Mental Health Bill 2007

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Extract from NSW Legislative Assembly Hansard and Papers Wednesday 9 May 2007.

Agreement in Principle

Mr PAUL LYNCH (Liverpool—Minister for Local Government, Minister for Aboriginal Affairs, and Minister Assisting the Minister for Health (Mental Health)) [7.50 p.m.]: I move:

That this bill be now agreed to in principle.

I am pleased to bring before the House the Mental Health Bill 2007. This bill is the culmination of an extensive consultation and review process commenced by the Government in 2003. Members will be aware that the Mental Health Bill 2006 was introduced in this House by the then Minister Assisting the Minister for Health (Mental Health) in November 2006. The second reading speech on that bill provides detail about the history of the review of the Act, its focus and some of the key provisions in this new piece of legislation. There is, I think, no need to revisit in detail the matters canvassed in the Minister's speech on the history leading up to the introduction of this important piece of legislation. I pay particular regard to the former Minister for the extraordinary role that she played in public consultation to get the bill to this point.

In introducing the Mental Health Bill 2007 it is appropriate that I restate the Government's commitment to mental health services, with this legislation remaining one of the keystones to supporting ongoing improvement and reform of these services. Whilst endorsing the comments made during the second reading speech in November last year, it is also appropriate that I outline again for the benefit of the House the aims and focus of the bill, and some of its key provisions. I will also outline some minor amendments to the bill that have occurred since its introduction last year.

The changes included in the new bill have as their focus a number of key reforms. These include a new part drawing together the key objects and patient protection provisions, including new provisions containing "principles of care and treatment"; recognition of the role of carers and patients, and recognition of their right to information and to be involved in care and treatment decisions—this addresses one of the main issues raised in the review, which was to enable the sharing of relevant information with patients and their carers, and support the involvement of both patients and carers in treatment decisions—and clarification of transportation provisions and the role of police to balance law enforcement and mental health priorities.

This aims to provide a more structured approach to admission and transport. The changes will also allow ambulance officers to take people who appear to be mentally ill to a hospital for treatment. The power will not be open ended but will be limited to where the ambulance officer is treating a person and providing ambulance services and where that officer has been authorised to make detention decisions.

Training and support for ambulance officers will be critical to ensure that they can safely and effectively perform this role. As such, the Ambulance Service will ensure that necessary training occurs as part of the authorisation process.

New, more detailed transportation provisions have been developed for the new bill. The new provisions aim to emphasise that NSW Health will take primary responsibility for patient transports, with requests for police involvement to be limited to where there are serious concerns about patient and/or staff safety. The revision of "prohibited treatment" provisions to include psychosurgery is another provision in the legislation. The bill lists a number of prohibited treatments that will not be permitted in New South Wales. These are deep sleep therapy, insulin coma therapy and psychosurgery. The definition of psychosurgery has been revised. It was crucial that the ban on psychosurgery did not prevent treatment and research into other debilitating medical conditions. The definition, therefore, allows the listing in the regulations of the medical conditions or illnesses for which treatment may be provided.

The legislation also features the streamlining of provisions relating to treatment in the community. This will be done by consolidating the current two orders into a single community treatment order that can be initiated while in care or in the community and allowing those orders to run for 12 months. One concern expressed by submissions on a single order was to ensure that appropriate criteria were used and to ensure that the person subject to the order would have a reasonable and proper opportunity to challenge its being made. To this end the bill provides for people in the community to be given 14 days notice of an application for an order. The test for issuing an order will be the same whether a person is in the community or detained in a facility, although their personal circumstances will, of course, be relevant to the order. Legal representation will be available, as with current processes, but a failure to attend on the notified date will allow an order to be issued in the person's absence. Orders will be able to be made by the tribunal or by a magistrate.

I turn now to clause 150 of the bill. Under the 1990 Act the tribunal is required to be constituted by three members, irrespective of the nature of the matter before it. This means that a full panel must be constituted for what are very often simple interlocutory matters, such as listing arrangements, arranging or changing venues, noting representation and simple adjournments. Clause 150 of the bill creates flexibility to allow simple matters such as these to be dealt with by a legal member of the panel—that is, the president, a deputy-president or another appointed lawyer—sitting alone.

The Government recognises that one-person panels should be limited to these minor and administrative matters and that it is important to ensure transparency in how decisions on constituting the panel are reached. The Government therefore proposes, in consultation with the tribunal, to develop regulations using the powers in clause 150 (5) to ensure that a full three-person panel sits where substantial or contested matters come before it. That is, the Government intends that the single member will be used only in procedural matters. There is the possibility that it might be extended to a very restricted class of emergency situations. That will be the subject of further discussion. It is also important to emphasise that these changes

do not affect the constitution of the tribunal in forensic matters. The provisions in relation to forensic patients have been retained and will continue to require the panel to be fully constituted by the president or a deputy-president, a psychiatrist and another suitably qualified member in forensic reviews.

The bill I now bring before the House generally reflects the 2006 bill but has been slightly revised and finetuned. For example, under the 1990 Act a range of different functions were allotted to a range of different offices, including the Director General, the Chief Health Officer, authorised officers appointed by the Director General, medical superintendents and medical officers working in the facility. The 2006 bill simplified these provisions. Other roles were designated functions of the Director General, largely replacing the old concepts of authorised officer. In operational practice there will be no change as the officers who are currently appointed as authorised officers will continue to exercise the function via a formal delegation from the Director General.

In the period since the 2006 bill was introduced, however, a number of additional references have been identified as needing to be changed to the Director General in keeping with this policy. This includes references to the Chief Executive Officer of the Ambulance Service in clause 4 and references to the authorised medical practitioner in chapter 4. Some minor changes have also been made as to who can approve forms used under the legislation. Currently, forms can be made by regulations or can be approved by the Minister. Changes have been made in the 2007 bill to allow the president of the Mental Health Review Tribunal to approve forms used by the tribunal.

The 2006 bill also limited the public facilities which could be gazetted as declared psychiatric facilities to premises of an area health service under the Health Services Act. There are, however, additional public facilities this terminology does not cover such as Justice Health and the Children's Hospital at Westmead. Both of these premises are statutory health corporations. The language of clause 109 has, therefore, been revised to refer to public health organisations, a term that covers all public facilities listed in the Health Services Act.

A limited number of changes have also been made to restore some aspects of the forensic provisions in the 2006 bill, taking them back in line with the 1990 Act. The main changes in this regard change the period of time in which a forensic patient must be reviewed from 12 months back to six months, as it is in the 1990 Act. The period of time between reviews is a matter that will be considered by the current forensic review. The 2006 bill also provided the Director General with a right of appearance when the tribunal is reviewing forensic matters. This marked a change from the current system where the government does not have any express right to appear. Such a right would be relevant if there were no executive discretion, and the tribunal or another judicial body made final decisions on release. However, the question of whether the executive discretion should be retained or not is still pending the outcome of the forensic review. The right to appear provision, therefore, has been removed in the 2007 bill so that the provisions reflect the current scheme in the 1990 Act. To leave the provision in there would have pre-empted the results of the review. I commend the bill to the House.