Legislative Assembly Hansard (Extract)

Mental Health Bill

Extract from NSW Legislative Assembly Hansard and Papers Wednesday 22 November 2006.

Second Reading

Miss CHERIE BURTON (Kogarah—Minister for Housing, and Minister Assisting the Minister for Health (Mental Health)) [10.22 a.m.]: I move:

That this bill be now read a second time.

I am pleased to bring before the House the Mental Health Bill 2006. The bill is the culmination of an extensive consultation and review process commenced by the Government in 2003. The bill also represents an important step in the Government's commitment to take the delivery of mental health services in a new direction. In 2006-07 the Government committed a record $946 million in recurrent funds to mental health services. An additional $939 million over five years has also been committed to improve mental health services and recruit staff throughout New South Wales. The Government is also mindful of the need to ensure that we have appropriate legislation in place to support the reforms we are making to the mental health system. The bill will ensure that we have a modern Mental Health Act, which is up to date and responsive to consumer, carer and mental health workers' needs.

The Mental Health Act has been operational for 15 years and remains largely as passed in 1990. Over those years there have been changes in the New South Wales health system—changes in the way mental health services are organised and provided. There have also been new regulatory developments, such as privacy laws, which have directly impacted on the legislation. Given these changes, the Government took the Act to the community to consider how it can be made more effective and more responsive to the current needs of patients and the community. In my previous role as Parliamentary Secretary to the then Minister for Health, now the Premier, I was proud to be part of the first comprehensive review of the Act. I note that in commencing the review the Government found great assistance in the work of the parliamentary Select Committee on Mental Health, which reported to Parliament in December 2002. The report of the committee represented a detailed picture of community concerns in relation to mental health services and provided an important context for the reform of the Act.

Seeking the involvement of the community has always been a key feature of legislative reform in this area. Each stage of the current review has been marked by extensive periods of public comment and discussion. First, in December 2003 before formally commencing the review, the Department of Health sought the views of stakeholders on the issues to be included in the review. In February 2004 the Government released the first discussion paper, "Carers and Information Sharing and the Operation of the Mental Health Act" with a call for submissions on the issues raised there. The review's second discussion paper was released in July 2004 and this major paper focused on the provisions of the Mental Health Act and again sought detailed submissions from the community.

I am happy to say that over the period following the release of the final discussion paper and throughout 2005 I was also able to obtain direct feedback on concerns and comment about the Act through a series of visits I conducted to mental health facilities around New South Wales—one of the largest community consultation processes ever undertaken across metropolitan and rural New South Wales. These meetings were attended by key stakeholders in mental health, including consumers, carers, public system staff and non-government service providers, and provided further opportunity for members of the community to have their say in the reform process.

In August this year I released the draft exposure Mental Health Bill 2006 report on the Mental Health Act, and with it the report on the review of the Mental Health Act. To ensure the bill addresses the issues identified in the review, a further round of consultation has been conducted. The feedback from the final round of consultation has been positive, with strong support for the main provisions of the bill. I am confident that the comprehensive consultation process has ensured that the Government has been able to address key concerns about the rights of consumers and carers and how best to ensure the legislative structure supports good and effective service delivery.

The positive feedback on the exposure draft bill is encouraging, with more than 50 submissions received. There have also been valuable comments on issues that need to be revised or amended. All the issues raised were carefully considered and have been incorporated where appropriate. Key areas of change include recognition and inclusion of carers in treatment decisions and plans, more flexible community treatment orders, a focus on interdepartmental co-operation and information sharing and an enhanced role for ambulance officers and health personnel in the admission and transport of patients. I am grateful so many people and organisations

contributed to the development of this important legislation. The extent and quality of the submissions reflect the degree of community interest in the care and treatment of people suffering from mental illness. This legislation has benefited greatly from the valuable contributions made by carer and consumer organisations, members of the community and health professionals.

The reform agenda for the Act has been guided by the establishment of important goals that have received widespread support from the community and health professionals. First, there is the recognition and support of the greater participation of carers, families and friends. The legislation does this by providing for the sharing of information relevant to the care and treatment of the patient so that carers can be notified when patients are admitted, transferred, absent or discharged. The bill provides a balance between the consumer and carer interest by providing consumers with the right to nominate or exclude persons as a primary carer. Second, there is the increased use of specialised ambulance services to transport people to and from facilities. Third, there is the development of sufficient flexibility in the legislative scheme to accommodate future changes and enhancements in service delivery. As I have already indicated, the Government realises that the legislative reform alone will not provide the necessary services and facilities that are required in New South Wales. So, we have announced a new direction in the delivery of mental health services, backed by a historic funding package to compliment our reforms to the Mental Health Act.

I will now take the House through some of the key reforms of this bill in more detail. Part 1 of chapter 4 of the bill establishes a new part entitled "Rights of Patients or Detained Persons and Primary Carers". This part draws together existing rights from the 1990 Act and expands them. In particular, clause 68 establishes principles for care and treatment. These principles identify principles that should be given effect to in care and treatment. These principles include assisting people with mental illnesses or disorders to live, work and participate in the community; ensuring the prescription of medicines for therapeutic purposes alone, recognising the age, religious and cultural needs of people with mental illnesses and involving patients in decisions about treatment. This part also addresses one of the main issues of the review: enabling relevant information to be shared with patients and their carers and supporting the involvement of both patients and carers in treatment decisions.

Recognition that carers and family members need greater access to patient information was one of the key issues arising from the Parliamentary Select Committee on Mental Health Services. The submissions to the review recognised the importance of carers, including family members, being given access to information that would assist them in providing care. However, many submissions were concerned to ensure that a patient is given some capacity to control who is to be considered a carer. Clauses 71 and 72 of the bill seek to balance these views by allowing a person to nominate a particular person to be their primary carer for the purposes of receiving information, allowing a person to identify persons whom they do not wish to have identified as the primary carer, and establishing a process for identifying who will be a carer when there is no nomination. The definition begins with a person's guardian and moves down the list of persons who may provide carer support to a patient.

Clauses 75 and 78 set out what type of information can be provided to the identified primary carer. Most importantly, Clause 79 provides for health service providers to take steps to involve both the patient and the carer in discharge planning discussions. In addition, the patient's statement of rights has been incorporated into the Act. As I have already indicated, the community consultation highlighted strong support for enhanced co-ordination of service provision by different agencies. The quality and relevance of these services can be improved if agencies work co-operatively, not only with the patient but also with each other. While this sort of co-operation must be developed by interagency liaison and cannot be legislated for, the bill contains a number of provisions designed to enhance co-operation between agencies. These include providing for health services to consult with other agencies when making discharge decisions. In clause 106 the administrative functions of the Director-General of the Department of Health have also been expanded to include assisting in promoting co-operation between different agencies involved in the provision of ongoing care or other services.

Another area where there was strong support for action was to amend the 1990 Act's provisions to provide a more structured approach to admission and transport and to allow ambulance officers to take people who appear to be mentally ill to a hospital for treatment. There was strong support from submissions to this proposal, which recognises that ambulance officers are likely to encounter persons who may need treatment for a mental illness. Adding them to the categories of people who can authorise involuntary admissions also brings New South Wales into line with other States. The power will not be open ended but will be limited to where the ambulance officer is treating a person and providing ambulance services, and where that officer has been authorised to make detention decisions. This last point reflects that the training and support for ambulance officers will be critical to ensure that they can safely and effectively perform this role. As such the ambulance services will ensure necessary training occurs as part of the authorisation process.

In line with proposals in discussion paper two, new express transportation provisions have been developed for the new bill. The new provisions are aimed to emphasise that New South Wales Health will take primary responsibility for patient transport, with requests for police involvement to be limited to where there are serious concerns about patient and/or staff safety. The bill also makes some changes to provisions dealing with treatment in the community. The most significant of these is to consolidate the current community counselling

orders and community treatment orders into a single order that can be issued while the person is in a mental health facility or living in the community. The main concern expressed by submissions on a single order was to ensure appropriate criteria were used and to ensure that the person who is subject to the order would have a reasonable and proper opportunity to challenge it being made. To this end, the bill provides that people in the community will 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 the current process, 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. Other changes made to the community treatment provisions include extending the maximum possible period of an order from 6 to 12 months. This option has been developed for clients with an ongoing illness that has been successfully managed in the community for some time. While it is envisaged that the six-month time period will remain the standard, the new provision will give the tribunal flexibility to make longer orders for suitable clients. Included in clause 61 is an express requirement that a person who is admitted to hospital as a result of breaching the order must be reviewed within 12 hours of arrival. This brings these provisions in line with the 12-hour timeframe imposed on the review of general and voluntary admissions, and ensures that a person's admission as an involuntary patient will not automatically revoke the order. This will allow the clinician in the admitting facility to assess if a person could be discharged on the existing order.

The bill includes provisions to regulate the use of electro-convulsive therapy [ECT]. There is a marked divergence of views in the submissions in relation to the use of ECT. Consumers in the community have strong concerns about the use of this treatment. Clinicians emphasise the effectiveness of the treatment for patients, particularly those for whom no other effective treatment has been found. The new bill carefully balances these concerns by continuing the requirement that ECT be strictly controlled and monitored. The number of treatments allowed has been limited in line with guidelines issued by the Royal Australian and New Zealand College of Psychiatrists. It provides very stringent requirements for ensuring that a person's informed consent is obtained. For involuntary patients, the treatment is permitted only after an inquiry by the tribunal. The treatment must be a reasonable and proper treatment, necessary or desirable for the safety or welfare of the patient.

In these circumstances the tribunal is able to approve 12 treatments. Additional treatments may be approved only in special circumstances, including where the treatment has been successful in the past. The bill also 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. New and innovative techniques and procedures in the field of neurosurgery, such as deep brain stimulation, have emerged for treatment and relief for persons suffering from Parkinson's disease, epilepsy, tremor disorders and chronic pain. It was critical that the ban on psychosurgery did not prevent treatment and research into treatment for these debilitating conditions. The definition therefore allows the listing in the regulations of the medical conditions or illnesses for which treatment may be provided.

A limited number of changes will also be made to the provision supporting the New South Wales Official Visitors program. The changes are designed to enhance the operation of the program. For example, clause 129 (3) provides Official Visitors with specific capacity to refer matters raising significant issues of public health or safety or a significant question as to the appropriate care or treatment of a client to authorities such as the Health Care Complaints Commission. Clause 134 explicitly recognises the right of both patients and carers to contact an Official Visitor to raise issues of concern for them, their family member or friend. Under the 1990 Act at least one Official Visitor conducting each visit had to be a medical practitioner. That has been varied and clause 129 now provides for a broader range of clinically qualified visitors. The provision recognises persons who are registered as medical practitioners and psychologists and permits adding further qualifications by regulation. This reflects the fact that a range of other professional groups will be equally capable of identifying health issues that may arise during a visit.

At the beginning of my speech I referred to the manner in which service provision has changed since the 1990 Act commenced operation. It is also clear that service provision has moved away from the structural system of care that was established in 1990. The current Act was based on a system where persons will only be provided involuntary care and treatment in large standalone gazetted units or through separately authorised health care agencies that administer community treatment orders. At an operational level, however, mental health services are increasingly being mainstreamed into the general health system, with services provided through a range of institutional and community settings. In addition, given that specialist mental health treatment units do not have general medical facilities, many patients now arrive via general hospital emergency departments due to presentations involving a range of medical and psychiatric issues.

The process under the 1990 Act for gazetting mental health facilities is, however, limited both in the recognition it can give to differing care models and in supporting the development of new models in the future. The draft exposure overhauls this process by making it flexible enough to recognise and support these developments in service provision while retaining a mechanism for accountability and oversight of involuntary care and detention. The revised provision in clause 109 will allow the Director-General to authorise and gazette classes of facilities.

This may include classes that are designed to provide ongoing inpatient care and treatment, and classes that provide community treatment or new classes, such as, psychiatric emergency care centres or short-term assessment centres.

The outline I have given to this point focuses on the key changes to the 1990 Act, which are included in the 2006 bill. It is important to note that the review also identified strong support for many of the existing structures and procedures. In particular, there was strong support for the retention of the current review and oversight process that operates through magistrates' inquiries and the Mental Health Review Tribunal and for the retention of the role of the Supreme Court. These processes have been retained intact. It is also important to note that the work on the mental health legislation will not end with the passage of this bill. As honourable members will be aware, the Government has asked the President of the Mental Health Review Tribunal, the Hon. Greg James, QC, to conduct a review of the provisions relating to forensic patients concurrent with a review of the administrative practices and procedures of the tribunal. Both of these reviews will be completed by August 2007.

The administrative review will examine current administrative practices and procedures of the Mental Health Review Tribunal with a view to enhancing the quality of decision-making and the efficient and economic operation of the tribunal. It will also look at the role of the tribunal within the broader forensics system. The provisions relating to the oversight review and release of forensic patients are contained in chapter 5 of the Mental Health Act 1990. These provisions were subject to review in Discussion Paper 2. During the consultation process a range of options and issues for reform arose in this area. The Government decided to request the president of the tribunal to further examine these options with a view to making final recommendations in this area.

The forensic review will look at a range of matters, including the appropriate authority or person to make decisions about the care, treatment and control of forensic patients, mechanisms for ensuring issues of public safety are properly considered, and the role of victims of crime and the means by which their views and concerns are addressed. Once the forensic review has reported its recommendations, the Government will further consider how best to proceed in this area. I wish to emphasise the improvements in mental health clinical care. The treatment of sufferers of mental illness in their interactions across the spectrum of all public services has been and remains a high priority for the Government. I commend the bill to the House.