admitted or are discharged prematurely because they do not have carers or family who would appeal.

### Questions

45. Do you think that concerns about non-admission and discharge are an issue that requires legislative and/or policy reform? Please provide reasons.
46. What do you think are the most appropriate means of addressing the issue? Why do you believe these are the most appropriate means?



47. If a mechanism for appealing decisions about non-admission and discharge was introduced, which independent body (or type of person/professional) should be responsible for hearing these appeals?
48. Are there any other comments you wish to make concerning this issue?

## 18. The Rights of Primary Carers

A number of carer groups have raised concerns around issues of carer rights and recognition in terms of the events and type of information that can be shared with both primary carers and other carers. Central issues of confidentiality and information sharing or disclosure raise the issue of rights of the consumer versus recognition and rights of the carer. Confidentiality is the cornerstone of all therapeutic relationships and is generally protected by law because of the public benefit in preserving confidentiality between a clinician and a patient.

Currently the Act states that certain information can be shared with a 'primary carer' but with the exception of young people between 14 and 18, certain information may still be withheld should the consumer wish (s72). A number of carer groups have requested that the type and detail of information accessible to them be extended and that, in some cases, this applies to 'un-nominated' carers or family members who may be affected, for example, by a consumer's discharge.

### 18.1. Nomination of primary carer

Sections 71 and 72 of the Act address the definition and nomination of a 'primary carer'. A primary carer has rights to certain information, including being notified of the consumer's admission, absconding, or discharge. A primary carer also has the capacity to approach an OV and be involved in discharge planning. The definition of 'primary carer' is detailed and may include the consumer's guardian, person nominated by the consumer, spouse, parent, or other relative or friend, or a person with a 'close and continuing' relationship with the consumer (s 71).

Whether voluntary or involuntary, upon admission to a MHF a consumer may nominate their primary carer, subject to a number of restrictions under s 71. In addition, a person subject to a CTO may also nominate their primary carer. If the consumer is too unwell to nominate a primary carer, they may be nominated by the AMO, and this may be confirmed or amended by the consumer when they are well.

### 18.2. Rights and recognition of primary carers and un-nominated persons

When considering what information should be given to primary carers, and other relevant persons, it is important to also consider issues of privacy and confidentiality. These are generally fundamental aspects of the health system but privacy and confidentiality may be overridden where there is a competing public policy or interest.

## *Provision of information to primary carers*

In accordance with s 79 of the Act, the primary carer is to be notified of the consumer's discharge from an inpatient facility. Some stakeholders have raised concerns about the type and extent of information provided to the primary carer at discharge being too generic. Staff report that primary carers are often only involved and informed when it is mandatory and at specific, limited times. It is proposed that more detailed information be provided to primary carers, including:

- advice on medication requirements
- non-pharmaceutical treatments or therapies
- future clinical or therapeutic appointments
- symptom monitoring
- strategies and contingency planning for acute episodes
- case managers and people to contact in case of emergencies

Some stakeholders have argued that more detailed information in these areas enhances support for the carer and consumer, and may facilitate a smoother transition to the community. The Act requires the MHF to consult with the primary carer about a discharge plan prepared for the discharge of the person from the facility. Section 79 (3) of the Act details discharge requirements in terms of planning discharge and follow up care and stipulates that an *'AMO must take all reasonably practicable steps to provide a ... patient...or person's primary carer with appropriate information as to follow-up care'*. This includes medication but could reasonably include the suggestions above.

This paper is seeking further feedback from interested parties regarding whether the Act currently allows for appropriate information to carers, if not why not, and whether the Act should be changed to increase the information given to primary carers.

## *Provision of information to those other than a primary carer*

Currently there is little guidance in the Act as to what, if any, circumstances the Act should permit or require disclosure of information to nominated carers, family members etc. *without* patient consent. This has been raised in relation to two issues in particular:

### **Absconding or discharge**

Some stakeholders have argued that a person other than the primary carer who may be affected by a patient's discharge or absconding have a right to be notified of such occurrences. Currently only primary carers have the right to information of events involving patients. This includes discharge, absconding or leave (s 78). Arguments in favour of this extension of rights seem valid should the consumer's care and integration back into the community be a variable or if the affected person wants to ensure that appropriate supports are available. For example, if that patient is going to be living with, or somehow requiring assistance or the liaison of follow-up care from, a person then it could be argued that the person should be notified of the patient's change in circumstances.

Family members may want information about discharge and leave approved for involuntary patients because, for example, they feel at risk or have fears of unwanted contact with the person. Currently such family members are advised to write to the Medical Superintendent of the relevant DMHF, to make them aware of their concerns, but there is no legal obligation to inform the family members of changes to the patient's circumstances.

## General information sharing

Stakeholders have also raised the issue that services will only communicate with the primary carer to the exclusion of other family members and have argued that the rights of primary carers should be extended to include them. It is not clear what *type* of information these stakeholders believe should be provided to family members. Unless a person is the primary carer, they do not currently have the right as specified in the legislation to receive the information about the consumer. The Act seeks to achieve a balance between consumer privacy and confidentiality and carer rights.

As discussed above, a consumer may also nominate persons who are excluded from receiving notice or certain types of information about the consumer (s 72(2)). An AMO or director of community treatment can revoke the nomination of a primary carer if they 'reasonably believe that the consumer, nominated person or any other is at risk of harm' or if 'the person who made the nomination was incapable' of doing so (s 72). Some stakeholders have argued (as above) that other family members or carers of persons who are placed at risk by the discharge of a consumer have a right to be informed.

Consideration must be given to the appropriateness or otherwise of extending some primary carer rights to family members, carers and/or other persons who have an ongoing relationship with the consumer. Consideration must also be given to the rights of the consumer to privacy, confidentiality and consent.

## *Provision of information to primary carers and family without patient consent*

On occasion carers and family (whether a primary carer or not) may become estranged from the consumer during the treatment process. Carers have expressed concern about this and have argued for their right to know if the patient is at least alive and still known to services. Currently this information would be withheld, unless the patient gave permission for it to be provided.

Although raising issues of privacy for the consumer, withholding this information from carers is not consistent with the intention of the Act which states in s68(j) that 'the role of carers for people with a mental illness or mental disorder and their rights to be kept informed should be given effect'. Information that details a consumer's contact with services but not their physical whereabouts may be a way to balance these competing needs.

### Questions

49. **What type of information relevant to follow-up care should be provided to the primary carer? Should the Act specify the types of information to be provided?**
50. **In what circumstances, if any, should the Act permit or require disclosure of information to persons affected by a patient's discharge (eg. absconding or leave)?**
51. **In what circumstances, if any, should primary carer rights be extended to other family members? What type of information should they be eligible to receive?**

52. In what circumstances should the Act permit or require disclosure of information to estranged carers and families without patient consent?
53. Are there any other comments you wish to make concerning the rights and recognition of primary carers?

## 19. Role of Official Visitors

Official Visitors (OVs) are appointed by the Minister (s128(1) and s129(1)) to visit people in mental health inpatient facilities in NSW and are available to assist consumers on CTO. OVs are independent from the health system and come from a range of cultural, professional and personal backgrounds. They aim to safeguard standards of treatment and care, and advocate for the rights and dignity of people being treated under the Act.

OVs make regular visits to all DMHFs across NSW. They talk to consumers, inspect records and registers, and report on the standard of facilities and services. They liaise with staff about any issues or concerns related to a consumer's safety, care, or treatment, and report any issues of concern to the Principal OV who in turn reports to the Minister.

OVs may act as advocates for consumers and families or, with permission, they can act to resolve such issues on their behalf. Consumers, carers, family, friends, staff and other people with an interest in the care and treatment of people with a mental illness can contact a nominated OV.

Section 129(3) describes four official functions:

- (a) to refer matters raising any significant public mental health issues or patient safety or care or treatment issues to the Principal official visitor or any other appropriate person or body,
- (b) to act as an advocate for patients to promote the proper resolution of issues arising in the mental health system, including issues raised by the primary carer of a patient or person detained under this Act,
- (c) to inspect mental health facilities as directed by the Principal official visitor and in accordance with this Part,
- (d) any other function conferred on official visitors by or under this or any other Act.

Other states in Australia have incorporated the definition and role of OVs in various ways. Most states have an equivalent of the NSW OV program; however, in Queensland the OV program operates under the Guardianship and Administration legislation, and in Victoria, OVs are responsible to the Public Advocate. In Western Australia (WA), the Draft Bill proposes a number of changes to the governance and administration of mental health in WA. The WA *Mental Health Review Board and Council of Official Visitors* will be replaced with a new *Mental Health Review Tribunal* and a *Mental Health Advocacy Service* for involuntary patients (including those referred for examination and some voluntary patients). The *Mental Health Advocate's* role is similar to that of OVs in NSW and previously in WA however the change of name reflects the proposed service's emphasis on personal advocacy rather than facility inspections. It is proposed that mental health

advocates will hear complaints, seek information from others and advocate appropriately (s 17; WA Draft Bill).

Under the proposed WA changes, the types of patients who can access advocacy support will be expanded to include referred persons and some voluntary patients. There will be a new requirement that every involuntary patient be contacted or visited by an advocate within seven days. The advocacy service will be led by a Chief Mental Health Advocate appointed by the Minister and its annual report will be tabled in Parliament ensuring a level of independence commensurate with the Principal OV. Special powers to access information are to be retained.<sup>21</sup>

## *Expanded Role of Official Visitors*

In terms of inspection rights (s 129 3c), the Act currently pertains to the role and rights of OVs *within* a MHF. This is also true for the WA and Victorian Acts. In WA, the draft Bill proposes an extension of the OVs role to include the inspection of authorised hospitals and licensed private psychiatric hostels to ensure that they are in a 'safe and suitable' condition.

In initial consultations the issue of extending OVs rights to monitor the care and treatment of consumers in medical wards (or those wards other than in a MHF) has been raised. Consumers have a right to receive quality care for any mental illness and/or physical illness, irrespective of the setting they are being treated in. It has been suggested that the legislation is amended so that an AMO is required to contact an OV if a consumer is mentally ill but being treated for medical issues in a general hospital ward so that the consumer has access to an OV.

In terms of advocacy, the Act currently enables OVs to act as an advocate for patients to promote resolution of issues arising in the mental health system. In addition to this role, it has been suggested that OVs could also assist patients to navigate the mental health system and to access community services. The majority of Local Health Districts (LHDs) presently employ consumer workers who can provide peer support and advocacy to consumers. OVs intimate working knowledge of the mental health system – gained through their experience assisting consumers to resolve issues arising in their care and treatment, also sees them well placed to do this.

## *Discussion*

Perhaps the broader issue is that the role of an OV needs to be clearly defined in terms of the nature and breadth of issues they report on. If the goal of quality care and best practice is foremost then the role of OVs is key, but needs to be clearly defined according to a systematic framework directly relevant to the mental health care of the consumer.

Currently, reports from OVs have included a wide range of issues in addition to quality of mental health care, including quality of food and the comfort of the environment. If it is the intention of the Act that 'consumer care, safety or treatment' is paramount then what are the appropriate areas of assessment and reporting? Is it the intention of the Act to legislate system response? In all States and Territories, OVs can report

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<sup>21</sup> Government of Western Australia, Mental Health Commission, *Explanatory Guide to the draft Mental Health Bill 2011*. December 2011, viewed on 18 August 2012

<[http://www.mentalhealth.wa.gov.au/Libraries/pdf\\_docs/Guide\\_to\\_the\\_draft\\_Mental\\_Health\\_Bill.sflb.ashx](http://www.mentalhealth.wa.gov.au/Libraries/pdf_docs/Guide_to_the_draft_Mental_Health_Bill.sflb.ashx)>

deficiencies but cannot hold a facility (medical or not) accountable. For example, in WA the Official Visitors Council has no power to require a facility to take action and requires advocacy at every level.

The role and scope of OV's needs to be more clearly defined in the Act. This particularly applies to governance and reporting pathways. One suggestion is closer liaison with the MHRT.

## Questions

54. **Should the role of the Official Visitors be expanded or more clearly defined? Please provide details.**
55. **Should Official Visitors have the right to monitor the care and treatment of consumers who are detained under the Act but admitted to wards other than a mental health facility?**
56. **What is the scope and best reporting pathways for Official Visitors? How can this be standardised?**
57. **Are there any other comments you wish to make concerning the role and responsibilities of Official Visitors?**

## 20. Role of Mental Health Review Tribunal

The MHRT is a specialist quasi-judicial body constituted under the Act. It has a wide range of powers that enable it to conduct mental health inquiries, make and review orders, and to hear some appeals, about the treatment and care of people with a mental illness.

The MHRT has a president, two full time and four part time deputy presidents, a registrar and approximately one hundred part time members. Other than for mental health inquiries which are generally conducted by a single legal member of the MHRT, each MHRT panel consists of three members: a lawyer who chairs the hearing, a psychiatrist, and another suitably qualified member. All MHRT members have extensive experience in mental health, and some have personal experience with a mental illness or caring for a person with mental illness.

The MHRT conducts hearings in hospitals and community health centres throughout the Sydney, Wollongong, and Newcastle metropolitan regions, and in Goulburn and Orange, and also conducts hearings for people living outside these areas either by video conference or by telephone.

### *Jurisdiction*

The MHRT has a wide jurisdiction, and conducts both civil and forensic hearings.



In its civil hearings, the MHRT may:

- conduct mental health inquiries and make Involuntary Patient Orders authorising the continued involuntary detention of a person in a MHF;
- review involuntary patients in mental health facilities, usually every three or six months, and in appropriate cases every 12 months;
- review voluntary patients in mental health facilities, usually every 12 months;
- hear appeals against an AMO's refusal to discharge an involuntary patient;
- make, vary and revoke CTOs;
- hear appeals against a Magistrate's decision to make a CTO;
- approve the use of ECT for involuntary patients;
- determine if voluntary patients have consented to ECT;
- approve surgery on a patient detained in a MHF;
- approve special medical treatment (sterilisation); and
- make and revoke orders under the NSW Trustee and Guardian Act 2009 for a person's financial affairs to be managed by the NSW Trustee.

The MHRT also reviews the cases of all forensic patients:

- who have been found not guilty by reason of mental illness;
- who have been found unfit to be tried; or
- who have been transferred from prison to hospital because of a mental illness.

The MHRT's decisions can involve the consideration of quite complex issues, and can impact directly on people's lives, health and liberty. In making its decisions, the MHRT seeks to balance several sets of often competing rights - the individual's right to liberty and safety and to freedom from unnecessary intervention, the individual's right to treatment, protection and care, and the right of the community to safety and protection.

## *Purpose*

The MHRT actively seeks to pursue the objectives of the Act. These are:

- to provide for the care, treatment and control of persons who are mentally ill or mentally disordered;
- to facilitate the care, treatment and control of those persons through community care facilities;
- to facilitate the provision of hospital care for those persons on a voluntary basis where appropriate and, in a limited number of situations, on an involuntary basis; and
- while protecting the civil rights of those persons, to give an opportunity for those persons to have access to appropriate care;

- to facilitate the involvement of those persons, and persons caring for them, in decisions involving appropriate care, treatment and control.

## Questions

58. **Should the Act be amended to further strengthen or clarify the role of the Mental Health Review Tribunal?**
59. **How can it be strengthened to further facilitate the objectives of the Act?**
60. **Should there be a formal relationship between the Official Visitor Program and the Mental Health Review Tribunal?**
61. **Are there any other comments you wish to make concerning the Mental Health Review Tribunal?**



# SUMMARY

This review will consider whether the policy objectives of the Mental Health Act remain valid and whether the terms of the Act remain appropriate for securing those objectives.

A variety of legislative issues, raised by a range of stakeholders, have been explored in this paper, including

- the principles that underpin the Act;
- how mental illness is defined under the Act;
- the rights of and processes for involuntary patients and the use of compulsory treatment;
- how to best provide greater opportunity and support for patients to participate in their treatment and care;
- the rights and role of primary carers and their families; and
- the role of the Official Visitors and the Mental Health Review Tribunal.

This paper does not put forward a proposed position but instead each chapter asks a number of questions, and interested parties are encouraged to provide feedback about the extent of each issue and the likely consequences of the changes that have been suggested by stakeholders.

Many of the issues raised are complex, and will evoke strong emotional responses.

At the heart of the process is the principle that people with a mental illness or mental disorder should receive the best possible care and treatment in the least restrictive environment enabling the care and treatment to be effectively given.

The Mental Health Act aims to clearly articulate the point at which the benefit for the mental health consumer and the community outweighs the restriction placed on the consumer's rights by the use of involuntary treatment.

Further information about the consultation process is outlined in section 1.3 of this paper, or can be found on the website – [www.health.nsw.gov.au/mhdao/review\\_nsw\\_mh\\_act\\_2007.asp](http://www.health.nsw.gov.au/mhdao/review_nsw_mh_act_2007.asp).



# REFERENCE WEBLINKS

## *International legislation*

### **Scotland**

<http://www.legislation.gov.uk/asp/2003/13/contents>

**Mental Health (Care and Treatment) (Scotland) Act 2003** - Section 299 Nurses power to detain pending medical examination

[http://www.legislation.gov.uk/asp/2003/13/pdfs/asp\\_20030013\\_en.pdf](http://www.legislation.gov.uk/asp/2003/13/pdfs/asp_20030013_en.pdf)

### **United Kingdom**

<http://www.dh.gov.uk/health/2011/07/mental-health-act/>

## *Australian legislation*

### **New South Wales**

<http://www.legislation.nsw.gov.au/viewtop/inforce/subordleg+553+2007+cd+0+N/?dq=Regulations%20under%20Mental%20Health%20Act%202007%20No%208>

### **Queensland**

<http://www.legislation.nsw.gov.au/sessionalview/sessional/subordleg/2007-553.pdf>

### **South Australia**

<http://www.legislation.sa.gov.au/LZ/C/A/Mental%20Health%20Act%202009.aspx>

### **Western Australia**

[http://www.mentalhealth.wa.gov.au/mentalhealth\\_changes/mh\\_legislation.aspx](http://www.mentalhealth.wa.gov.au/mentalhealth_changes/mh_legislation.aspx)

### **Victoria**

<http://www.health.vic.gov.au/mentalhealth/mhactreview/>

