Review of the NSW Mental Health Act 2007

Report for NSW Parliament: May 2013

Summary of Consultation Feedback and Advice
Acknowledgement


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.
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# SUMMARY OF REVIEW OUTCOMES

This table presents a high-level summary of the issues and review outcomes that are detailed within this report.

## GENERAL CONSENSUS THAT NO LEGISLATIVE CHANGE IS REQUIRED

<table>
<thead>
<tr>
<th>4 (a). Definition of mental illness</th>
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<tbody>
<tr>
<td>Section 4 defines ‘mental illness’.</td>
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<tr>
<td>It appears that the definition of mental illness is appropriate and no changes to the Act are suggested.</td>
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## GENERAL CONSENSUS THAT SOME LEGISLATIVE CHANGE MAY BE REQUIRED

<table>
<thead>
<tr>
<th>1. Objects and principles</th>
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<tbody>
<tr>
<td>The first object of the Act is:</td>
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<tr>
<td>‘to provide for the care, treatment and control of persons who are mentally ill or mentally disordered’.</td>
</tr>
<tr>
<td>It may be appropriate to amend the Act:</td>
</tr>
<tr>
<td>• by removing the word ‘control’ from the objects (s3) and title of the Act and replacing it with terms such as ‘protection’, ‘detention’ and/or ‘involuntary treatment’.</td>
</tr>
<tr>
<td>• by adding a term which encapsulates the ‘recovery-focused care’ principle in the principles of care and treatment within the Act.</td>
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<tr>
<th>4 (b). Definition of mental illness – exclusion criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under s16, certain words or conduct may not indicate mental illness or disorder, e.g. where the person has a developmental disability of mind.</td>
</tr>
<tr>
<td>Consideration could be given to amending the exclusion criteria under s16 (j) to reflect contemporary language such as ‘the person has an intellectual disability or developmental disability’.</td>
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<thead>
<tr>
<th>6. Mental health review tribunal orders delaying discharge of persons</th>
</tr>
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<tbody>
<tr>
<td>When considering an appeal against a refusal to discharge a person, 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 community treatment order (CTO), nor can it delay a person’s discharge under the current wording in the Act (s 44(4)).</td>
</tr>
<tr>
<td>It may be appropriate to amend the Act to allow the MHRT, at an appeal hearing against a refusal to discharge a detained person, to be able to make a CTO or to defer the discharge of the person for up to 14 days.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>7. Discharge after making a community treatment order</th>
</tr>
</thead>
<tbody>
<tr>
<td>The MHRT is required to review each person who has been detained in a DMHF to determine whether their ongoing detention is warranted. There is no power to delay discharge when a CTO is made if the patient does not agree to stay as a voluntary patient (s41).</td>
</tr>
<tr>
<td>It may be appropriate to amend the Act to allow the MHRT, when making a CTO in relation to a detained person, to delay the person’s discharge for up to 14 days where it is in the person’s best interest.</td>
</tr>
</tbody>
</table>

<table>
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<tr>
<th>8. Review by the mental health review tribunal at least once every 12 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under s9, 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.</td>
</tr>
<tr>
<td>It may be appropriate to amend the Act to include a requirement that voluntary patients must be reviewed at least once every 12 months of continuous voluntary and involuntary residence in mental health facilities.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>14. Detention on order of a magistrate or police officer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Where a person has been brought to the DMHF for assessment by a police officer under s22, and the DMHF does not consider that the person meets the criteria for involuntary treatment, the facility can only detain the person for a period not exceeding one hour pending the person’s apprehension by a police officer (s32(4)).</td>
</tr>
<tr>
<td>It may be appropriate to consider amending s32(4)(a) to extend the length of time that a mental health facility may detain the person pending the person’s apprehension by a police officer, from ‘a period not exceeding one hour’ to the minimum time possible but a period not exceeding two hours.</td>
</tr>
</tbody>
</table>
### 15. Detention of voluntary inpatients

Under s 10(1), an AMO may detain a voluntary patient if the officer considers the person to be a mentally ill or disordered person. The Act does not allow for a voluntary patient to be held pending the AMO’s assessment. However, a Schedule 1 assessment could be undertaken by an AP.

It may be appropriate to amend the Act to permit the senior nurse on duty to hold a person for up to two hours while awaiting either a Schedule 1 assessment to be undertaken or for an AMO to cause the person to be detained under s10, with a requirement for the nurse being able to demonstrate that they are trying resolve the situation as soon as practicable.

### GENERAL CONSENSUS THAT FURTHER TARGETED CONSULTATION MAY BE APPROPRIATE

#### 2. Decision making capacity and supported decision making

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

It may be appropriate to undertake further consultation that includes in-depth analysis of the possible models of involuntary provision of treatment, the possible unintended consequences of any changes, and the likely resource implications; and monitoring and evaluation of the implementation of a supported decision making model in other jurisdictions to inform any future possible approach in NSW.

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

The Act has provisions providing for a substituted consent regime for non-mental health treatment, particularly surgery. However, these provisions are inconsistent and vary depending on the status of the detained person.

It may be appropriate to undertake further consultation that includes discussion of the potential consequences of a move to align the provisions of the Mental Health Act and the Guardianship Act, particularly in relation to a mentally ill person’s decision to refuse potentially life-saving treatment.

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

Section 27(a) deals, in part, with the initial examination by an AMO of a person detained in a DMHF. If, after the AMO’s examination (first Form 1), a person is found to be neither mentally ill nor mentally disordered, the person must not be detained.

The Act does allow for persons seeking voluntary admission to a MHF to request that the medical superintendent of the facility reviews a decision by an AMO to refuse admission or discharge (s11).

It may be appropriate to undertake further consultation that includes whether it would be appropriate to amend the Act such that:
- where a decision has been made to not involuntarily admit a person, that a psychiatrist or the medical superintendent must undertake an additional assessment of the person where a carer or service provider makes such a request; and/or
- where the first Form 1 has been completed by an AMO who is not a psychiatrist, and where they have come to the conclusion that the person does not meet the criteria for detention under the Act, a further Form 1 must be completed by a psychiatrist.

#### 9. Initial involuntary treatment in the community

Involuntary treatment in the community, in the form of CTOs, can only be authorised by the MHRT. 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.

It may be appropriate to undertake further consultation that includes:
- whether the MHRT should be able to waive the 14 day notice period for urgent CTO applications.
- Consideration should be given to establishing appropriate timeframes for the MHRT to hold reviews of urgent CTO applications and that consideration be given to whether these reviews can be held in such a timely fashion that the issues raised in the discussion paper are effectively addressed.
- That, if the above MHRT proposal does not effectively address the issues raised in the discussion paper, consideration be given to the development of an initial involuntary community treatment regime that operates on a similar basis to initial involuntary inpatient treatment.

#### 10. Role of the mental health review tribunal

Section 27(d) includes: “The person must be brought before the Tribunal as soon as practicable after admission (subject to meeting the requirements set out above).”

It may be appropriate to undertake further consultation that includes:
- whether the proposal that the MHRT and OVs should be able to refer matters to each other warrants further investigation, noting that there are other mechanisms under...
In practice, the MHRT generally conducts a mental health inquiry about two weeks after the person is admitted to a MHF.

### 11. Role of the official visitors

Official Visitors (OVs) are involved in the advocacy and care of people under the Act who receive treatment at a MHF. (Chapter 5). This includes raising issues of patient safety, care or treatment, and advocacy on behalf of the patient in relation to issues arising in the mental health system.

OV Program inspection rights under the Act currently pertain to MHFs only.

It may be appropriate to undertake further consultation that includes:

- whether it is appropriate to allow OVs to inspect non mental health facilities where persons who have been detained under the Act are receiving non-mental health treatment. This should include analysis of the financial implications of any such changes.
- whether it is appropriate to amend the Act to provide more direction as to the role of the OVs and the types of issues that the OVs should consider when undertaking inspections of DMHFs to ensure that OVs are fulfilling functions in accordance with their role as an independent investigative and governance mechanism over the mental health system.

### 12. Initial assessment for involuntary detention

Under s19, an AP can complete a Schedule 1 allowing a person to be taken to, and initially detained in a DMHF for assessment.

Only medical practitioners can complete the Form 1 which allows for a person’s continued detention and involuntary treatment at a DMHF.

It appears to be appropriate to retain the requirements for Form 1s to be completed by an AMO only. However, it may be appropriate undertake further consultation about whether the Act should be amended to allow an AMO from another mental health facility within the same LHD to complete the first Form 1 in exceptional circumstances where an AMO is not available at that facility within the initial 12 hour period of detention or whether there are alternative solutions to this issue.

### 13. Transport of persons for assessments

Currently, Form 1 assessments can only occur in a DMHF (s27). 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.

It may be appropriate for further analysis and consultation to be undertaken on this issue, particularly in relation to determining a preferred mechanism(s) to address the concerns raised during the consultation process, including the potential cost implications of any such proposal, the level of involvement by relevant agencies in providing relevant services, as well as to the minimum requirements that would need to be met for a facility to be involved in any such proposal.

### 16. Community treatment orders

There is no requirement in the Act that the affected person be a mentally ill person for a CTO to be made by the MHRT.

It may be appropriate to undertake further analysis and consultation in relation to this issue with a view to determining whether legislative change to the criteria for granting CTOs is warranted.

### 17. Private mental health facilities detaining and involuntarily treating person under the Act

Under the Act, persons may only be detained and involuntarily treated in DMHFs. Private mental health facilities (PMHF), which are granted licences to operate as such by the DG under s115, may also operate as DMHFs. Currently, no PMHFs are DMHFs.

It might be appropriate to undertake further analysis and consultation in relation to whether there is a need to amend the Act to further promote the capacity for PMHFs to be DMHFs; and/or specify any requirements that PMHFs need to meet before they can become DMHFs; and/or specify any restrictions that should be placed around PMHFs that are also DMHFs.

### 18. Review of treatment planning and medication

Section 68(h) provides that every effort that is reasonably practicable should be made to involve consumers in the development of treatment plans and plans for ongoing care.

It may be appropriate to undertake further consultation on this issue, including whether to amend the Act to require carers and consumers to be consulted prior to a CTO being discontinued or revoked; require the MHRT to be advised when a CTO is revoked; and establish a requirement for formal six-monthly review of treatment including CTOs.
19. **Consumer engagement in the development of treatment plans**
It has been suggested that the process of engaging consumers in the development of treatment plans could be beneficial. Advance Care Directives (ACDs) (advance statements/agreements) and could potentially apply to ongoing treatment decisions in a mental health context.

It may be appropriate to undertake further consultation on this issue, including whether the legislation should be amended to require that each consumer is to have a treatment plan that is regularly reviewed, and whether treating teams and the MHRT should be required to have regard to these plans in making decisions about the patient’s care and treatment.

20. **The rights of primary carers**
A primary carer must be appointed for each consumer receiving care and treatment under the Act. The primary carer can either be nominated by the consumer or, in certain situations, appointed according to conditions outlined in s71-72. Currently, other carers, such as family members or loved ones, do not have rights to any form of information except if the consumer agrees for information to be provided or if the medical officer believes that they may be at risk (if a patient absconds and there is an Apprehended Violence Order (AVO)).

It may be appropriate to undertake further consultation to consider whether to amend the Act to:
- explicitly permit up to two people to be nominated as the primary carer, including a child/adolescent acting as a young carer;
- consider differentiating between different types of carer and support people;
- clarify the types of information that each group should receive; and
- (re)name each role with a relevant title.

21. **Children with mental illness**
Children can be admitted involuntarily under the Act in the same way as adults. There are, however, some specific provisions that relate to the voluntary admission and treatment of children. The primary carer of a child is generally the parent. Where the child is over the age of 14, they may nominate someone other than a parent as their primary carer. Children generally have the same rights as adults under the Act.

It may be appropriate to undertake further consultation regarding whether the principles for care and treatment should be amended to express the preference for children and adolescents to be treated by a Child & Adolescent (C&A) psychiatrist and/or in a C&A unit, and whether greater emphasis should be given in the principles for care and treatment to providing treatment that is appropriate to the consumer’s age and cognitive development. It may also be appropriate to consider the inclusion of a provision in the Act which provides legal representation for all children (16 years and under) when they are subject to a MHRT hearing.

22. **Electroconvulsive therapy for children**
Under the Act, the same rules for consent to electroconvulsive therapy (ECT) treatment apply to children under the age of 18 as they do to adults.

It may be appropriate to undertake further consultation regarding whether ECT should remain a treatment option for children (i.e. no age restriction) and the appropriateness of a requirement for assessment by C&A psychiatrist, preferably with experience in the use of ECT, when ECT is proposed for any child aged 16 years or under.

23. **Declaration of financial interest**
The Act requires that any financial relationship between the medical practitioner proposing and administering ECT and the facility be disclosed to the patient.

It may be appropriate to undertake further consultation on whether, and how, the requirements for declaration of financial interest by medical practitioners prescribing and administering ECT should be amended to address the practical implication issues.

24. **Psychosurgery**
Psychosurgery is a prohibited treatment under the Act.

It may be appropriate to undertake further consultation on this issue, including:
- whether psychosurgery should be renamed ‘neurosurgery for mental disorders’ and non-ablative brain stimulation techniques should be excluded from the definition of this term;
- whether the Act should continue to prohibit ablative neurosurgery and whether to allow non-ablative brain stimulation techniques with robust regulation and oversight and mandatory informed consent by the patient;
- whether a review process similar to the previous Psychosurgery Review Board provisions should be reinstated to regulate use of non-ablative brain stimulation techniques.
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 12 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 of Health (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).
REVIEW OF THE NSW MENTAL HEALTH ACT 2007

The NSW Mental Health Act 2007 (the Act) requires the Minister to review the Act ‘to determine whether the policy objectives of the Act remain valid and whether the terms of the Act remain appropriate for securing those objectives’. This review must be undertaken five years after the Act was 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.

The outcomes of the Review indicate that the policy objectives of the NSW Mental Health Act 2007 remain largely valid and provide an appropriate legislative framework for the mental health system. Broadly, the view is that the structure of the Act is robust, and on balance the content is supported. However, a number of issues have emerged from the consultation, and while some relate more to the implementation of the legislation (rather than the Act itself), there are opportunities to amend some sections of the Act to reflect contemporary language and emerging evidence, improve operational clarity and alignment with other legislative approaches in relevant areas.

Review and consultation process

The Act has a direct and profound impact on people with mental illness, their family, friends and carers, health professionals, the emergency services and the general community. As part of this review, it was important to gather feedback that reflected this breadth of views and experiences, and recommendations for changes to the legislation.

The Ministry of Health employed a range of methods for seeking public and expert input into this review of the Act, and these are outlined below.

Discussion paper and public submissions

A discussion paper was prepared by the Ministry of Health to introduce some of the issues and to stimulate discussion and comment on areas of the legislation which might require review or amendment.

In March 2012, a range of 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 were included in the discussion paper.

A number of the issues raised in the discussion paper are complex and not easily resolved. The discussion paper was not intended to capture all areas of the legislation which might require review or amendment. Comments and feedback were sought on any issues related to the legislation, including those not covered in the discussion paper.
The discussion paper was released on 26th September 2012 for public consultation. The paper was published on the Ministry of Health website, a letter was sent to relevant stakeholders to alert them and their memberships to the paper, and a press release was issued by the Minister for Mental Health. Written submissions in response to the discussion paper were requested by 5pm on Monday 17th December.

A total of 95 written submissions were received, including from consumers (including current involuntary/forensic patients), family and carers of consumers, health professionals and medical colleges/associations, health service providers (including non-government organisations), consumer and carer support networks and organisations, emergency services, academics, and State Government departments. A full list of the respondents is available in Appendix One.

In addition to feedback about the legislation, many of the submissions raised concerns about implementation, policy and resourcing issues; however this report summarises only the legislative issues. The non-legislative issues will be considered separately to this review of the Act.

**Survey of current involuntary patients**

It was recognised that people who are currently detained under the provisions in the Act, may find it difficult to respond to the call for public submissions or to attend a Community Consultation Forum.

To address this, a short survey form was developed to collect feedback from a sample of inpatients (including forensic patients), facilitated by the local Consumer Support Workers from selected metropolitan and rural areas. Despite following up with the local staff, only a small number of survey responses were received by the Ministry of Health.

**Community consultation forums**

In addition to releasing the discussion paper, the Ministry of Health hosted eight Community Consultation Forums across New South Wales:

- Orange, 2nd October 2012
- Penrith, 3rd October 2012
- Lismore, 8th October 2012
- Newcastle, 9th October 2012
- Sydney, 10th October 2012
- Broken Hill, 15th October 2012
- Shellharbour, 18th October 2012
- Albury, 19th October 2012

The forums were successful in attracting a cross-section of perspectives. Effort was made to attract the attendance of consumers and carers, and their attendance at the forums made for a much richer and rewarding exchange of views.

At each forum, attendees were asked to complete a demographic sheet to ascertain who attended, the stakeholder groups they were part of and how far they had travelled. This is summarised in the tables below.
### Summary of attendees at each forum, by stakeholder group (self-identified)

<table>
<thead>
<tr>
<th>STAKEHOLDER GROUP</th>
<th>Mental Health Consumer (%)</th>
<th>Carer (%)</th>
<th>Clinician or MH worker (%)</th>
<th>NGO worker (%)</th>
<th>Official visitor (%)</th>
<th>Police or Emergency Services (%)</th>
<th>Legal (%)</th>
<th>Govt Dept (%)</th>
<th>Other (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orange</td>
<td>3.1</td>
<td>6.2</td>
<td>53.8</td>
<td>20.0</td>
<td>1.5</td>
<td>1.5</td>
<td>0.0</td>
<td>1.5</td>
<td>9.2</td>
</tr>
<tr>
<td>Penrith</td>
<td>10.6</td>
<td>4.3</td>
<td>51.1</td>
<td>17.0</td>
<td>4.3</td>
<td>0.0</td>
<td>2.1</td>
<td>10.6</td>
<td>6.4</td>
</tr>
<tr>
<td>Lismore</td>
<td>12.9</td>
<td>24.2</td>
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<td>21.0</td>
<td>3.2</td>
<td>6.5</td>
<td>1.6</td>
<td>6.5</td>
<td>11.3</td>
</tr>
<tr>
<td>Newcastle</td>
<td>16.4</td>
<td>10.4</td>
<td>35.8</td>
<td>31.3</td>
<td>3.0</td>
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### Summary of distance travelled by forum participants

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Independent Community Consultation Panel

An Independent Community Consultation Panel was established to lead the public consultation process on behalf of the Ministry of Health.

The individuals listed below were invited by the Minister for Mental Health 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)**

Mr Sebastian Rosenberg spent 17 years as a public servant before becoming Deputy CEO of the Mental Health Council of Australia from 2005-09. He has worked as a Senior Lecturer in national mental health policy at the Brain and Mind Research Institute (BMRI) since 2008 and is a PhD Candidate, working to develop A National Mental Health Report Card for Australia. Mr Rosenberg was also the Expert Facilitator on the Taskforce to Establish the NSW Mental Health Commission.

**Mr Rob Knowles**

Mr Rob Knowles is a farmer and company director, has been Chair of the Mental Health Council of Australia since April 2006 and was most recently appointed a Commissioner with the National Mental Health Commission. Mr Knowles is: a member of the National Health and Hospital Reform Commission; Chair of the Mental Illness Fellowship of Australia; Chair of the Royal Children's Hospital Campus Council; and a member of the Board of the Brotherhood of St Lawrence. He is a former Victorian Minister of Health, Housing and Aged Care and has a strong interest in services for consumers and their families and carers.

**Mr John Feneley**

Mr John Feneley is the Commissioner of the NSW Mental Health Commission. He has extensive experience in the mental health sector as former Deputy President of the Mental Health Review Tribunal and through mental health policy and law reform work as former Assistant Director General, NSW Attorney General Department. Mr Feneley has also served on the Board of the Schizophrenia Fellowship and on government boards and committees, including the Youth Justice Advisory Committee, the Child Death Review Team and the Legal Profession Admission Board.

**Dr Lynne Lane**

Dr Lynne Lane is the New Zealand Mental Health Commissioner. During her time as Commissioner, her achievements have included the development of *Blueprint II: How things need to be*, which sets out a 10 year strategy to improve the mental health of all New Zealanders and what needs to happen to achieve this vision.

As a Public Health Physician she has 20 years experience in health service delivery, strategic planning, funding and service management in both the public and private sector. She has held a number of senior roles in the public sector including Director of Public Health in the New Zealand Ministry of Health.
**Expert Reference Group**

An Expert Reference Group (ERG), comprised of representatives from key mental health stakeholder groups and individuals with legal expertise, was established by the Ministry of Health with recommendations for membership endorsed by the Minister for Mental Health. The full list of ERG members is in Appendix Three.

The ERG was asked to provide expert advice and feedback to the Ministry of Health on the issues that were raised during the public consultation process. The ERG was asked to highlight key issues that are important for the NSW Government to consider in relation to any potential changes to the Act; however, the ERG was not required to achieve a consensus view on any particular issue or to make specific recommendations for future legislation.

The advice provided by the ERG has been summarised in the relevant sections of this report.

**Next steps**

In line with s201 of the Act, this report has been prepared for consideration by the NSW Government. It summarises the process undertaken to review of the NSW Mental Health Act 2007, the legislative issues raised and considered, the feedback provided during public consultation and the advice from experts. A summary at the conclusion of each section aims to assist the Government in determining next steps.

This Report is intended to be read in conjunction with the Discussion Paper which provides further detail and context about the issues discussed in this report.
CONSIDERATION OF CHANGES TO THE LEGISLATION

1. Objects and principles

The current legislation / situation

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 Act 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.

Under the Act, the following principles of care and treatment 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:

(a) 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,
(b) 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,
(c) 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,
(d) 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,
(e) people with a mental illness or mental disorder should be provided with appropriate information about treatment, treatment alternatives and the effects of treatment,
(f) 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,
(g) the age-related, gender-related, religious, cultural, language and other special needs of people with a mental illness or mental disorder should be recognised,
(h) 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,

(i) 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,

(j) the role of carers for people with a mental illness or mental disorder and their rights to be kept informed should be given effect.

**Discussion paper**

The discussion paper did not ask any specific questions about the objects or the principles, but it did include discussion about the United Nations *Convention on the Rights of Persons with Disabilities*.

**Feedback from community consultation forums**

At all forums, some participants raised concerns about the use of the term ‘control’ in the title and objects of the Act, and felt that this word should be removed or replaced.

Forum participants also discussed the inclusion of principles of recovery in the next Act, and the importance of maintaining the principle of least restrictive care.

**Feedback from public submissions & survey**

Thirty-eight submissions were received in relation to the objects and principles, including from five Medical Association/College/Committees, four Local Health Districts (LHDs) and associated specialty networks, six government departments, NGOs and Carer and Consumer Groups (including Peak Organisations), academics, Legal Aid, the Mental Health Review Tribunal (MHRT), and the Official Visitors (OVs).

1.1. **Use of the term ‘control’**

There were seven submissions that raised concern about the use of the term ‘control’ in the first object of the Act:

‘to provide for the care, treatment and control of persons who are mentally ill or mentally disordered’

These submissions were from one NGO, two NSW government departments, the OVs, and consumer and carer groups.

These respondents considered that it was no longer appropriate to refer to ‘control’ of patients, and that this was contrary to the move towards greater emphasis on patient-centred care and patient involvement in planning their treatment for a long-term condition and the growing support for the recovery approach to mental health treatment.

**Other jurisdictions**

There is no reference to the ‘control’ of patients in the purpose or objects of the legislation in any other Australian jurisdiction. Current legislation and draft bills focus on the care, treatment, protection and recovery of people with mental illness.
The current Victorian (VIC) Mental Health Act 1986 includes the following similar object (s4(1)(a)):

- to provide for the care, treatment and protection of mentally ill people who do not or cannot consent to that care, treatment or protection;

And the Victorian Mental Health Bill Exposure Draft 2010 includes (s6(1)(a)):

- provide for the treatment of persons with a mental illness while at the same time protecting their rights and balancing their rights with the rights of other persons;
- promote the wellbeing and recovery of persons with a mental illness by advancing their inclusion and participation in the community.

In Western Australia (WA), the current Mental Health Act 1996 includes (s5):

- The objects of this Act include —
  - to ensure that persons having a mental illness receive the best care and treatment with the least restriction of their freedom and the least interference with their rights and dignity; and
  - to ensure the proper protection of patients as well as the public; and
  - to minimize the adverse effects of mental illness on family life.

And, the latest Western Australian Mental Health Bill 2012 includes (s9(1)):

- The objects of this Act are as follows —
  - to ensure people who have a mental illness are provided the best possible treatment and care —
    - with the least possible restriction of their freedom; and
    - with the least possible interference with their rights; and
    - with respect for their dignity;
  - to ensure the protection of people who have or may have a mental illness;
  - to ensure the protection of the community.

In Tasmania (TAS), the current Mental Health Act 1996. (s6) and the Tasmanian Mental Health Bill 2012 both include:

- The objects of this Act are —
  - to provide for the care and treatment of persons with mental illnesses in accordance with the best possible standards while at the same time safeguarding and maintaining their civil rights and identity; and
  - to ensure that, in relation to patients, all appropriate measures are taken to protect the safety of the patients and other persons.

The Queensland Mental Health Act 2000 (s4) states:

- The purpose of this Act is to provide for the involuntary assessment and treatment, and the protection, of persons (whether adults or minors) who have mental illnesses while at the same time —
  - safeguarding their rights and freedoms; and
  - balancing their rights and freedoms with the rights and freedoms of other persons.

Note: only the relevant objects from each Act or Bill are included above.
1.2. Recovery-focused care

Some respondents considered that the Act needed to give greater emphasis to the principles of recovery-focused, and trauma-informed, care and proposed inclusion of a new object or principle, or change to the existing objects or principles, to formally require a focus on recovery-focused care.

One submission highlighted the provisions in the Scottish Mental Health (Care and Treatment) Act 2003, which has a section that outlines the Local Authority’s (similar to local government in NSW) responsibilities and obligation for promotion of ongoing care, education and community integration of mental health clients during admission (e.g. services designed to promote well-being and social development; and assistance with travel) and following discharge from the facility to promote a recovery-orientated approach within the Scottish Mental Health Act.

1.3. Prominence of the principles

Many of the respondents raised concerns about how the current objects and principles were being implemented and the consequences for health services/staff when treatment was not provided in line with the objects and/or principles.

A number of submissions suggested that the principles of care and treatment be moved to the front of the Act, after the objects. The principles are currently positioned at the start of Chapter 4 Part 1 of the Act, which details the ‘Rights of patients or detained persons and primary carers’ (s68).

1.4. Human rights

A number of respondents referred to the United Nations Convention on the Rights of Persons with Disabilities (the UN Convention), which includes people with a mental illness. These respondents considered that the current principles in the Act refer to some of the rights recognised under the Convention but considered that the principles and objects could be strengthened and expanded to guarantee the rights and civil liberties of people with mental illness. Some respondents noted that the objects in the Act provide for protection of people’s human rights but felt that this principle was not reflected in the rest of the Act.

Some submissions acknowledged that it was important to balance a consumer’s right to self-determination with their right to receive appropriate and necessary treatment for their mental illness.

A range of suggested amendments were made in single submissions, for example:

- One respondent proposed that section 68(a) of the Act be improved by including the principle of the least restrictive or intrusive treatment, in addition to providing treatment in the least restrictive environment. They considered that such an amendment would make the provision consistent with Principle 9(1) of the UN Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care, which states:

  ‘Every patient shall have the right to be treated in the least restrictive environment and with the least restrictive or intrusive treatment appropriate to the patient’s health needs and the need to protect the physical safety of others.’

Many of the other suggestions related to increased emphasis, or better implementation, of the existing principles.
Advice from the Expert Reference Group

The ERG was asked to consider the following questions:

1. Should the term ‘control’ be removed from the title and objects of the Act?
2. What should the Ministry of Health consider in rewriting this object (s3(a))?
3. Should the Act give greater emphasis to the principles of recovery-focused and trauma-informed care?
4. Should the principles of care and treatment be given greater prominence in the Act by moving them near the front of the Act, after the objects? Or should they remain at the start of Chapter 4?
5. What should the Ministry of Health consider in making changes to the Act to take the United Nations Convention on the Rights of Persons with Disabilities into account?

The ERG provided the following advice about key issues that should be considered when making a decision about the legislation:

- One member commented that in the current legislation, the objects (s3) refer to the care, treatment AND control, whereas s14 refers to the care, treatment OR control of the person.
- The word ‘control’ was considered to be derogatory by some members, and there was consensus that the language is old fashioned and should be amended. Some members commented that the use of the term ‘control’ gives an impression to the treating team that is inconsistent with a recovery focus. Consumers are opposed to the word control because it increases stigma.
- Some members commented that the purpose of control is to prevent harm and give protection. Some members suggested that ‘protection’ could be substituted in place of ‘control, and that the language could be changed to “in a limited number of circumstances use involuntary treatment”.
- However, a strong view was expressed by many members that the use of coercive care does need to be expressed in the Act since this is one of the main purposes of the Act. It is important to recognise that a purpose of the Act is to permit coercion and control and that the words in the Act must reflect the reality.
- One member suggested the essence of the United Nations Convention on the Rights of Persons with Disabilities should be reflected in the Act.
- Advice suggests that courts do not take objects into consideration unless there is ambiguity in the Act, however, they send a message to the community and are very important for people on the ground. The objects should be used for telegraphing important ideas, leaving the mechanics to specific provisions. The Act works via specific provisions not the objects.

Summary

Taking into account all of the information and advice gathered during this review of the Act, it may be appropriate to amend the Act: by removing the word ‘control’ from the objects (s3) and title of the Act and replacing it with terms such as ‘protection’, ‘detention’ and/or ‘involuntary treatment’; adding a term which encapsulates the ‘recovery-focused care’ principle in the principles of care and treatment within the Act. It is further suggested that consideration be given to whether the Act is consistent with the principles in the UN convention.
2. Decision making capacity and supported decision making

The current legislation/situation

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 have. This is also a legal right – 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; however, 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.

Substituted decision making and supported decision making

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 declared mental health facility (DMHF), based on the person’s risk of harm to themselves or others.

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.

As a consequence, some Australian states and other countries have moved, or are moving, towards an increased focus on safety over risk, and more inclusive (supported) decision making about treatment plans for people with mental illness, in preference to the current substituted decision making model.

In a supported decision making model, a presumption would be made that all patients have the capacity to make decisions regarding their treatment and care. Where a patient was unable to make a decision about their treatment at a particular point in time, they would be supported to be involved in the decision making process as far as reasonably possible.

United Nations Convention on the Rights of Persons with Disabilities

The UN 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 UN 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 UN Convention recognises the legal capacity of persons with disabilities. It has been interpreted by some legal academics as meaning 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. This interpretation shifts the focus from substituted decision making to supported decision making¹.

**Discussion paper**

In relation to this issue, the discussion paper asked the following questions:

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

**Feedback from community consultation forums**

Some forum participants expressed considerable interest in any new NSW legislation fully exploring the balance between focus on a person’s capacity and their risk of harm in determining their need for involuntary treatment, including giving consideration to draft Bills from other jurisdictions. However, forum participants did not express any clear options or strategies.

**Feedback from public submissions & survey**

Thirty-four submissions discussed the possibility of making amendments that would embed into the Act a presumption of decision making capacity and a supported decision making model for persons with a mental illness. Respondents included five Medical Association/College/Committees, four LHDs and associated specialty networks, four government departments, NGOs and carer and consumer groups (including peak organisations), academics, Legal Aid, the MHRT, and the OV's.

There was no consensus in the submissions about the most appropriate way forward, with many of the submissions supporting further work and further consultation on this issue.

A range of reasons were given for supporting a move towards a presumption of decision making capacity and supported decision making in the Act, including consistency with the UN Convention, recent draft legislation in VIC and TAS, and the United Kingdom requirements under the Mental Capacity Act 2005 (UK). In addition, the VIC Law Reform Commission has recommended extensive changes to current guardianship legislation that would effect a much greater emphasis on supported decision-making over substituted decisions, than currently exists under the Guardianship and Administration Act 1986 (VIC).

A range of concerns and reasons were also given for not supporting a move towards a presumption of decision making capacity and supported decision making in the Act, including the decision in WA to reinstate the provisions of their 1996 Act in the 2012 Bill, following consultation on the draft requirements for assessment of capacity in the 2011 draft Bill.

Respondents also raised a range of issues related to defining decision making capacity, the reliability between assessors of capacity, concern that capacity can fluctuate more rapidly than risk over the course of time, resourcing any changes, and how this concept flows through into community treatment orders (CTOs).

One submission commented that the removal of an individual’s freedom and enforcement of medication, while having long-term benefits, is also associated with significant harms (side-effects). Therefore, the respondent considered that it could only be justifiable for a clinician to involuntarily treat a patient if the purpose is to prevent greater harm.

Overall, consultation feedback acknowledged the current national and international move towards a more patient-centred approach to providing mental health treatment, and some respondents felt that it was important for the legislation to reflect this philosophical change.

**Advice from the Expert Reference Group**

In relation to this issue, no specific advice was sought from the ERG although members were able to raise issues of interest. The ERG did not provide any advice or comment in relation to this specific issue.

**Summary**

Taking into account all of the information and advice gathered during this review of the Act, it may be appropriate to undertake further consultation that includes in-depth analysis of the possible models of involuntary provision of treatment, the possible unintended consequences of any changes, and the likely resource implications; and monitoring and evaluation of the implementation of a supported decision making model in other jurisdictions to inform any future possible approach in NSW.
3. Treatment for conditions other than a mental illness

The current legislation/ situation

As well as providing for the involuntary mental health treatment of detained persons, the Mental Health Act also has provisions providing for a substituted consent regime for non-mental health treatment, particularly surgery. However, these provisions are inconsistent and vary depending on the status of the detained person and, in some cases, allow a competent person’s refusal to consent to be overridden. Further, the substituted consent provisions are not as comprehensive as the provisions of the Guardianship Act 1987 in relation to the information to be provided to the substituted decision maker or the matter the substituted decision maker must take into account.

Discussion paper

In relation to this issue, the discussion paper asked the following questions:

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

Feedback from community consultation forums

The Independent Community Consultation Forums Panel Report included a suggestion that there should be consistency between the Mental Health Act and Guardianship Act in relation to involuntary treatment for non-psychiatric illnesses, though perceived inconsistencies were not articulated in any detail.

Feedback from submissions

Twenty seven submissions were received in relation to the issues regarding non-mental health treatment. There was a general consensus that the current provisions in the Act relating to the provision of non-mental health treatment were not appropriate and that the provisions should be better aligned with the provisions of the Guardianship Act.

There was firm agreement by respondents that the provisions of the Guardianship Act better respect the rights of people to make their own non-mental health decisions and that where a person lacks capacity, the Guardianship Act still requires the views of the person to be taken into account before substituted consent is obtained.
**Advice from the Expert Reference Group**

The ERG was asked to consider the following questions:

1. Where a patient is detained in a DMHF, should the MHRT, (as well as the Guardianship Tribunal), also be able to consent to treatment in relation to a patient who lacks the capacity to consent?
2. Should the MHRT be able to consent to special medical treatment in relation to a patient who lacks the capacity to consent?
3. Where a patient detained in a DMHF has capacity to consent, but refuses to consent to non-mental health treatment, should the State retain a right to direct treatment in extreme situations where the patient’s life is at risk?
4. If the State should retain such a right, which person or body should be able to authorise treatment on the patient’s behalf?

The ERG provided the following advice about key issues that should be considered when making a decision about the legislation:

- There are many complexities and challenges to consistently and accurately determining whether a person has the decision making capacity to consent to (potentially life-saving) treatment for non-mental health conditions.
- Where a person is assessed as not requiring detention for involuntary mental health treatment, it is considered that they should be able to make decisions about their treatment. However, it may still be necessary to assess a voluntary patient’s decision making capacity at the time that they are consenting to medical treatment for a non-mental health condition.
- There needs to be greater consistency in decision making for all patients who lack decision making capacity, whether those decisions are made under the Mental Health Act or under the Guardianship Act.
- It was proposed that when a person is detained for mental health treatment, the MHRT could make decisions regarding non-mental health treatment (similar to the role that the Director General of Health (and delegates) currently hold).
- Another proposal was that the Primary Carer could be empowered to make decisions with a similar mechanism to the Guardianship Act provisions and processes. If a move was made to align the Mental Health Act with the Guardianship Act, it would be possible to rely on the ‘person empowered’ to make decisions. Under the Guardianship Act, it is only necessary to seek consent from the Guardianship Tribunal if the person objects to the decision made by the ‘person empowered’.

**Summary**

Taking into account all of the information and advice gathered during this review of the Act, it may be appropriate to undertake further consultation that includes discussion of the potential consequences of a move to align the provisions of the Mental Health Act and the Guardianship Act, particularly in relation to a mentally ill person’s decision to refuse potentially life-saving treatment.
4. Definition of mental illness

The current legislation/situation

Section 4 of the Act defines ‘mental illness’ 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).

Discussion paper

In relation to this issue, the discussion paper asked the following questions:

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

Feedback from community consultation forums

No feedback on this issue was provided in the Independent Community Consultation Forums Panel Report.

Feedback from public submissions & survey

In total, 32 submissions addressed one or more questions in the discussion paper pertaining to the definition of mental illness in the Act. Respondents included five government departments, four LHDs and associated speciality networks, NGOs, consumers, carers and carer organisations, emergency services, clinicians, academics, the NSW Nurses and Midwives Association, RANZCP, the MHRT and the OVs.

Most respondents (including clinicians, MHRT, Legal Aid, LHDs and speciality networks, NSW Branch of C&A Psychiatry, Medical Services Committee and RANZCP) agreed that the current definition is robust and that the flexibility of the symptomatic based definition allows for the treatment of acutely unwell persons with a range of conditions, including personality disorders and dementia.

Five respondents preferred the proposed broader definition in the WA draft Mental Health Bill as they felt it would strengthen the definition and be more appropriate to young offenders:
A person has a mental illness if the person has a condition that —
(a) is characterised by a disturbance of thought, mood, volition, perception, orientation or memory; and
(b) significantly impairs (temporarily or permanently) the person’s judgment or behaviour.

Three respondents felt that the current definition should be amended to specifically include diagnoses of personality disorders and dementia with the following reasons stated:

- Currently, the Act does not adequately address the care and management of individuals with personality disorders.
- It is recommended that no person presenting with emotional distress be explicitly excluded from receiving assistance under the Act.
- Currently, mental health legislation and services in NSW are too focused on treatment and support of people with a severe mental illness, which means that individuals with mental conditions, such as personality disorder (PD) and dementia, receive inadequate or insufficient support.

In response to the question regarding whether any conditions should be explicitly excluded from the definition of mental illness, 12 submissions were received with five respondents stating that intellectual and developmental disability and dementia should be excluded unless coexisting with an identified mental illness or disorder.

Other relevant comments included that:

- There remains confusion about the definition of mentally disordered persons, leading to varying thresholds for deciding this category.
- If NSW were to try to expand the Act to cover all kinds of mental illness and treatment, there would be very serious implications for the resources required by the MHRT.
- People with intellectual or developmental disability should not be denied access to mental health treatment on the basis of their disability alone.
- The definition of mental illness should be amended to more clearly include the phenomenology exhibited in anorexia nervosa and to delete the word ‘irrational’ from criterion (e).
- s16. That Clause (j) ‘the person has developmental disability of mind’ under ‘Certain words or conduct may not indicate mental illness or disorder’ is reworded to: ‘the person has an intellectual disability or developmental disability’.
- The provision of capacity could be put in. Insight should not be the only measure of capacity. The measure of capacity test could be lowered for mentally disordered persons. The Scottish test which is impairment of capacity rather than loss of capacity could be used.

Submission comments specific to personality disorders included that:

- A broad definition of mental illness or mental disorder such as that in the Mental Health Act 2007 (UK) is supported, where ‘mental disorder’ means any disorder or disability of the mind. The Act’s narrow definition leads to inconsistencies in assessment decisions and therefore inconsistent access for people with personality disorders to appropriate acute care. This can have an impact on the effectiveness of other types of service provision for people with personality disorder.
• It would not be appropriate to broaden the definition, in particular to include PDs, unless the nature of mental health facilities and the services they offer were significantly expanded to provide adequate services to this or other client groups.

• Other than for brief containment in crisis, there is little evidence that involuntary treatment is beneficial in the treatment of primary severe personality disorder. Provision for brief involuntary inpatient treatment exists within the definition of mentally disordered.

• People with personality disorders may be treated when exhibiting symptoms of mental illness or when exhibiting dangerous or irrational behaviour that brings them within the definition of mentally disordered persons.

• Personality disorders should be defined in the Act. Personality disorders are often linked to trauma and require trauma informed care. The benchmark for assessment should be whether the disorder has led to the person being unable to function to their capacity. The definition should also consider mental disorders due to drug and/or alcohol abuse. Often disorders under this circumstance (dual diagnosis or co-morbidity) will subside when the drug wears off.

Respondent comments specific to dementia included that:

• People with dementia who are manifesting mental illness and meet the current criteria for being mentally ill should be (and currently are) able to be detained under the Act.

• Although a person with dementia may experience symptoms such as psychosis, dementia itself is not a mental illness or disorder, and should only be diagnosed when an assessment can occur that relates to the person’s mental health and their capacity or cognitive functioning is impaired by a mental illness or disorder.

• A direct reference to dementia could be inserted and a class of mental health facility (MHF) be set up to only admit people suffering from dementia.

Advice from the Expert Reference Group

In relation to this issue, no specific advice was sought from the ERG although members were able to raise issues of interest. The ERG did not provide any advice or comment in relation to this specific issue.

Summary

Taking into account all of the information and advice gathered during this review of the Act, on balance it appears that the definition of mental illness is appropriate and no changes to the Act are suggested. However, consideration could be given to amending the exclusion criteria under s16 (j) to reflect contemporary language such as ‘the person has an intellectual disability or developmental disability’.
5. **Non-admission and discharge of persons brought involuntarily to a declared mental health facility**

*The current legislation/situation*

Section 27(a) of the Act deals, in part, with the initial examination by an authorised medical officer (AMO) of a person detained in a DMHF. The Act requires that if, after the AMO’s examination (first Form 1), a person is found to be neither mentally ill nor mentally disordered, the person must not be detained.

Under the Act, an AMO is not required to be a psychiatrist.

At present, there is no mechanism in the Act for reviewing an AMO’s decision not to detain a person in a DMHF. Nor is there a right under the current Act to appeal an AMO’s decision to discharge an involuntary patient or detained person under s12.

The Act does allow for persons seeking voluntary admission to a MHF to request that the medical superintendent of the facility reviews a decision by an AMO to refuse admission or discharge (s11).

Under s79 of the Act, the AMO must take all reasonably practical steps to ensure that a patient or person detained in a DMHF, their primary carer and any agencies involved in providing relevant services to the person, their primary carer and any dependents, must be consulted in relation to discharge planning and any subsequent treatment.

*Discussion paper*

In relation to this issue, the discussion paper asked the following questions:

- Do you think that concerns about non-admission and discharge are an issue that requires legislative and/or policy reform? Please provide reasons.

- What do you think are the most appropriate means of addressing the issue? Why do you believe these are the most appropriate means?

- 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?

*Feedback from community consultation forums*

Feedback from the Community Consultation Forums was that some right of review in this area would be an important addition to the Act. The question was to determine a mechanism that could deliver a fair and swift reconsideration of a decision not to involuntarily admit a person.
Feedback from public submissions & survey

Twenty-six submissions commented on 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. Respondents included four Medical Association/College/Committees, five LHDs and associated specialty networks, four government departments (including Police), NGOs and carer and consumer groups (including peak organisations), Legal Aid, the MHRT and the OVs.

The majority of submissions identified this as an area requiring reform. Most submissions commented on the right to ‘appeal’ a decision not to involuntarily transport or admit (Schedule 1) or continue to detain a person (Form 1). The question of an appeal/review mechanism of a decision to discharge a detained person received less attention in the submissions.

A common concern expressed in submissions from carers, some clinicians and some service providers, was that the health professional conducting an assessment to determine whether to involuntarily transport or detain a person needed to take more account of the carer’s experience and observations of the person. This was seen to be a particular issue in situations where, during the mental health assessment, the person performs in a way that is not indicative of current functioning. These submissions either explicitly or implicitly recognised that family members or other carers, rather than the consumer, are more likely to have concerns about refusal to detain a person or the decision to discharge a detained person.

Other matters raised were:

- a view that a person who lacks decision making capacity should be able to access treatment that is in their best interests, without having to show that they are at imminent risk of harm to themselves or others; and
- difficulty in accessing appropriate treatment in a timely way, particularly in the community, before the person’s condition deteriorates to the level where they do meet the current criteria for involuntary admission.

Key reasons for wanting reform were:

- to gain timely access to mental health treatment;
- so that the views of the person(s) referring the individual for admission were given due consideration by the AMO; and
- concern that the AMO may have come to the decision about whether to continue detaining a person based on limited information about the person’s mental state and behaviours indicative of mental illness or mental disorder.

Legislative vs policy/clinical practice changes

There was a spread of opinions on whether reforms associated with these questions should occur through amendments to the Act or through policy and staff training:

- three submissions clearly articulated the need for legislative change
- six stated that changes should not be legislative
- the bulk of submissions did not express a preference for legislation or policy, or did not address the issue of the mechanism for change.
A few respondents considered that there was no need for change.

**Review vs external appeal process**

The majority of submissions considered that a review of the AMO’s clinical decision not to involuntarily admit a person should be dealt with through a ‘second opinion’ process. This was viewed as preferable to a formal appeal conducted by an external body. Some submissions recognised a role for the MHRT in conducting a review of the clinical decision, but indicated this should follow internal review processes such as an appeal to the medical superintendent or a second opinion by a psychiatrist not involved in the original decision.

Submission writers put forward a number of alternatives for handling objections to the AMO’s decision not to detain a person including:

- Second opinion/internal review options:
  - a requirement that the AMO, when not a psychiatrist, must confer with a psychiatrist on their decision;
  - establishment of a second opinion mechanism from an experienced psychiatrist or a psychiatrist not involved in the original clinical decision;
  - the AMO’s decision to refuse involuntary admission could be reviewed by the Medical Superintendent.

- External review options such as:
  - the AMO’s decision to refuse admission could be appealed to the MHRT;
  - the OVs could provide a mechanism whereby consumers, carers or relatives could request their intervention to review the decision.

A few submissions suggested ways of providing care in the community following a decision not to involuntarily admit a person, such as a requirement that a referral for a follow-up visit by community mental health staff within a few days of non-admission is part of the ‘discharge’ arrangements.

**Other issues for consideration that were raised**

Many submissions recognised the complexity of the issues raised and identified several other matters that might have bearing on situations of non-admission of a person to involuntary treatment or discharge of a detained person. These included:

- timeliness of an appeal process, particularly if an external review process were established
- the impact of external appeal processes on clinical and administrative decision making
- difficulties and legality of continuing to detain a person pending consideration of an appeal/review
- concern that detention pending such an appeal would be at the cost of the person’s rights
- pressures put on the mental health system’s capacity and requirement for additional clinical and infrastructure resources
- removal of clinical decision making capacity from those trained to make such decisions, which would be a precedent in the health system
- potential danger of abuse by family or other persons
the need to determine just what is being ‘appealed’ and who would have the right to appeal
the balance between the rights of the person versus the views of family and other parties
measures that would be used to ensure the person’s attendance at the subsequent appeal hearing

Advice from the Expert Reference Group

The ERG was asked to consider the following questions:

1. Should the Act require that the assessing AMO give due consideration to the views of the person(s) referring the individual for admission?
2. Should the Act be amended to establish a right of review where the AMO decides a person does not meet the criteria for detention?
3. Should the Act also be amended to establish a right of review where an accredited person (AP) or medical practitioner refuses to detain a person who has presented to an ED or inpatient DMHF on a Schedule 1?
4. If amended, what conditions for the review process should be provided for in the Act?
5. In situations, where the AMO decides a person is mentally ill or disordered, but does not meet the criteria for detention, should the Act require development and documentation of an agreed plan discharge/ follow up arrangements?
6. Should the Act be amended to establish a right of review regarding a decision to discharge an involuntary patient?

The ERG provided the following advice about key issues that should be considered when making a decision about the legislation:

- If the person is assessed as not meeting the criteria for detention and involuntary treatment under the Act, they cannot be held pending an appeal or review process.
- It was suggested that the initial assessment process could be improved to ensure consistency and clinical standards. If a junior AMO conducted the initial assessment then a review by a senior clinician/ consultant psychiatrist could be incorporated (mandated for) prior to the person being discharged.
- Any review of an assessment outcome, or additional assessment, should be undertaken by someone with equal or higher qualifications.
- AMOs should take family/ carer opinions into consideration when making decisions under s27. Whether this currently occurs or not is variable across the State.
- In addition, it would be good at the assessment stage if clinicians asked, and had regard to, the consumer’s or carer’s living situation. For example, any tenuous living arrangements or the possibility of losing public housing if the person did not receive treatment.
- It was suggested that a section be included on the Form 1 which indicates the information provided by the carer/ family member and why the information was or was not taken into consideration. However, it was considered that ultimately the decision to detain a person should be a clinical decision.
- If it is mandated that family/ carer information be sought when making s27 assessments and the service was unable to contact them, the person could be held unnecessarily. It was suggested that the words ‘if practicable’ could address this concern.
• In addition, due regard should be given to the views and history that could be provided by people other than family/carer, e.g. the medical practitioner who completed the Schedule 1, police or ambulance staff, social worker etc.

• Limited information is currently collected on Form 1 assessments, particularly regarding reasons for refusal to admit. If information is not collected, what then would be the basis for appeal, or evidence upon which the appeal can be judged?

• Acknowledgement that the Form 1 assessment is a clinical judgement at a given point in time, and the consumer’s clinical presentation was likely to change over time; therefore, any ‘review’ in the future could only be a new clinical assessment and not a review/appeal of the previous decision.

• It was further suggested that a systemic review could be undertaken on a regular basis and reported to the NSW Mental Health Commission or Minister for Mental Health. This review could be linked to negative outcomes/impacts for carers.

• The current system appears to be set up to provide inpatient care or no treatment if not admitted to hospital. What alternative service should be offered to a person who is not admitted to hospital? It was suggested that a flowchart be developed outlining the various options available depending on the acuity of the person. The onus should be on the clinical service to follow up or refer to another service where appropriate. Offering a card with a telephone number was not considered adequate follow-up.

• Hospitals and LHDs have complaints processes that could be used but these do take considerable time for a response, and this might not be appropriate in an acute situation.

• Although it is good to use an amendment to the Act to encourage change in practice it cannot be the only measure undertaken. Changes would need to be followed up with policy and monitoring.

Summary

Taking into account all of the information and advice gathered during this review of the Act, it may be appropriate to undertake further consultation that includes whether it would be appropriate to amend the Act such that:

• where a decision has been made to not involuntarily admit a person, that a psychiatrist or the medical superintendent must undertake an additional assessment of the person where a carer or service provider makes such a request; and/or

• where the first Form 1 has been completed by an AMO who is not a psychiatrist, and where they have come to the conclusion that the person does not meet the criteria for detention under the Act, a further Form 1 must be completed by a psychiatrist.
6. Mental Health Review Tribunal orders delaying discharge of persons

The current legislation/situation

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.

Discussion paper

In relation to this issue, the discussion paper asked the following questions:

- Do you believe 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?

Feedback from community consultation forums

No feedback on this issue was provided in the Independent Community Consultation Forums Panel Report.

Feedback from public submissions & survey

Submissions on this question were received from 17 organisations including the NSW Nurses and Midwives Association, four LHDs and associated specialty networks, two NGOs, three NSW government departments, Legal Aid, the MHRT, and the OVs.

All but one respondent supported the proposed amendments, although some respondents placed qualifications on their support. These qualifications included that:

- Delayed discharge should only be allowed for up to seven days as arrangements for a patient’s safe return to the community can be made within this timeframe.
- The exercise of the proposed power to defer discharge should not become a common occurrence, and should be exercised only in the best interests of the patient.

There were no objections to the proposal; however one submission, from the Medical Services Committee, was ambivalent as to whether the proposed changes were required. The Committee’s comments included that it is not appropriate to consider making a CTO at such a hearing and would require the nature of the
appeal hearing to be changed. The Committee suggested that the MHRT could defer a hearing for up to two weeks to allow a CTO application to be developed.

**Advice from the Expert Reference Group**

The ERG was asked to consider the following questions:

1. Should any restrictions be placed on delayed discharge and/or making CTOs at such an appeal hearing, over and above those conditions already placed on making CTOs and deferring discharge under other provisions of the Act?

The ERG provided the following advice about key issues that should be considered when making a decision about the legislation:

- The MHRT should be able to delay discharge or make a CTO at appeal hearings. Most members supported a 14 day limit for delayed discharge.

**Summary**

Taking into account all of the information and advice gathered during this review of the Act, it may be appropriate to amend the Act to allow the MHRT, at an appeal hearing against a refusal to discharge a detained person, to be able to make a CTO or to defer the discharge of the person for up to 14 days.
7. Discharge after making a Community Treatment Order

The current legislation/situation

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.

Discussion paper

In relation to this issue, the discussion paper asked the following questions:

- Do you believe 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?
- If you do believe that such an amendment is appropriate, do you think that any restrictions should be placed on such orders?

Feedback from community consultation forums

No feedback on this issue was provided in the Independent Community Consultation Forums Panel Report.

Feedback from public submissions & survey

Submissions on these questions were received from 13 organisations including the NSW Nurses and Midwives Association, three LHDs and associated specialty networks, an NGO, three NSW government departments, Legal Aid, the MHRT, and the OVs.

All respondents who addressed these questions supported the proposed amendments, although most respondents had qualifications to this support and/or proposed restrictions that they felt should be placed on any such amendments. Nearly all respondents felt that a maximum timeframe should be placed on the period that a person could be detained before either being discharged or before a further review was
required. Some favoured a mandatory maximum length of detention (14 days was the most common response) while others felt that the period of detention should be able to be extended, although only in certain circumstances and subject to MHRT review and very strict conditions.

Other issues raised by respondents include:

- Review and appeal options should be available to persons subject to delayed discharge after a CTO is made, as occurs for other detained persons.
- Delayed discharge should only be allowed if the person remains a mentally ill person. If the person is not a mentally ill person then it would be contrary to the meaning of the Act to order further detention if the person wanted discharge.
- The MHRT should only authorise a delay, after a CTO is made, where it is determined that:
  - a delay in transition to the community is necessary to arrange appropriate support and services to prevent serious harm to the person or serious deterioration in their mental or physical health or serious harm to another person; and
  - there is no other appropriate means available for arranging services for the person.

**Advice from the Expert Reference Group**

The ERG was asked to consider the following questions:

1. What maximum timeframes, if any, should be placed on delayed discharge?
2. Should the MHRT be given the power to extend delayed discharge? If so, how many times, for what maximum period of time, and based on what rationale?
3. What appeal/review mechanism, if any, should be available for persons subject to delayed discharge on a CTO?
4. What requirements, if any, should there be about notifying primary carers of delayed discharge, appeal hearings etc?

The ERG provided the following advice about key issues that should be considered when making a decision about the legislation:

- The MHRT should be able to delay orders for 14 days for practical issues such as finding accommodation. Some members stated that there should not be any capacity for making a further order delaying discharge even where practical issues have not been addressed.
- One member suggested delayed discharge should be limited to a 7 day period with the option to extend if necessary.

**Summary**

Taking into account all of the information and advice gathered during this review of the Act, it may be appropriate to amend the Act to allow the MHRT, when making a CTO in relation to a detained person, to delay the person’s discharge for up to 14 days where it is in the person’s best interest.
8. Review by the Mental Health Review Tribunal at least once every 12 months

The current legislation/situation

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.

It has been proposed by some 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.

Discussion paper

In relation to this issue, the discussion paper asked the following questions:

- 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?

Feedback from community consultation forums

No feedback on this issue was provided in the Independent Community Consultation Forums Panel Report.

Feedback from public submissions & survey

Submissions on these questions were received from 17 organisations including the NSW Nurses and Midwives Association, the Commission for Children and Young People, four LHDs and associated specialty networks, one NGO, three government departments, Legal Aid, the MHRT, and the OVs.

All respondents who addressed these questions supported the proposed amendments, although one respondent placed a qualification on its support, i.e. that there should be a requirement that voluntary patients be reviewed every three months, to ensure service accountability and to avoid an individual receiving unnecessarily restrictive care and treatment.

Advice from the Expert Reference Group

In relation to this issue, no specific advice was sought from the ERG although members were able to raise issues of interest. The ERG did not provide any advice or comment in relation to this specific issue.
Summary

Taking into account all of the information and advice gathered during this review of the Act, it may be appropriate to amend the Act to include a requirement that voluntary patients must be reviewed at least once every 12 months of continuous voluntary and involuntary residence in mental health facilities.
9. Initial involuntary treatment in the community

The current legislation/situation

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.

An argument has been put forward that, if mentally ill persons could be involuntarily 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 some stakeholders that the Act be amended to allow community DMHFs to provide initial involuntary community treatment (IICT) of persons in the community without a CTO approved by the MHRT.

The VIC Mental Health Act 1986 allows for CTOs to be made by ‘authorised psychiatrists’ for up to 12 months. The VIC Mental Health Review Board only reviews CTOs if they are extended after the initial 12 months, with the review occurring within eight weeks of a CTO being extended.

The VIC 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’ would, within seven days of a CTO being made, assess whether the CTO had been made in accordance with the Act. It is proposed that for extensions of a CTO beyond three months, the authorised psychiatrist must apply to the MHRT for an ‘Extended Treatment Order’.

The South Australia Mental Health Act 2009 allows for a CTO to be made by a medical practitioner or an ‘authorised health professional’ for up to 28 days. The Guardianship Board must review the CTO as soon as practicable after the CTO has been made, and can make a further CTO.

The WA Mental Health Act 1996 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 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. A Mental Health Tribunal would then be responsible for reviewing each CTO as soon as practicable, 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.

Discussion paper

In relation to this issue, the discussion paper asked the following questions:
Do you believe that the Act should be amended to allow for initial involuntary treatment of persons in the community? Why/Why not?

What restrictions, if any, do you believe should be placed on initial involuntary treatment in the community, and why?

**Feedback from community consultation forums**

It was stated in the Independent Community Consultation Forums Panel Report that:

“While the overall process of CTOs has improved, there was some concern in the consultations about the delay, often two weeks, between application for a CTO and approval being given ... It was suggested that provisions be made to permit treatment to occur, even before the CTO is in place to curtail this delay.”

**Feedback from public submissions & survey**

Submissions on this issue were received from 18 organisations including the NSW Nurses and Midwives Association, the Commission for Children and Young People, four LHDs and associated specialty networks, two NGOs, three NSW government departments, Legal Aid, the MHRT, and the OVs.

There was an extremely mixed response to the proposal, with eight organisations broadly supporting the proposal, six organisations rejecting it, and four organisations expressing somewhat ambivalent views.

Reasons provided for objecting to the proposal included that:

- MHRT CTO hearings are a safeguard which prevents pressure being placed upon clinicians to provide treatment by interested persons and protects consumers from coercive practices.

- The proposal removes natural justice by imposing involuntary treatment in acute situations on the say so of a MH professional without any review process.

- In circumstances where the urgency of the circumstances requires a CTO determination within the 14 day notice period, then it would be appropriate to allow the MHRT to waive the notice period. The Act already makes provision for the waiving of a notice period in circumstances of urgency (s101(5)(a)). This would ensure that the patient’s interests have the protection of the treatment plan and the order is promptly considered by the MHRT.

Comments from those organisations that were ambivalent about the proposal included that:

- To subject a patient to IICT without being given the opportunity to place a submission before the MHRT is very likely to undermine the legitimacy of the CTO, and therefore the authority of the treating team in administering the CTO. Generally, if a patient presents as unwell enough to require urgent community treatment within 14-18 days of notice of an MHRT hearing to manage significant risks posed or faced, then they are probably unwell enough to be detained in hospital as a mentally ill patient.

Many respondents were of the view that, in order for IICT to be implemented, a person would need to be found to be either mentally ill or mentally disordered under the Act by suitably qualified clinicians, similar to the requirements in s27 for inpatient involuntary treatment. Most respondents who held this view suggested that at least one psychiatrist should be involved in undertaking the assessments, although some suggested...
that APs could also be involved at the initial stage, with follow up assessments by psychiatrists when practicable.

A majority of respondents also expressed the opinion that a timely review of IICT should be conducted by the MHRT (the most commonly expressed view was that such a review should occur within 14 days of IICT being initiated).

Other specific issues and requirements that some organisations thought should be considered in developing an IICT system included that:

- Community mental health resources might need to be increased if this change created an extra workload for mental health services.
- IICT should take into account the views of the person and carers and any preferences expressed through advance agreements or nominated persons.
- Adequate monitoring of consumers on IICT orders (possibly including involvement by OVs) would be important and an IICT system will require clear guidelines for implementation and monitoring.
- Persons subject to IICT, and their carers, should have the right to appeal to the MHRT against that treatment.
- The requirements for making a CTO are of a lower threshold than those for involuntary inpatient care and do not require any testing of capacity to make judgements about need for care. If emergency community care is intended as an alternative to inpatient care then a similar definition may be necessary. If that is the case then it would place a burden on the community treatment team to avoid the patient coming to harm, something almost impossible without containment. A phrase that indicates that a person is not quite at the same degree of risk would be necessary – e.g. in the near future the person will become at risk and require inpatient care without intervention at this point. Without such a phrase, staff would have to err on the side of inpatient care.
- An alternative to IICT would be to consider reducing the 14 day notice period for the MHRT to hear applications for a CTO. A shorter period of four or seven days may strike an appropriate balance between the need to afford a person procedural fairness and the need to act quickly where there is evidence that a person’s condition is deteriorating.

**Advice from the Expert Reference Group**

The ERG was asked to consider the following questions:

1. Considering the nature of the submissions, should the proposal be abandoned or does it warrant further consideration?
2. If it warrants further consideration, what are the main issues that require investigation?
3. What criteria would need to be satisfied in order for a person to become subject to IICT – the same criteria as for a CTO, the same criteria as for involuntary patient admission (s27), or some other criteria? Should consideration of the views of family and carers (where practicable) be included as a criterion?
4. Who should conduct the assessments to determine whether someone should be subject to IICT?
5. What sort of appeal process, if any, should be available for a person subject to IICT?
6. What should be the maximum timeframe that a person can be subject to IICT before a MHRT hearing must be held?
7. Does the MHRT have the legal and practical capacity to hear CTO applications urgently?
8. Would IICT be likely to increase workload for the public mental health system in general, and for community MHSSs in particular?
9. Should there be provision for external monitoring of persons under an IICT regime? If so, who should be responsible for monitoring and how should it occur?
10. What information, if any, should be provided to persons subject to IICT?

The ERG provided the following advice about key issues that should be considered when making a decision about the legislation:

- One member expressed the view that when people engage in treatment they are less willing to go to hospital and that treatment needed to be provided in the right place and at the right time. CTOs are presently designed for people who are being discharged from hospital.
- One member stated that clinicians should not be able to initiate initial involuntary treatment.
- If the MHRT could waive the 14 day notice period in urgent cases then such matters could be considered promptly by the MHRT, which might effectively alleviate many of the issues raised in the discussion paper. Some support was expressed for this proposal. A view was expressed that the initial treatment proposal would be far too cumbersome (e.g. what treatment and appeals processes would be allowed).
- There was strong support for CTOs but a mix of views were expressed regarding initial involuntary treatment in the community. Some members stated that involuntary treatment and detention may be more appropriate if the person is unwell.
- A member stated that in-principle people should be able to receive treatment in the community without requiring a hospital admission.
- One member stated that an overall involuntary patient order could be introduced which follows a person whether they being treated are in hospital or in the community.
- A member stated that there is a need to increase flexibility in providing community treatment, which this proposal would allow. In this member’s view, it would be reasonable for clinicians to authorise initial involuntary treatment in the community (pending a review by the MHRT) given that clinicians can currently do so in inpatient facilities.

**Summary**

Taking into account all of the information and advice gathered during this review of the Act, it may be appropriate to undertake further consultation that includes:

- Consideration being given to whether the MHRT should be able to waive the 14 day notice period for urgent CTO applications.
- Consideration should be given to establishing appropriate timeframes for the MHRT to hold reviews of urgent CTO applications and that consideration be given to whether these reviews can be held in such a timely fashion that the issues raised in the discussion paper are effectively addressed.
- That, if the above MHRT proposal does not effectively address the issues raised in the discussion paper, consideration be given to the development of an initial involuntary community treatment regime that operates on a similar basis to initial involuntary inpatient treatment.
10. Role of the Mental Health Review Tribunal

The current legislation / situation

Section 27(d) includes: “The person must be brought before the Tribunal as soon as practicable after admission (subject to meeting the requirements set out above).”

In practice, the MHRT generally conducts a mental health inquiry about two weeks after the person is admitted to a MHF.

Discussion paper

In relation to this issue, the discussion paper asked the following questions:

- Should the Act be amended to further strengthen or clarify the role of the MHRT?
- How can it be strengthened to further facilitate the objectives of the Act?
- Should there be a formal relationship between the Official Visitor Program and the MHRT?
- Are there any other comments you wish to make concerning the MHRT?

Feedback from community consultation forums

Forum participants noted that Tasmania’s draft mental health legislation seeks to reduce the waiting time for MHRT hearings down to four days, a significant difference from the two week period people in NSW must wait. Some participants stated that swifter hearings would reduce client stress and provide for an earlier appeal if that was necessary.

Another opinion expressed was that the MHRT process was overly legalistic. To be specific, the MHRT was felt to establish an inappropriately adversarial environment between lawyers, sometimes leading the best interests of the consumer to get lost. The community consultations indicated there would be considerable merit in the development of some specific training for lawyers working in the MHRT so they can better appreciate the setting and apply a different framework to their work in this environment.

The Forums also revealed some concern that the MHRT may not always have the evidence necessary for accurate and fair reviews and to reach the best decisions. In particular, it was suggested that appearances at the MHRT should seek to engage a broader cross-section of the people who know the patient best, including family, friends, perhaps the general practitioner, so as to ensure the MHRT has what it needs for an evidence-based review process.

It was suggested the Act should clarify who supervises or monitors operation of the MHRT. This would be an important element in ensuring system accountability.
**Feedback from public submissions & survey**

Twenty-two submissions provided feedback on the role and responsibilities of the MHRT, including from the MHRT, two medical association/college/committees, two LHDs and associated specialty networks, three government departments, NGOs and carer and consumer groups (including peak organisations), academics, Legal Aid, and the OVs. Specific issues that were raised by a number of respondents included:

### 10.1. Timing of initial mental health inquiry

A number of submissions (from consumers, carers and health professionals) raised concern about the timing of the initial review following the admission of an assessable person (mental health inquiry – s27(d)). Submissions noted the increase in time to approximately four weeks following the transfer of this responsibility from the Magistrates to the MHRT, and then the aim to reduce the time to two weeks following the Report on the “Evaluation of Efficacy and Cost of the Mental Health Inquiry System”\(^2\). Those submissions that commented on this issue generally felt that a requirement to hold inquiries ‘as soon as practicable after admission but no later than seven days after admission’ (similar to when inquiries were undertaken by the Magistrates) was appropriate and an important amendment. Some submissions acknowledged that such an amendment was likely to require additional resources for the MHRT.

In addition, some submissions proposed that ‘face to face’ reviews be specified as the standard practice for all assessable persons attending the mental health inquiry and that video conferencing only be used in exceptional circumstances. These submissions considered that this would reduce the stress and confusion that may be experienced by acutely unwell patients subjected to video conferencing and the exposure of clinical staff to increased risk when managing the ‘often distressed and confused patient following such experiences’.

### 10.2. Other feedback

Other comments and suggestions included:

- The legislation on the proceedings of the MHRT should include consideration of any dependent children or young people in the care of the person with a mental illness or the person’s partner. Should concerns exist about risk of significant harm in regard to the children or young people, a report to FACS (Community Services) is warranted.

- There are several instances when the MHRT considers that it would be useful if it could refer information to others, including:
  - Referral of contempt of the MHRT, similar to provisions found in s131 of the Administrative Decisions Tribunal Act 1997.
  - Where a patient has received treatment from a number of hospitals, or local health districts (and/or in a prison or forensic setting), it may be that the MHRT has the most comprehensive history of the patient’s mental health and treatment. It could greatly assist the current treating team to be able to access the information held by the MHRT. This ability to share information would be beneficial for all patients receiving compulsory treatment, whether as an inpatient or in the community.

• Section 154 provides for legal representation before the MHRT. It would be useful to clarify that the
MHRT can still proceed without a legal representative being available in appropriate circumstances,
 e.g. where the urgency of the matter (e.g. ECT or surgery) is such that any delay would place the
person at serious risk of harm, and where the right to legal representation is used as a deliberate
delaying tactic on the part of the patient and/or the legal practitioner.

• Provide patients with the right to have a support person accompany them at MHRT hearings.

10.3. Link with Official Visitors Program

The majority of the submissions that addressed the question regarding a formal relationship between the
MHRT and the Official Visitor Program were not supportive of a more formal relationship between the two
organisations. In particular, most submissions noted that it was important to maintain and support the
independence of the OV Program; however, a number of submissions did comment on the need for
collaboration and communication at a close level between the OV Program and other mental health agencies
such as the MHRT and the NSW Mental Health Commission to help enhance each services function.

It was noted that there is currently a Memorandum of Understanding between the OV Program and the
MHRT which outlines the processes for sharing information and collaborating to resolve common issues.
However, other submissions felt that it may be appropriate to provide a mechanism for the MHRT to refer a
particular issue to the OV Program for investigation, follow up or review. This would provide a more
formalised pathway for investigation of systemic issues or matters of importance to particular patients.

One submission highlighted the different consumer/carer perceptions of the two organisations, where the
MHRT is viewed as ‘the law’ and the OV’s are more likely to be perceived as being on the consumer’s side.

Advice from the Expert Reference Group

The ERG was asked to consider the following questions:

1. What should the Government take into consideration in deciding whether to amend the Act to
   require the MHRT to conduct initial mental health inquiries within a certain time period of admission
   of the person?
2. What should the Government take into consideration in deciding whether to amend the Act to
   require the MHRT to conduct initial mental health inquiries ‘face-to-face’, and when might it be
   appropriate to use video-conferencing (or similar) technology?
3. Should any of the issues raised above be further explored to consider the possible implications of
   any proposed changes to the legislation?

The ERG provided the following advice about key issues that should be considered when making a decision
about the legislation:

• Some members suggested that the Act should specify a time period within which to conduct mental
  health inquiries, such as that the inquiry should be conducted as soon as practicable but not more
  than 7-10 days after the Form 1s were completed.
• It was suggested that it is a question of where mental health funds are best spent – whilst detained
  persons could be seen within shorter timeframes by the MHRT, this would come at a substantial
  additional cost. Increased use of video-conferencing in inquiries by the MHRT could also reduce
timeframes.
• One member stated that timeliness of inquiries is very important but that video-conferencing should not be used as it further distresses consumers. It is important that consumers have sufficient time to stabilise enough to enable them to engage and prepare for the inquiry, and to give more opportunity for carer involvement.

• One member commented that there are a range of safeguards for detained persons under the Act, including that the AMO must discharge a person if they no longer meet the requirements for detention and that the person has the right to seek discharge and appeal to the MHRT if discharge is refused.

• One member commented that there should not be a time limit placed on inquiries, and if one were imposed, then the MHRT would require a bridging power for cases where for some reason the inquiry cannot be held within those timeframes, such as where it is in the person’s interests, to ensure that the MHRT retains jurisdiction.

**Summary**

Taking into account all of the information and advice gathered during this review of the Act, it may be appropriate to undertake further consultation that includes:

• Consultation and analysis be undertaken to consider whether there is a need for amendment to the mental health inquiry provisions. This should include analysis of the financial impact of such changes and whether this would represent the most effective use of mental health funds.

• That consideration be given to whether the proposal that the MHRT and OVs should be able to refer matters to each other warrants further investigation, noting that there are other mechanisms under the Act that allow for investigation of individual and systemic issues.

• That consideration be given to undertaking analysis and consultation in relation to whether MHRT proceedings should include consideration of dependent children or other persons, whether there should be a capacity to refer information by the MHRT to others, whether there should be a capacity for the MHRT to proceed where a legal representative is not available, and whether there should be a right for consumers to have a support person accompany them to a MHRT hearing.
11. Role of Official Visitors

The current legislation/situation

In NSW, Official Visitors (OVs) are involved in the advocacy and care of people under the Act who receive treatment at a MHF, whether voluntarily or not. The role and scope of Official Visitors is outlined in Chapter 5 of the Act. This includes raising issues of patient safety, care or treatment, and advocacy on behalf of the patient in relation to issues arising in the mental health system. An OV may inspect MHFs with no formal notice and has a right to see ‘registers, books, records and other documents’ upon request (s131(3)(c)). The appointment, inspection rights, reporting pathways and advocacy role of OVs are detailed in s128-135 of the Act. OV Program inspection rights under the Act currently pertain to MHFs only and cover the ‘care, treatment and control of voluntary and involuntary patients plus patients who are subject to a community treatment order’.

Discussion paper

In relation to this issue, the discussion paper asked the following questions:

- Should the role of OVs be expanded or at least more clearly defined?
- Should OVs 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?
- What is the scope of their practice and best reporting pathways for Official Visitors? How can this be standardised?

Feedback from community consultation forums

Participants in both the forums and public submissions raised a number of common themes. Whilst all acknowledged the importance of the Official Visitor program there was consensus that the scope and boundaries of the role required further clarity.

Feedback from public submissions & survey

Twenty-four submissions (including two LHDs, MHRT, OVs, government departments, and NSW Consumer Advisory Group) were received. With the exception of one respondent, who felt that no legislative change was necessary, all agreed that the role of an Official Visitor should be more clearly defined. Whilst none argued for a reduction in the role, the majority (including the OVs) clearly stated that any expansion should not occur without clarification of the scope and reporting pathways entailed. A number of submissions suggested that this role be better controlled, audited and supervised.

Problematic issues were identified and included:

- reported professional boundary violations
- reports beyond the scope of mental health care and treatment
- incorrect reports and a lack of requirements to check accuracy
There was general consensus that the Act should be amended to allow OVs visiting rights to non-MHFs such as medical wards. A smaller number suggested that this be further extended to include non-government settings, and community boarding houses, etc. The Commission for Children and Young People agreed that OVs should have the power to enter a non-MHF; particularly because children and adolescents are often admitted to paediatric hospitals and medical wards which may not be specialised in child and adolescent mental health.

A smaller number of submissions suggested that there be mandated periods under which OVs must contact new patients (both voluntary and involuntary) particularly for children or young people. All agreed that the Act needed to provide more clarity in terms of accountability and reporting pathways. There were a variety of suggestions on how this might be achieved.

Other issues raised

An issue raised by a smaller number of public submissions was a need for the Act to further clarify the roles and relationships between the MHRT and the OVs (this has been addressed in the Chapter on the Role of the MHRT).

Other suggested areas needing clarification included:

- more formalised and standardised pathways for both reporting and investigation of issues
- further defining the role of the Principal Official Visitor (POV) (e.g. in terms of leadership of OVs and as an intermediary to the Minister)
- further discussion of who the POV should report to (e.g. the Mental Health Commissioner; the Minister; MHDAO)
- clearly legislated mechanisms for a DMHF’s ability to report boundary violations or code of conduct issues to an independent body. There were various suggestions as to who this independent body might be.

As discussed, specific suggestions for expansion included:

- more frequent visits; particularly where there are issues of ongoing concern
- the ability to report misconduct to the HCCC and assist in the investigation
- a mandate for OVs to report serious misconduct by mental health services to the Minister for Health and the NSW Ombudsman.

Advice from the Expert Reference Group

The ERG was asked to consider the following questions:

1. Should the role of Official Visitors be better or more clearly defined in the Act?
2. Does the role of Principal Official Visitor need to be further defined?
3. Whilst there was agreement that the legislation be broadened to allow OVs to visit patients in non MHFs, there were suggestions to include other non-government and community concerns such as boarding houses. Should the OV Program have rights of inspection in other related facilities and if so, what kind?
4. Should the Act be amended so that OVs inspect facilities more often? If so, how often and under what circumstances?
5. What are the best reporting pathways? For example, should the POV report to MHDAO, MHRT, the Mental Health Commissioner, the Minister?
6. How can the Act incorporate better accountability for the OV Program? Should a strict code of conduct be implemented via the POV or another body?

The ERG provided the following advice about key issues that should be considered when making a decision about the legislation:

- The role of the OVs should be as independent observers of clinical care and monitoring of policy implementation.
- An advocacy role (i.e. promoting the views of a particular patient) is different to an investigator/auditor role.
- Both system advocacy/arbitration and individual person advocacy are covered under the Act as roles of the OVs. Some members considered that the two roles should not be undertaken by one person/organisation.
- It was suggested that the OVs report to the Minister through the Mental Health Commission, but the POV may need to maintain direct access to the Minister/Minister’s office. This would allow the Commission to review issues and funnel them to the relevant agencies.
- The MHRT would like to be able to request that OVs investigate particular issues identified through MHRT hearings and report back to the MHRT.

Summary

Taking into account all of the information and advice gathered during this review of the Act, it may be appropriate to undertake further consultation that includes:

- Consideration being given to whether it is appropriate to allow OVs to inspect non mental health facilities where persons who have been detained under the Act are receiving non-mental health treatment. This should include analysis of the financial implications of any such changes.
- Consideration be given to whether it is appropriate to amend the Act to provide more direction as to the role of the OVs and the types of issues that the OVs should consider when undertaking inspections of DMHF to ensure that OVs are fulfilling functions in accordance with their role as an independent investigative and governance mechanism over the mental health system.
12. Initial assessment for involuntary detention

The current legislation/ situation

Under section 19 of the Act, a medical practitioner or AP 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.

APs are experienced, and specially trained and appointed health practitioners who may be nurses, psychologists or social workers.

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 experience with mental health may be problematic in some DMHF emergency departments that undertake Form 1 assessments, particularly in regional areas. It was proposed that giving APs the authority to complete an examination as part of a Form 1 certificate could help to address this resourcing issue.

Discussion paper

In relation to this issue, the discussion paper asked the following questions:

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

Feedback from community consultation forums

No feedback on this issue was provided in the Independent Community Consultation Forums Panel Report.

Feedback from public submissions & survey

Submissions on this issue were received from 31 respondents, including five Medical Association / College / Committees, five LHDs and associated specialty networks, five government departments, NGOs and carer and consumer groups (including peak organisations), academics, Legal Aid, the MHRT and the OVs.
Completion of Form 1 assessments by APs

There were diverse, and at times strongly opposed, views about whether APs should be able to complete an assessment as part of a Form 1.

Those submissions that supported the role of APs being expanded to include completion of Form 1 assessments provided a range of reasons and comments, including:

- APs are already trained by the Department, experienced in mental health care and authorised to schedule people. Empowering APs to undertake a Form 1 examination where medical or psychiatric resources are limited (in particular, in rural and remote settings) may allow more timely access to the examination in some instances, reducing the waiting time of persons awaiting examination; however, it does significantly change the processes of the Act which will need to be broadened to include non-medical initial assessments.

- It is important that completion of a Form 1 examination by an AP does not jeopardise the potential for a psychiatrist also to examine the patient.

Those submissions that were opposed to the role of APs being expanded to include completion of Form 1 assessments provided a range of reasons and comments, including:

- Whether a person has a mental illness, as defined by the Act, is a medical judgment and medical practitioners are subject to professional scrutiny designed to ensure that the public have faith that such diagnostic decisions are made competently and ethically.

- Currently, 1-3 medical practitioners are involved in the completion of Form 1s. One respondent considered that requiring 1-3 medical practitioners to undertake the assessment acts as a procedural safeguard to ensure a patient’s liberty is not unduly restricted. In addition, allowing APs to complete Form 1 assessments may lead to situations where a person is discharged on the sole opinion of an AP in circumstances where a psychiatrist may have formed the view that the person required ongoing involuntary mental health treatment. In the circumstances, there may be more viable solutions to improve access to medical practitioners that ought to be considered (such as video conferencing).

- While acknowledging the difficulties in obtaining access to medical or psychiatric staff in some circumstances, the MHRT considers it important that the existing requirements in relation to the completion of a s19 Schedule and the Form 1s be retained. The power to detain a person is a significant one. The present statutory requirement that the person authorising detention has a certain level of training and expertise is an important safeguard.

- In addition, concern was raised that the proposed change to allow APs to complete Form 1 assessments was about issues with resources, rather than to improve the quality of care or treatment decisions.

Advice from the Expert Reference Group

The ERG was asked to consider the following questions:

1. What should the Ministry of Health consider in determining whether it is appropriate for APs to have a role in completing Form 1 examinations?

The ERG provided the following advice about key issues that should be considered when making a decision about the legislation:
• Completion of the Form 1 requires clinical diagnosis and this is generally considered to be the domain of psychiatrists. There was some support for the view that only AMOs should be able to make such diagnostic decisions.

• One member noted that the Act allows a person to be detained for up to 12 hours before the first Form 1 needs to be completed, and considered that this should be sufficient time to arrange for an AMO to undertake the Form 1 assessment.

• One member considered that it was important to avoid completion of Form 1’s by an AP becoming a common practice. It should only be permitted in exceptional circumstances where a doctor was not available.

• Some members considered that if an AP had completed the Schedule 1 then medical practitioners should be required to complete both Form 1s.

• It was noted that it is not possible to have different requirements for who can complete Form 1’s in different areas (e.g. rural vs. metropolitan areas).

• It was suggested that Nurse Practitioners (NP) could complete Form 1 examinations.

• It was proposed that the skills criteria for APs could be listed in the Act.

**Summary**

Taking into account all of the information and advice gathered during this review of the Act, and on balance, it appears to be appropriate to retain the requirements for Form 1s to be completed by an AMO only. However, it may be appropriate undertake further consultation about whether the Act should be amended to allow an AMO from another mental health facility within the same LHD to complete the first Form 1 in exceptional circumstances where an AMO is not available at that facility within the initial 12 hour period of detention or whether there are alternative solutions to this issue.
13. Transport of persons for assessments

The current legislation/situation

Currently, under the Act, Form 1 assessments can only occur in a DMHF (s27). 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.

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, medical practitioners complete ‘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.

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

The AMO must discharge, or must not involuntarily admit 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).

Discussion paper

In relation to this issue, the discussion paper asked the following questions:

- 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?
- 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?
- What practical issues do you think need to be addressed in implementing such a proposal and how do you think they should be addressed?

Feedback from community consultation forums

It was stated in the Independent Community Consultation Forums Panel Report that:
“Overwhelming feedback from the consultation was that transportation is a critical matter, given that in rural areas of NSW a person may require several hours transportation which can often be dangerous and traumatic in itself, before any treatment has been provided....”

“While the number of gazetted facilities has increased over the years, the police certainly feel that this restriction [i.e. that the person must be taken to a DMHF] forces them to transport people long distances. There is also inconvenience to consumers and carers who have to travel long distances with, in some cases, increased associated hazards. And for patients who are then refused admission, some consumers advised that they have been left without any means to return home...”

The report listed a number of suggestions for improvement to such transport, including:

- Undertaking more remote assessments (by video-link) to reduce the requirement for transportation, including potentially broadening the number of facilities that might be permitted to conduct such remote assessments legally;
- Enhancing the police/ambulance response with more mental health specialist response capacity.

**Feedback from public submissions & survey**

Submissions on these issues were received from 19 organisations and one individual, including the NSW Nurses and Midwives Association, the Australian Medical Association, six LHDs and associated specialty networks, two NGOs, four NSW government departments, Legal Aid, the MHRT, the Ambulance Service of NSW, Police, the Transcultural Mental Health Centre and the OVs.

Most submissions (15 organisations and one individual) broadly supported the proposal, two organisations rejected it, and two organisations expressed somewhat ambivalent views.

Reasons provided for objecting to the proposal included that:

- All NSW health facilities should have the resources to conduct a safe and thorough assessment and manage mental health patients safely at all times.
- The proposal would not be workable as once the police and ambulance hand over a client they leave the facility unless there are medical or violence issues necessitating further involvement by these parties. Significant risk factors would arise in rural and remote areas due to resourcing and capacity to safely detain persons awaiting assessment and until suitable transfer is available.

Issues that many respondents thought should be considered as part of the proposal include funding, training, minimum facility requirements, time limits on detention, and transfer of care. Some respondents indicated that minimum facility requirements should potentially include distance from an inpatient DMHF, appropriately trained staff, a safe assessment room with video-conferencing, and adequate security.

Some respondents believed that a separate class of DMHF needed to be developed for the purpose of conducting Form 1 assessments.

Some respondents felt that OVs should inspect such facilities in order to ensure compliance with the Act, whereas one respondent thought that such inspections would be superfluous as it would be unlikely that any detained persons would be present during an OV inspection.

Other issues that organisations thought needed to be considered in further developing the proposal, as well as qualifications and conditions they placed on their support for the proposal, included that:
• This amendment should also flow onto s33 orders under the MHFP Act. This would mean that if the court makes a s33 order under the MHFP Act, the video-link would be arranged from the court that makes the s33 order for examination at a DMHF, where the court has video-link facilities.

• The establishment of a network of senior clinicians in the public system (with access to video-link facilities) able to provide external advice to non-declared health facilities should be considered as an alternative to the proposal.

• The perceived need for the proposal should be investigated, including a review of the prevalence rates of instances where people are transported long distances unnecessarily and refused admission.

• When the person has been apprehended by police in a rural or remote area of NSW and there are no prescribed health facilities in close proximity to the police station, it may be possible to devise a system where the person can be detained in the police station for a short while to be examined by a person authorised to complete a schedule. The person could then be transported to the DMHF only if a schedule is completed.

• Consideration should be given to the provision of return transport for the consumer if they are not deemed to require involuntary treatment.

• Hospitals selected for video-link assessments could be aligned to locations where there are DMHFs in the community class to maximise the availability of suitably qualified and knowledgeable staff. OVs currently visit all DMHFs where CTOs are administered and OVs could also inspect such hospitals at the same time as the community DMHFs.

• The Ministry should be looking at what resources there are in particular towns where there are concerns. Training health professionals in these towns to deal with this type of situation efficiently may be one of the solutions.

Advice from the Expert Reference Group

The ERG was asked to consider the following questions:

1. Should a new class of DMHFs be established to allow Form 1 assessments to occur, or should the transport provisions in the Act be amended to allow limited detention in such facilities for the purposes of assessment? If the latter, how could it be ensured that police and ambulance would only take people to appropriate facilities rather than to any health facility? Or are there other suitable places that persons could be taken to for a Form 1 assessment by video-conference?

2. What should be the minimum requirements for a health facility to be used for such assessments?

3. What restrictions or conditions, if any, should be placed around the use of such facilities?

4. Should s33 orders for assessment under the MHFP Act be able to be conducted from court/cells by video-link to a DMHF?

The ERG provided the following advice about key issues that should be considered when making a decision about the legislation:

• There is a need to provide alternative/additional places for performing a Form 1 assessment.

• There was general agreement that a separate assessment class of DMHF should be created which would be permitted to detain persons for the purpose of undertaking a Form 1 assessment; however, there was some concern expressed about ensuring that those facilities had sufficient
security and staff with the skills to conduct assessments. It was suggested that police should stay at the facility while the assessment was taking place (although this would require the assessment to be undertaken promptly).

- Two members strongly opposed s33 orders for assessment being conducted via video-link from court/cells as proposed in one public consultation submission.

**Summary**

Taking into account all of the information and advice gathered during this review of the Act, it may be appropriate for further analysis and consultation to be undertaken on this issue, particularly in relation to determining a preferred mechanism(s) to address the concerns raised during the consultation process. Specific consideration could be given to the potential cost implications of any such proposal, the level of involvement by relevant agencies in providing relevant services, as well as to the minimum requirements that would need to be met for a facility to be involved in any such proposal.
14. Detention on order of a Magistrate or police officer

The current legislation / situation

Where the person has been brought to the DMHF for assessment 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 22 of the Mental Health Act 2007), and the DMHF does not consider that the person meets the criteria for involuntary treatments, the facility 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:

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

Stakeholders had previously 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 had been suggested that the time be extended to four hours.

Discussion paper

In relation to this issue, the discussion paper asked the following questions:

- 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?
- Are there any other comments you wish to make concerning this issue?

Feedback from community consultation forums

Some forum participants supported the provisions in the Act which allowed people to be diverted from the justice system and into mental health care where appropriate.
Feedback from public submissions & survey

In total, 21 submissions addressed one or both of the questions in the discussion paper that related to section 32 of the Act. Respondents included three medical association/college/committees, three LHDs and associated specialty networks, four government departments (including Police), NGOs, carer and consumer groups (including peak organisations), Legal Aid, and the OV.

There were divergent opinions amongst respondents: three respondents supported the proposal that the time limit for a police officer to attend and take custody of a person be increased to four hours; eight respondents supported consideration of an extended time period (of varying lengths) but only in exceptional circumstances which should be clearly defined within the revised Act; and, seven respondents did not support an increased time period. Three respondents (including Police) who responded to this section of the discussion paper did not respond to the specific questions and did not give a view on whether the time period should be increased.

Those submissions that supported an increase in the time period with limitations, or only in exceptional circumstances, or did not support an increase in the time period, raised the following options and issues for consideration:

- Several respondents suggested that the mental health assessments should be undertaken in a holding cell under the jurisdiction of the police, rather than transferring the person to a DMHF.
  - One respondent acknowledged the resource implications for the health system associated with this suggestion, but considered that there would be reduced costs for the police and corrective services.
  - In addition, the submission noted that this would reduce the issues associated with police waiting with a person while the assessment is undertaken.

- Mental health facilities should not be able to detain a person who does not meet the criteria for involuntary inpatient treatment under the Act.

- The time limit should remain at one hour, but include recognition that, in exceptional circumstances, the time limit may need to be extended to up to four hours. A number of submissions considered that one hour was sufficient time for police to attend and apprehend the person, and felt that this is working reasonably well at the moment.

- The time limit should be set at two hours:
  - Even in a rural/remote setting there should be a police station near the hospital with staff who could attend and apprehend a person within two hours.
  - However, in more remote areas, up to four hours might be appropriate.

- The maximum time limit should be for an initial two hours, but with extension for a further hour (three hours in total) in specific exceptional circumstances, set out in the legislation.

- The time limit should be extended to 3 - 7 hours.

- The maximum time limit should be four hours; however, several submissions expressed concern that any extension in the time period should not become the norm in either the metropolitan or rural areas. Regulations will be required to ensure that a person is not detained any longer than has been common practice to date.
Other issues for consideration that were raised in the submissions include:

- There are resource implications and policy implications:
  - If the person is detained in a safe assessment room whilst awaiting police attendance and apprehension, the seclusion policy must be applied and the person will require 1:1 nursing for first hour and then 10 minute observations.
  - If the person is assessed in general hospital emergency departments (as is common), an extension of this timeframe will impact significantly on the KPIs associated with reducing waiting times in the Emergency Department and ensuring that the health service is able to secure and detain such individuals until an appropriate handover back to police.

- Interaction between the Mental Health Act and the MHFP Act.
  - In particular, a request has been made that, where a magistrate orders that a person be taken to a MHF for assessment, and that person is found not to be a mentally ill person and returned to court, the doctor provide reasons to the court for their decision.

- The Law Reform Commission’s report, *People with Cognitive and Mental Health Impairments in the Criminal Justice System: Diversion* (2012), considered the legislative provisions dealing with the referral of people to a DMHF by police, and on the order of a magistrate. A Senior Officers Committee has been established to assist in preparing a Government response to this report, and this issue could be considered as part of that process.

- Discharge planning could allow for earlier communication with police and earlier or faster police attendance to avoid this problem. While recognising the public interest issues involved, this respondent was reluctant to support detention that is not based on treatment needs.

**Advice from the Expert Reference Group**

The ERG was asked to consider the following questions:

1. Does the ERG consider that it is necessary to extend the period of time that a MHF can detain a person pending the person’s apprehension by a police officer?
2. If so, which option does the ERG consider to be the most appropriate balance of rights and responsibilities of all parties?
3. Were an extension to the time period allowed in exceptional circumstances only, how should these circumstances be defined?

The ERG provided the following advice about key issues that should be considered when making a decision about the legislation:

- The length of time that a person can be held following an assessment which found that they were not a mentally ill person (as defined in the Act) should be kept to a minimum. One member suggested that a two hour time limit strikes a reasonable balance between practical/resourcing aspects and limitations on a person’s freedom.
- A member stated that where a person was brought to a facility under a s33 MHFPA order, the DMHF needed to provide prompt assessment if they expected police to stay at the facility during the assessment in order to reduce the pressures on police resources.
• One member stated that the diversion functions under the MHFPA and Mental Health Act are very important mechanisms to divert persons away from the criminal justice system and into mental health treatment, and it is therefore important that these functions are facilitated to the greatest degree practicable.
• If a person was admitted under the MHFPA and the health service contacted Police to attend and apprehend the person at discharge, then it should be the minimum time possible. If Police apprehended the person and brought them to hospital for assessment (s22) then the time should be 2 hours.
• One member considered that further Police advice should be sought on this issue.
• It was noted that the Department of Attorney General and Justice (DAGJ) is reviewing ss32, 33 of the MHFPA as part of the Law Reform Commission review and report.

**Summary**

Taking into account all of the information and advice gathered during this review of the Act, it may be appropriate to consider amending s32(4)(a) to extend the length of time that a mental health facility may detain the person pending the person’s apprehension by a police officer, from ‘a period not exceeding one hour’ to the minimum time possible but a period not exceeding two hours.
15. Detention of voluntary inpatients

The current legislation/situation

A voluntary patient may discharge themselves from a MHF at any time. On occasion, 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. However, presently, the NSW Mental Health Act empowers an AP (who may be a nurse, psychologist, social worker) or medical practitioner to schedule a voluntary patient under s19.

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 WA Act is currently under review and the proposed changes include 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 six hours to allow them to be medically assessed.

Discussion paper

In relation to this issue, the discussion paper asked the following questions:

- Does the NSW Mental Health Act need to include a provision that allows a nurse employed by the MHF to hold a voluntary patient wanting to discharge themselves against medical advice? Why/why not?
- Under what circumstances, if any, would it be reasonable to hold a voluntary patient who wanted to discharge themselves before an AMO could undertake a review?
- 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 AMO?
- If mental health nursing staff were to have such authority:
  - what skills and experience would be required?
  - should a specific staff position (or positions) in the facility be nominated?
**Feedback from community consultation forums**

It was stated in the Independent Community Consultation Forums Panel Report that there should be:

- Flexibility and increased recognition of APs – other people who can take up responsibilities under the Act such as nurses, social workers and others.

- Remove sole reference to the Medical Officer under the Act and enable a broader definition of AP to make it easier to get into care.

**Note:** the above comment is unclear, however, it may be a suggestion to give APs the same power as AMOs under the Act.

**Feedback from public submissions & survey**

Submissions on these questions were received from 27 organisations, comprising eight government bodies, including Legal Aid and the MHRT; seven organisations, including the NSW Nurses and Midwives Association and Public Interest Advocacy Centre; six LHDS and associated speciality networks; five individuals, including doctors and public health workers; and one peak carer organisation.

**Including a provision to enable nurses to detain voluntary patients**

A majority of submissions supported the notion of allowing nurses to detain voluntary inpatients where they posed an imminent risk of harm to themselves or others. A minority of submissions opposed the notion, commenting that to do so would infringe on an individual’s right to freedom.

Several respondents commented that nurses could already detain voluntary inpatients under common law:

- If there was a foreseeable risk of serious harm to self or others, then the common law probably provides a limited justification in such circumstances to briefly detain a person to assess for the presence or absence of decision making capacity. We suggest that, to aid in clinician’s understanding of the law and therefore improve clinical care and protection of patient rights, it may be helpful to reflect these elements of the common law within the provisions of the Mental Health Act by adding provisions permitting clinicians to detain a person for a very brief period where detention is necessary to determine whether compulsory treatment could be given under the Act.

- The common law, through the defence of necessity to the torts of trespass and false imprisonment, allows hospitals to detain and even restrain people if the alternative is the immediate risk to life or an immediate possibility of serious harm to themselves or others. NSW Health has developed protocols to assist and guide health professionals in such circumstances. These common law legal principles apply in all medical situations and could apply to an involuntary patient in such exceptional circumstances.

One respondent commented that the Act appeared to empower an AP or a medical practitioner to detain a person in a MHF, on the basis of a certificate about the person’s condition and queried whether such a provision was necessary.

Another respondent commented that nurses could probably do this already without a provision, and several respondents noted that this situation could be covered by nurses ‘duty of care’ obligations. For example, one respondent commented:
Currently, nursing staff may temporarily refrain from discharging a patient who requests to be discharged until a suitable review is made. This is especially so for patients about whom nursing staff are concerned and could be seen as a duty of care requirement. Relevant scenarios include the patient considered Mentally Ill/Disordered and at risk of harm for whom a voluntary admission is considered least restrictive who subsequently seeks discharge.

A submitter also noted that this was already occurring in practice:

- The Act should contain a provision that allows a nurse employed by the MHF to hold a voluntary patient wanting to discharge themselves against medical advice. However, such a provision should have the proviso that a nurse exercising this function be suitably qualified and that this only be allowed under exceptional circumstances (e.g. psychiatrist is not available). It is the understanding of Legal Aid NSW that nurses holding voluntary patients is common practice and it is desirable that the circumstances in which such detention is authorised should be made clear.

The Nurses and Midwives Association commented that a provision for ‘nurses holding power’ was necessary to ensure the safety of the patient and to protect the nurse from legal action.

**Time limits on detention of voluntary patients**

Respondents put forward a range of time limits for the detention of voluntary inpatients ranging from 2 -12 hours. Some respondents noted the difficulties of imposing time limits in isolated towns. One respondent proposed at least 48 hours, depending on the case. Very few respondents justified why they chose a specific time limit. One respondent proposed 12 hours to bring the time limit in line with other modes of detention in mental health facilities. Some submissions stated that once the time limit had expired, videoconferencing or Skype should be used. Other submissions commented that once the time limit had expired, the AMO should have one further hour to conduct an assessment. One submission supported the Scottish example provided in the discussion paper.

**Skills and experience of nurses authorised to detain voluntary patients**

In respect of skills and experience, a range of options were put forward including APs, registered nurses, senior registered nurses and the senior nurse on duty. Varying levels of experience were put forward ranging from 3–5 years. Two organisations submitted that two registered nurses should agree to the decision to detain a voluntary patient.

**Whether a specific position should be appointed**

Four respondents opposed facilities nominating a specific staff position. Only one respondent provided a reason, stating that if this were the case, then the option to detain a voluntary patient would only be available when someone in that position was on duty.

Five respondents supported facilities nominating a specific position. One respondent supported the establishment of a Senior Psychiatric Nursing Intervention Specialist. One respondent supported appointing a specific position so that there was always someone available to make an assessment 24-hourly, and so that no ambiguity arose as to which role had the appropriate authority. Legal Aid stated that the AMO should be responsible for nominating appropriate staff. The MHRT proposed amending s10(1) and s10(2) of the Act to allow an AP to detain a voluntary patient, rather than limiting the power to an AMO.
Advice from the Expert Reference Group

The ERG was asked to consider the following questions:

1. If a nurse in a MHF suspects a voluntary inpatient is at risk of harm to themselves or others, are either common law provisions or duty of care obligations sufficient to detain the inpatient until an AMO arrives?
2. In what other circumstances might a nurse need to detain a voluntary inpatient?
3. In such circumstances, would common law or duty of care provisions be sufficient to detain the person?

The ERG provided the following advice about key issues that should be considered when making a decision about the legislation:

- The Act needs to provide holding powers to manage mentally ill patients in urgent situations. One member advised that in similar situations in the United Kingdom nurses can hold patients for up to four (4) hours.
  [N.B. Review by the Ministry of Health found that s5(4) of the UK Mental Health Act 1983\(^3\) states that a nurse of the prescribed class may hold a patient for up to six (6) hours in cases where it is considered unsafe for an in-patient to leave the hospital – this provision was not amended in the Mental Health Act 2007]
- One member considered that nurses should have two (2) hours to hold a person pending assessment by an AMO, but would need to demonstrate that they were trying to resolve the situation as soon as practicable.
- Members noted that there can be delays in getting access to an AMO by video-link. In addition, a clinician who was not physically in the same MHF as the patient might not have sufficient knowledge of the patient and their history, and might not be able to act quickly enough in an urgent/emergency situation.
- It was suggested that an AP could initiate the scheduling process in this situation, and the person could therefore be held for up to 12 hours awaiting an assessment by an AMO.
- Clear guidance needs to be provided to nursing staff about how to respond in this situation.
- Members noted that in similar situations in Scotland, nurses can hold patients for up to two (2) hours. \([s299(2)]\)

Summary

Taking into account all of the information and advice gathered during this review of the Act, it may be appropriate to amend the Act to permit the senior nurse on duty to hold a person for up to two hours while awaiting either a Schedule 1 assessment to be undertaken or for an AMO to cause the person to be detained under s10, with a requirement for the nurse being able to demonstrate that they are trying resolve the situation as soon as practicable.

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16. Community Treatment Orders

The current legislation/situation

Under the Act, a CTO can only be made by the MHRT. In order for the MHRT to make a CTO, it must have determined that (s53(3)):

- 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.

There is no requirement in the Act that the affected person be a mentally ill person for a CTO to be made. This contrasts with the MHRT’s review of a person who has been involuntarily admitted to an inpatient facility, which is known as a mental health inquiry. This inquiry, as well as the MHRT’s review of involuntary patients, requires that the MHRT must be satisfied, on the balance of probabilities, that the detained person is a mentally ill person before it can make an order for that person’s ongoing detention (ss35, 38).

Discussion Paper

This issue was not raised in the Discussion Paper.

Feedback from Community consultation forums

No feedback on this issue was provided in the Independent Community Consultation Forums Panel Report.

Feedback from public submissions & survey

Four submissions that were received in relation to the Review Discussion Paper suggested that the criteria for making a CTO should be amended. Three of these submissions proposed that a person must be a mentally ill person or a mentally disordered person in order for a CTO to be made. The other submission suggested that a CTO could only be made if the MHRT has made a finding that the affected person is a mentally ill person, or is likely to become a mentally ill person within the next 3 months.

It is unclear if the submissions were proposing that the mentally ill/disordered person requirement be added to other criteria that must be satisfied in order to make a CTO, or if they wanted this proposed requirement to replace one (or more) of the existing criteria.

No rationale was provided in any of the submissions as to why the CTO criteria should be amended in such a way. The aims of the proposed amendments may possibly be to either raise or lower the threshold for making a CTO, or it may be to make the CTO criteria more consistent with the criteria that must be satisfied for an involuntary inpatient treatment order to be made.
Advice from the Expert Reference Group

The following questions were asked of the ERG:

1. Should the criteria for making a CTO be amended to include a requirement that the affected person be a mentally ill person or a mentally disordered person, or that the person is likely to become a mentally ill person within the next 3 months? Why/why not?
2. If so, should this requirement be in addition to the other CTO criteria, or should it replace one or more of those criteria?

The ERG provided the following advice about key issues that should be considered when making a decision about the legislation:

- Some members were of the view that the current criteria in the Act should be retained. There is a requirement in the Act that the person must have a history of mental illness. A person should not need to currently be a mentally ill person when their longitudinal history shows that they are very likely to become unwell if they do not receive treatment. The proposal that a criterion be included that a person would be likely to become a mentally ill person within three months is arbitrary and would require clinicians to speculate.
- Some members considered that the current CTO criteria make it almost impossible for a person’s CTO to be revoked or not continued if the treating mental health service continually applies for CTO renewals.
- One member suggested that the criteria could be amended to require that a person would become mentally ill if they were not under a CTO.
- Some members suggested that at some point a person should be given the opportunity to cease mandatory treatment under a CTO by indicating that in the past they were a mentally ill person but that they now have insight into their circumstances, including that they could be detained and involuntarily treated if they stopped taking medication.
- One member stated that the test for making a CTO should include whether the person will become a burden on others if the CTO was not granted.
- One member stated that even if the criteria were amended, there would still need to be a community safety test.
- One member suggested that the criteria could be amended to include a requirement that a person be at risk of harm to themselves or others if a CTO was not granted.
- Some members suggested that after three to five CTOs, the MHRT should be able to discontinue a person’s CTO if the person stated that they would continue receiving treatment, and if the treating mental health service stated that they would remain in contact with the person. It was also suggested that subsequent applications for continuation of the CTO should not be able to be approved unless the MHRT was of the opinion that the person would become a mentally ill person if the CTO was not granted.

Summary

Taking into account all of the information and advice gathered during this review of the Act, it may be appropriate to undertake further analysis and consultation in relation to this issue with a view to determining whether legislative change to the criteria for granting CTOs is warranted.
17. Private mental health facilities detaining and involuntarily treating persons under the Act

The current legislation/situation

Under the Act, persons may only be detained and involuntarily treated in DMHFs. Section 109 of the Act allows the Director General of Health to declare any premises to be a DMHF and may:

- limit the provisions of the Act or the purposes under the Act for which the facility is a DMHF;
- designate a DMHF as a facility of a specified class;
- designate the purposes for which a DMHF of a specific class may be used;
- impose restrictions on the use of a DMHF for specified purposes;
- impose any other restrictions in relation to the operation of the facility as a DMHF.

This section may apply to premises where the owner or person who has control of the premises has agreed that the premises may be used as a DMHF.

Private mental health facilities (PMHFs), which are granted licences to operate as such by the DG under s115, may also operate as DMHFs. This principle is supported by s110, which states that a DMHF “that is also a private mental health facility ceases to be a declared mental health facility if the licence for the facility is cancelled under Division 2”. If approved by the DG, PMHFs that are also DMHFs would be allowed to detain and involuntarily treat persons under the Act, subject to any conditions or restrictions placed on the facilities by the DG.

Currently, no PMHFs are DMHFs under the Act and therefore these facilities are only able to provide treatment to voluntary patients.

Discussion Paper

This issue was not raised in the Discussion Paper.

Feedback from Community consultation forums

The Independent Community Consultation Forums Panel Report noted that a representative from private hospitals had asked at one of the forums whether private hospitals could become DMHFs for people with private insurance to create new pathways into care.

Feedback from public submissions & survey

This issue was not specifically raised in the submissions.
Advice from the Expert Reference Group

This issue was raised by the Ramsay Health representative on the ERG, who reported that, in Queensland, the private sector is able to take involuntary patients, and stated that this assists the public sector in moving patients through the mental health system. The representative requested that the ERG consider whether a more explicit statement should be included in the Act about private facilities being able to treat involuntary patients (if approved by the Director General of Health).

The ERG provided the following advice about key issues that should be considered when making a decision about the legislation:

- Some members stated that, whilst they did not have any objection in principle to private facilities providing involuntary treatment, the standards regulating any such private facility should not be any less than those imposed on the public system.
- One member objected to private facilities providing involuntary care, stating that it is a public responsibility to provide care where it is of a coercive nature and that such care should not be outsourced.
- A number of members considered that private facilities would be likely to ‘cherry pick’ patients, taking only the easier to manage patients, while the more complex, difficult to manage and high risk patients would continue to be managed by the public system.
- Some members indicated that allowing private facilities to provide involuntary treatment could be beneficial in some circumstances, such as for older persons who are incapable of providing consent for ECT. Private facilities might only be able to provide for such niche markets, with most mainstream patients still obtaining treatment through the public system.
- One member stated that private facilities could offer more choice for patients and carers in terms of the mental health care offered.
- Some members indicated that private facilities that provide involuntary treatment should have to comply with relevant Ministry Policy Directives and Guidelines, which could be made a requirement of licensing under private health facility legislation.
- One member stated that there is an issue with the relationship between public and private health providers and that formal arrangements would be required between the two sectors.
- Some members raised concerns about private facilities that provided involuntary treatment potentially having financial incentives to detain persons for longer than required.

Summary

Taking into account all of the information and advice gathered during this review of the Act, it might be appropriate to undertake further analysis and consultation in relation to whether there is a need to amend the Act to further promote the capacity for PMHFs to be DMHFs; and/or specify any requirements that PMHFs need to meet before they can become DMHFs; and/or specify any restrictions that should be placed around PMHFs that are also DMHFs.
18. Review of treatment planning and medication

The current legislation/situation

Stakeholders have suggested that a provision could be included in the Act to empower consumers to apply to the MHRT (or another body/person) 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.

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.

Section 68(h) of the Act provides that every effort that is reasonably practicable should be made to involve consumers in the development of treatment plans and plans for ongoing care, however some stakeholders have suggested that in practice this ideal falls somewhat short (see section 18).

Discussion paper

In relation to this issue, the discussion paper asked the following questions:

- Should the Act be amended to include provisions for patients to apply for a treatment review and if so, what limits should be placed around this?
- Should patients on a CTO also be able to apply for a treatment review?
- Should the treatment review be undertaken by the MHRT or another party? What would be the role of the Medical Superintendent?

Feedback from community consultation forums

No feedback on this issue was provided in the Independent Community Consultation Forums Panel Report.

Feedback from public submissions & survey

A legislated formal mechanism for treatment review was supported by respondents; however there were divergent opinions with regard to who should undertake the review, the proposed timeframes, and the role of the Medical Superintendent.

In total, 28 submissions were received with most respondents agreeing that consumers on a CTO should have the same right of access to a treatment review process as involuntary patients.

Although respondents agreed overall that a formal treatment review process should be legislated for, only 14 submissions provided an opinion as to who should conduct the review. Seven respondents felt that treatment reviews should be conducted by a non-treating psychiatrist, with five suggesting that the Medical Superintendent be responsible for coordinating the independent review and others suggesting that MHRT reviews could be a forum for consumers to raise concerns about their treatment. It was generally agreed
that it would not be appropriate for the MHRT to conduct the review itself unless there was a proposed change to the treatment plan.

Other relevant comments included:

- Primary carers and guardians should also be able to apply for a treatment review in situations where the consumer lacks capacity to do so. For Aboriginal consumers it is important that family members and carers also be able to request a review.
- The review must involve an assessment of the clinical notes and medication, as well as a face to face interview with the consumer.
- In the case of a child or young person, it would be desirable if the treatment review or second opinion was from a psychiatrist who specialises in child or adolescent mental health.
- Consumers should have access to treatment reviews and second opinions as a matter of principle. Patients already have the capacity to request a review by the Medical Superintendent in terms of discharge and other concerns. In practice, patients often use this as an opportunity to discuss any need for a second opinion or review of their treatment and this can be mediated by the Medical Superintendent.

**Advice from the Expert Reference Group**

The ERG was asked to consider the following questions:

1. Should a formal process be stipulated in the legislation to allow a consumer on a CTO to seek and receive a review of their medication/treatment? If so, who should provide this review?
2. Considering both the rights of the consumer and the resources available, how often should a consumer be able to seek a review of their treatment?
3. Are there any additional factors or concerns that the Government should consider in relation to treatment reviews for consumers on CTOs?

The ERG provided the following advice about key issues that should be considered when making a decision about the legislation:

- It should be enshrined in the Act that a patient and Primary Carer should be consulted if it is proposed to revoke a CTO and advice provided to the MHRT. If there was disagreement then a second opinion should be sought or the MHRT should decide.
- There was general agreement that psychiatrists not involved in the patient’s care should conduct reviews of medication and treatment and that a patient should be entitled to a six-monthly review.
- The Chief Psychiatrist questioned the value of a second opinion – what power would the second opinion have under the Act? Would a third opinion be required if the second opinion differs to that of the treating team?
- A review mechanism is a good idea as it will lift clinical practice.
- There was general consensus that there should be a robust check of the need for a person to be on continuous CTOs (e.g. after five years).
Summary

Taking into account all of the information and advice gathered during this review of the Act, it may be appropriate to undertake further consultation on this issue, including whether to amend the Act to require carers and consumers to be consulted prior to a CTO being discontinued or revoked; require the MHRT to be advised when a CTO is revoked; and establish a requirement for formal six-monthly review of treatment including CTOs. Feedback proposed that these reviews be conducted by a non-treating psychiatrist with equal or higher qualifications to the treating psychiatrist.
19. Consumer engagement in the development of treatment plans

The current legislation/situation

The process of engaging consumers in the development of treatment plans can empower consumers, promote opportunities for therapeutic communication and promote consistency in the management approach. Advance Care Directives (ACDs) (advance statements/agreements) usually refer to written statements of wishes, more commonly in the context of ‘end of life’ decision making but can also apply to ongoing treatment decisions in a mental health context.

Discussion paper

In relation to this issue, the discussion paper asked the following questions:

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

Feedback from community consultation forums

There was some support for more widespread use of advance directives by consumers and carers to clearly state preferred treatment arrangements while the consumer is well. This will require some further work to ensure these tools have adequate legal standing under the Act and cater for situations in which a person might change their mind.

Feedback from public submissions & survey

In total, 27 submissions were received that addressed one or both of the questions in the discussion paper that related to ACDs and formalising, in legislation, the development and management of treatment plans. Submissions were received from a range of Government and non-government organisations, consumers, carers and carer organisations, clinicians, LHDs and associated speciality networks, academics, the NSW Nurses and Midwives Association, the MHRT and the OVs.

In general, respondents supported the proposal with some comments including:

- Similar to the provisions in the WA draft Mental Health Bill 2011, the NSW Act should encourage patients to make advanced health directives that set out what they want to happen if they become incapable of making decisions for themselves. These directives should be held in the patient’s file and the patient’s psychiatrist and the MHRT should be required to have regard to these directives in making a decision about the patient’s care and treatment, particularly in the situation where a patient does not have the capacity to participate in decision making about their care.

- Support provisions being included in the Act which enshrine the rights of consumers to exercise choice and to direct treatment and support, wherever possible. Consumer participation and control
in the development of treatment and support plans promotes the development of a partnership between the consumer and mental health professions.

With regard to the question posed in the discussion paper, *in what circumstances should treatment plans be allowed to be overridden*, some comments from respondents included that such plans should be able to be overridden:

- In situations where there is serious immediate risk of harm to self/others
- When the person is admitted as an involuntary patient
- Where there are genuine and significant concerns about a person’s capacity to make healthy and informed choices about aspects of their life, particularly when they increase the risk to themselves or those around them. An appeal/review mechanism could be made available for people when their wishes/views need to be overridden.
- It is only in the circumstance that a person is deemed not to have capacity, and is unable or unwilling to be supported to make decisions, that a treatment plan should be overridden without agreement from the consumer.

Some additional issues highlighted by respondents include:

- The current Act makes limited references to involving consumers in the development of treatment plans and does not set out any practical steps to achieve this. Nor does it state what should be in a plan, when a plan should be prepared and when it should be reviewed, and who should be involved in the preparation of plans.
- In VIC, treatment plans are regularly reviewed which helps to ensure that such plans do not have to be overridden. Legal Aid NSW is of the view that treatment plans should be considered and honoured wherever possible.
- A consumer’s documented preferences should never be binding on either the treating team or the MHRT. The treating team and the MHRT need to be able to respond appropriately to a consumer’s changing mental or physical health and/or advances in mental health treatment and could not do so safely if they were bound to follow the wishes of the consumer.
- There may be practical difficulties with storing and retrieving a record of a consumer’s treatment preferences, so that the document can be readily accessed and considered when a person is unwell. This would be made more difficult if the person is being treated at a number of different health facilities.

**Advice from the Expert Reference Group**

The ERG was asked to consider the following questions:

1. If NSW were to develop new provisions in the Act recognising ACDs, what structures/ frameworks would need to be created to support this?
2. The MHRT has supported ACDs being recognised in legislation, however it has also stated that ACDs should not be binding on the treating team or MHRT. What therefore would be the role of the MHRT? Is there a role for the NSW Mental Health Commissioner or NSW Chief Psychiatrist?
The ERG provided the following advice about key issues that should be considered when making a decision about the legislation:

- ACDs are legally binding documents, often used in end-of-life decision making and not in the mental health context.
- It is preferable for all consumers to have a treatment plan which the treating team and the MHRT have regard in making a decision about the person’s care and treatment.
- The Act needs to be very explicit if treatment plans are to be binding otherwise there could be anxiety from staff that were observing a person’s treatment plan.
- Treatment plans from consumers often include arrangements for pets, children, house security as well as bad experiences with or preferences for particular medications. This issue is more of a whole-of-life ‘going to hospital’ plan.
- One member suggested that development of a treatment plan be included in the legislation and that the MHRT and treating team must give regard to, but not be bound by it.
- To avoid confusion, it was suggested that ACD terminology not be used in the mental health context when referring to treatment planning and arrangements for when the person is admitted to hospital.

**Summary**

Taking into account all of the information and advice gathered during this review of the Act, it may be appropriate to undertake further consultation on this issue, including whether the legislation should be amended to require that each consumer is to have a treatment plan that is regularly reviewed, and whether treating teams and the MHRT should be required to have regard to these plans in making decisions about the patient’s care and treatment.
20. The rights of primary carers

The current legislation/situation

Carers are an integral part of the support system sometimes required by people suffering a mental illness. More recently, carers and representative groups have received greater recognition of their fundamental role and their needs for information, support, and guidance. A number of issues were raised in the discussion paper, which primarily focused on the nature of the information they received during treatment and discharge, and the legislating of what could and could not be released to both nominated carers and extended family or others involved in a consumer’s care and support.

Currently, under the Act, a primary carer must be appointed for each consumer receiving care and treatment under the Act. The primary carer can either be nominated by the consumer or, in certain situations, appointed according to conditions outlined in s71-72 of the Act. A consumer can also nominate who is to be excluded from receiving information (s72(2)). The Act stipulates that a primary carer can request information on medication (s73) and must be informed by the AMO of a person’s initial involuntary detention within 24 hours, where practicable (s75). The AMO must also take ‘all reasonably practicable steps’ to give a primary carer notice of a mental health inquiry and events affecting detained persons such as absconding, transfer or discharge (s78). In relation to discharge, the Act requires an AMO to consult the primary carer in planning discharge, and provide the primary carer with ‘appropriate information as to follow-up care’ (s79). Currently, other carers, such as family members or loved ones, do not have rights to any form of information except if the consumer agrees for information to be provided or if the medical officer believes that they may be at risk (if a patient absconds and there is an Apprehended Violence Order (AVO)).

The Act allows for a consumer to revoke or vary a primary carer nomination. An AMO or a director of community treatment is not required to give effect to, or vary or revoke a nomination if they believe that this would put the patient, the nominated person, or any other person at risk, or if they believe that the person is incapable (s72(7)).

Discussion paper

In relation to this issue, the discussion paper asked the following questions:

- What specific information should be provided to nominated carers?
- Under what circumstances should information be disclosed to either nominated or non-nominated individuals without patient consent?
- What are the rights of non-nominated persons (e.g. extended family or support people) to receive certain types of information?

Feedback from community consultation forums

In both the forums and public submissions there were recurrent requests for increased communication between DMHF and carers. The Act requires that information on medication, initial detention, details of mental health inquiries, rights of appeal, events affecting the consumer, plus discharge and treatment planning be given to primary carers (s73-79). Carers reported that this information was not routinely shared
with them and that staff were unsure of the requirements and thus reluctant to do so for fear of contravening the Act. Whilst there is a need for increased staff training and awareness in the Mental Health Act, there is also a need to clarify what other types of information needs to be available and when this can and cannot be shared with a consumer’s primary carer, and with other carers and family members.

**Feedback from public submissions & survey**

Thirty-three submissions addressed the questions raised in the discussion paper, including four LHDs and specialty networks, seven consumers/carers, Legal Aid, the MHRT, Carers NSW, and the NSW Carers Advisory Council. With a few exceptions, most felt that the Act needed to be specific about the types of information to be provided to carers or those involved in the consumer’s care. Suggestions included: medication requirements; non pharmaceutical treatments or therapies; future clinical/therapeutic appointments; symptom monitoring; indicators of risk; strategies and contingency planning for acute episodes; case managers and other contacts in case of emergencies. Most submissions felt that the Act should also legislate that this information also be provided to those involved in active support or follow up care (e.g. should the consumer be residing with them).

A range of reasons were given for expanding or limiting the type of information available to carers with or without a consumer’s consent. Discussion around the issue of when to share information with carers without consumer consent primarily centred on the rights of the individual versus the carer. The balance of feedback from consumers, clinicians and carers was that the rights of the consumer must be primary, however there were a small number of exceptions where it was agreed that this should be considered very carefully. All submissions agreed that, in the case of a consumer’s discharge or absconding, an AVO against the consumer was a justifiable reason to revoke confidentiality.

In relation to estranged carers or family, respondents generally agreed that it would be reasonable for loved ones (primary carers or not) who are estranged from a consumer, but wanting to be reassured of their existence, to have this information released to them with the proviso that their actual whereabouts would not be disclosed. The current Mental Health Act does not allow for this. Other submissions were more cautious, arguing that estranged carers should only have access to such information if they were at risk.

**Additional issues raised**

Four additional issues were raised in the submissions:

- Nominated carers should formally accept their role before they become recognised as primary carers under the Act.
- A number of submissions suggested that the consumer be able to nominate more than one carer and also recognise that young carers, such as children of the consumer, should be included in the hierarchy of person’s who could be appointed as primary carers
- Two respondents felt that issues of confidentiality with carers was also an opportunity for the Act to provide clearer guidance on the sharing of personal and health information and its intersection with other personal and health information management legislation. For example, should disclosure of information detailing diagnosis and treatment etc. be accessible to services that provide care or have contact with people suffering a mental illness? In some cases ‘police are attempting to assess and control a perceived risk to safety of the individual, health staff, and themselves, without having any substantial information on which to base that risk assessment’.
One respondent suggested that there should be a legislative requirement to contact the primary carers for people detained for 12 months or longer.

**Advice from the Expert Reference Group**

The ERG was asked to consider the following questions:

1. Should the Act be amended to detail specific information to be provided to the primary carer at discharge? If so, what should this include? Should it also be provided to other persons who are involved in ongoing consumer care?
2. Should the Act require persons to formally accept a nomination or appointment before they are considered to be a primary carer, and to allow the consumer to nominate more than one primary carer?
3. Should the Act allow disclosure of a consumer’s existence (but not whereabouts) to estranged carers and family members? Include a legislated requirement to contact the primary carers for people detained for 12 months or longer?

The ERG provided the following advice about key issues that should be considered when making a decision about the legislation:

- Some members considered that the current form for consumer nomination of a primary carer should be amended to include a section that allows primary carers to provide consent.
- Where the primary carer agrees to act in that caring role, they should be provided with all relevant information to enable them to perform that role (and be considered to be part of the treating team).
- The Act requires clarification about whether the primary carer nomination also refers to community treatment.
- The Act could be expanded and clarified to include what information should be available, to whom, and when it should cease or is able to be stopped by the consumer. A suggestion was that two classes of carer be established – the person(s) who is the primary person providing care to the consumer and needs sufficient information to carry out that role, and a support person who is permitted to receive some information. It was also raised that it should be possible to nominate more than one primary carer (e.g. both parents, or partner and mother).
- It was mentioned that the Transfer of Care policy provides clear information about what information should be provided to carers and others involved in the patient/consumer’s care.
- The Health Information Privacy Act does enable information to be provided to carers. It was also noted that, where the patient is able/chooses to give consent, information can be provided to anyone that the patient wishes to have that information.
- It was suggested that the terminology be amended, with ‘nominated person’ or ‘nominated carer’ suggested as alternatives.
Summary

Taking into account all of the information and advice gathered during this review of the Act, it may be appropriate to undertake further consultation to consider whether to amend the Act to explicitly permit up to two people to be nominated as the primary carer, including a child/adolescent acting as a young carer; consider differentiating between different types of carer and support people; clarify the types of information that each group should receive; and (re)name each role with a relevant title. It may also be appropriate to clarify that the primary carer role, rights and responsibilities apply when a consumer is receiving compulsory treatment in the community (i.e. subject to a CTO).
21. Children with mental illness

*The current legislation/situation*

The issue of children specifically was not addressed in the discussion paper; however, a number of respondents raised issues concerning children, which have been included in this section for further discussion.

The detention provisions in the Act apply to children (those less than 18 years) who come within the definitions of a ‘mentally ill person’ or a ‘mentally disordered person’. Children can be admitted involuntarily in the same way as adults. For voluntary admission, the Act contains the following specific provisions:

- If the child is under 16 years of age, the AMO must notify the parent as soon as practicable of the voluntary admission.
- If the child is 14 or 15 years of age, they may choose to continue as a voluntary patient even where the parent objects.
- If the child is less than 14 years, parental consent is essential for a voluntary admission to proceed.
- If the child is less than 14 years, the AMO must discharge them if there is a request from a parent to do so.

The primary carer of a child is generally the parent. Where the child is over the age of 14, they may nominate someone other than a parent as their primary carer. However, where the child is between 14–18 years, the Act states that a parent may not be excluded from receiving notice of information about the child unless the AMO reasonably believes that to do so may put the child at risk of serious harm.

Children in general have the same rights as adults under the Act, including the same rights to information and legal representation. Children’s inexperience, however, can add another layer of complexity in considering how they can best be assisted to understand and exercise those rights.

Some other jurisdictions (WA, VIC and ACT) have moved to, or are considering moving towards, including further provisions to recognise children, for example in the area of ECT.

The WA Act is currently under review and in addition to changes on ECT, it is proposed that the Act recognise that mental health services must be sensitive and responsive to factors, including age – which it enshrines in its principles. It is proposed that Part 17 of the WA Act be dedicated to the treatment of children with a mental illness. The proposed Part 17 enshrines a ‘best interest’ principle whereby the best interests of the child must be a primary consideration; it also provides that regard must be had to the child’s wishes and the views of the parent or guardian. In respect of voluntary child patients, Part 17 empowers a child to make an application for admission, discharge or make a decision in respect of his/her own treatment, provided he/she has requisite capacity. There are no age limits placed on this (the proposed Act sets out what is required to show that a child has capacity). Part 17 also sets out that it is preferable for child inpatients to receive services in a children’s hospital or a part of the hospital that is separate from adults – except in circumstances where it is considered appropriate given the child’s age, maturity, gender, culture and spiritual beliefs.
With the exception of ECT, the discussion paper did not ask respondents any questions in relation to the treatment of children under the Act. However, several respondents made submissions on this subject.

**Feedback from community consultation forums**

It was stated in the Independent Community Consultation Forums Panel Report that:

- The Act should better reflect the different needs of different ages – especially in relation to treatment of children.
- There is an anomaly between the MH Act and the Child Protection Act that requires clarification.
- In relation to the role of the Primary Carer, a suggestion is that the Act needs to provide a mechanism where limited information can be given to those who act as carers or otherwise support the person. This may simply involve confirming that a parent’s child is currently a voluntary or involuntary patient to relieve the parent’s anxiety concerning their child’s whereabouts.
- Section 16a of the *Children and Young Persons (Care and Protection) Act 1998* permits new levels of information sharing. Need to ensure it is appropriate to engage carers.

**Feedback from public submissions & survey**

In addition to the comments on children and ECT, seven respondents made comments on the treatment of children under the Act. Submissions were received from four government bodies, including the Commission for Children and Young People and MH Kids; two organisations; and one LHD. Submission comments have been grouped thematically below:

**Age-appropriate care, with reference to developments in other jurisdictions**

Several respondents commented on the lack of specific provisions regarding the treatment of children with a mental illness, citing provisions in the UK Mental Health Act 2007 and draft WA Mental Health Bill 2012, which mandate certain requirements/considerations in respect of children. The UK Mental Health Act contains provisions to ensure children receive treatment in in-patient settings that are appropriate to their age, subject to their needs, with the purpose of preventing the inappropriate admission of children and young people to adult psychiatric wards except in atypical circumstances.

Several respondents also noted that both the UN Convention on the Rights of Persons with Disabilities and the UN Convention on the Rights of the Child hold up the ‘best interests of the child’ as either a primary consideration or principle.

**Review by the MHRT**

In respect of treatment reviews and representation before the MHRT, one respondent made a number of suggestions including that children should always be represented by a solicitor, have access to funding for second medical opinions and be provided with an advocate/support person (in addition to the parent/carer) who could represent the child’s interests and explain/support them through the proceedings/mental health system. The Commission also put forward that children should be subject to more regular MHRT reviews given their rapid development. The Commission made reference to the draft VIC Mental Health Bill, in which it is proposed that a young person (under 18 years) may only be placed on a Treatment Order for a maximum of three months. The Commission noted that the draft WA Mental Health Bill includes a proposal...
that a youth advocate must contact a child soon after its admission to a MHF, to provide support and assistance to the child (although it should be noted that this may have changed, as under the WA Green Mental Health Bill 2012, a mental health advocate (not specifically a youth advocate) must contact the child within 24 hours after the time when the involuntary treatment order is made – clause 337).

Capacity to consent

Several submissions raised the notion of supported decision making, noting that medical practitioners should consider whether minors have the ability to consent to medical treatment based on an assessment of their capacity. The Sydney Children’s Hospital stated that treatment for children aged 14 and 15 years was a ‘grey area and should be clarified.’ The same respondent commented that many 14 and 15 year olds have the capacity to make an informed decision about treatment and that their views should be taken into account.

Children in Out-of-Home Care

The Department of Families and Community Services (FACS) raised a specific concern in relation to children in Out-of-Home-Care (OOHC), including children who are at an ‘immediate and substantial risk of harm to themselves’. FACS noted that, in the absence of a legislative provision to appropriately respond to children and young people in OOHC under both the Mental Health Act and Children and Young Persons (Care and Protection) Act 1998, FACS is required to seek a Supreme Court Order so that it is able to provide short-term therapeutic security. FACS put forward that consideration should be given to the appropriate legislative framework for providing services and support, which are at times involuntary, for young people with complex needs and mental health issues who are at significant and immediate risk of harm to themselves.

Young carers

FACS and other respondents, including NSW Kids & Families, commented that the Act should recognise the special needs of children of parents with a mental illness – who are sometimes young carers.

Advice from the Expert Reference Group

The ERG was asked to consider the following questions:

1. Should the NSW Mental Health Act include a chapter/section that specifically addresses children?
2. If so, what areas should be covered in this section, for example consent, views of primary carers, inpatient treatment, out-of-home care, etc.?

The ERG provided the following advice about key issues that should be considered when making a decision about the legislation:

- Members considered that children and adolescents should always be legally represented, in addition to having a primary carer and any rights of the parents/guardians under this and other legislation.
- In addition, children and adolescents should be treated by, or have clinical input from, a Child & Adolescent (C&A) psychiatrist if possible. Some members felt that it should be made explicit that children should not be treated in adult facilities where possible.
- In line with the UN Convention, the best interests of the child should be foremost.
- It was suggested that a separate chapter be developed in the Act to cater specifically for children and could include: primary carer notification, consent, representation and ECT as examples.
- It was noted that a developmental age of less than 14 years may also raise similar vulnerabilities.
Summary

Taking into account all of the information and advice gathered during this review of the Act, it may be appropriate to undertake further consultation regarding whether the principles for care and treatment should be amended to express the preference for children and adolescents to be treated by a C&A psychiatrist and/or in a C&A unit, and whether greater emphasis should be given in the principles for care and treatment to providing treatment that is appropriate to the consumer’s age and cognitive development. It may also be appropriate to consider the inclusion of a provision in the Act which provides legal representation for all children (16 years and under) when they are subject to a MHRT hearing.
22. Electroconvulsive therapy for children

The current legislation/situation

Currently, under the Act, the same rules for consent to electroconvulsive therapy (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. If the child lacks the capacity to consent, no other person may consent on their behalf. For example, parents cannot consent on behalf of a child who lacks the capacity to consent, or who refuses to give their informed consent. 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.

The VIC Mental Health Act is currently under review and the proposed changes include that ECT may only be performed on a person under 18 years of age with the approval of the Mental Health Tribunal.

The WA Act is currently under review and the proposed changes include that ECT will be prohibited on children less than 14 years, and that ECT may only be performed on children aged 14–18 years with the approval of the Mental Health Tribunal.

The ACT Mental Health Act is under review, and the proposed changes include that ECT will be prohibited on children less than 12 years, and that two medical opinions, and an order by the ACT Civil and Administrative Tribunal, will be required for children aged 12–18 years.

Discussion paper

In relation to this issue, the discussion paper asked the following question:

- Should the legislation include any specifications regarding the treatment of children with ECT? If yes, please provide details.

Feedback from community consultation forums

It was stated in the Independent Community Consultation Forums Panel Report that there should be:

- Changes to the rules for ECT to a maximum of 12 sessions before review
- The Act needs specific provisions dealing with people less than 18yrs, for example in relation to provision of ECT.

Feedback from public submissions & survey

Submissions on this question were received from 27 organisations comprising nine government bodies, including the MHRT and Commission for Children and Young People; eight organisations, including the Medical Services Committee and PIAC; five LHDs and associated specialty networks; four individuals, including doctors and public health workers; and one peak carer organisation. Three key themes emerged from the submissions: the notion of a second opinion; the issue of consent; and the efficacy of ECT for children.
Second opinions

Fifteen respondents considered that where ECT had been recommended by the child’s treating psychiatrist that an appropriate safeguard would be to mandate the requirement for a second opinion. A number of options were put forward regarding who should provide this second opinion, including:

- A psychiatrist in child and adolescent mental health
- An independent psychiatrist
- A psychiatrist with a speciality in neuroscience.

Consent requirements

A number of divergent views were put forward on the issue of consent for voluntary and involuntary child patients. These views included that:

- An ECT determination from the MHRT should be required for certain age groups of persons less than 18 years, irrespective of the child’s capacity to consent.
- In making an ECT determination, the MHRT should have regard to the views of the patient and carers/guardians.
- Parents should be able to provide consent for their child.
- Different consent requirements should apply, depending on the age of the child. For example, allowing parents to consent to ECT on their child if the child is a voluntary patient, less than 16 years and not refusing ECT. Children aged 16 or 17 years should undergo a capacity assessment for ECT consent and may be capable of providing ECT consent independently of their parent or guardian.
- Supported decision making should be used to obtain consent from involuntary patients.
- Capacity to consent should provide the right to refuse treatment, noting that the Act presently allows the MHRT to make an ECT determination to administer ECT on a child, even if the child has capacity to consent and has refused treatment.

One respondent noted that in other areas of medicine, children can and do participate and consent to therapies, including major invasive medical treatments. This respondent referenced a discussion in the NSW Law Reform Commission’s *Young People and Consent to Health Care* publication (2008).

Efficacy of ECT

Several respondents discussed the efficacy of ECT on children. Divergent views were put forward, with some respondents calling for a ban on ECT and others noting that it could be life saving in some circumstances. Views put forward included:

- Requiring an ECT determination from the MHRT for all persons less than 18 years is an appropriate safeguard given the ‘limited data on the effectiveness of ECT in this age-group.’ This respondent noted that ‘while current evidence does not demonstrate a differential age effect for younger populations, a differential benefit for tricyclic antidepressants (which are less effective in children) has been demonstrated.’
- ECT should be prohibited and only reintroduced to the Act with strict limitations, if there is a strong evidence base for its use. This respondent cited the World Health Organisation Resource Book on
Mental Health, Human Rights and Legislation, which states that ‘there are no indications for the use of ECT on minors, and, hence, this should be prohibited through legislation.’

- Banning ECT could be ‘unnecessary and potentially harmful’. This respondent noted the absence of evidence that ECT was being misused on children, and that ECT could be effective in limited circumstances, citing several medical cases.
- ECT could be lifesaving (status epilepticus, uncontrolled seizures), and that it should not be banned for children under 12 years.
- It is ‘widely accepted’ that ECT is an undesirable treatment for persons under 18 years due to the possible risks to a developing brain. However, ECT might be used where a child had unremitting psychosis and had not responded to any medication.
- The British National Institute for Health and Clinical Excellence (NICE) had commented that: ECT is used very rarely in young people with depression, and should not be used in children aged 5–11.

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Other

Separate to addressing the notion of specific safeguards for ECT on children, respondents also made a number of general comments about ECT:

- Consideration should be given to permitting binding advance directives and amending section 94(4) such as to allow time for meritorious appeals to be prepared and filed in the Supreme Court pursuant to section 163 of the Act.
- Whether the regulation of ECT treatment for children should be subject to the same requirements for special medical treatment under the Children and Young Persons (Care and Protection) Act 1998 (section 175), and where a child is in Out-Of-Home-Care, the administration of psychotropic drugs under the Children and Young Persons (Care and Protection) Regulation 2000 (clause 15).
- Where treatment of pregnant women with ECT is considered, obstetric consultation should be sought.

Advice from the Expert Reference Group

The ERG was asked to consider the following questions:

1. For the purposes of ECT on children, what criteria should constitute a ‘second opinion’ under the Act?

The ERG provided the following advice about key issues that should be considered when making a decision about the legislation:

- Members noted that the draft Victorian Bill proposed a ban on the use of ECT for children under 13 years.
- The ERG was opposed to any prohibition being placed on the use of ECT to treat children, and there was broad agreement that there should be restrictions but there was no agreement about age limits.
• It was noted that no evidence has been provided or sourced to demonstrate that ECT is unsafe for use in a paediatric setting; however, there is also a lack of evidence to demonstrate effectiveness.
• One member recommended that there should be a panel of appropriate experts to make decisions about ECT for children on a case-by-case basis, while other members considered that a second opinion should be sort from a C&A psychiatrist before proceeding with ECT treatment for a child.

Summary

Taking into account all of the information and advice gathered during this review of the Act, it may be appropriate to undertake further consultation regarding whether ECT should remain a treatment option for children (i.e. no age restriction) and the appropriateness of a requirement for assessment by C&A psychiatrist, preferably with experience in the use of ECT, when ECT is proposed for any child aged 16 years or under.
24. Declaration of financial interest

The current legislation/situation

The current wording of the Act requires that any financial relationship between the medical practitioner proposing and administering ECT and the facility be disclosed to the patient. 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.

Clause 17 of the Mental Health Regulation 2007 ‘Procedure before consent to electro convulsive therapy’ prescribes that Part 1 of Form 6 ‘Information and Consent – Electro Convulsive Therapy’ must be completed. Part 1 includes a section on disclosure of financial relationships by both the person proposing the treatment (Item A) and the medical practitioner who proposes to administer the treatment (Item B).

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 that all medical practitioners (irrespective of specialty, treatment or patient population) disclose any financial interest.

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 in Part 1 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 Part 1 in Form 6 prior to the patient receiving ECT.

Discussion paper

In relation to this issue, the discussion paper asked the following questions:

- 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?)
- Should the requirement for disclosure of financial relationships be limited to the administration of ECT, or should it be broader, for example medication, surgical procedures or admission to and treatment within private facilities?
Feedback from community consultation forums

There was no feedback from forums about financial disclosure in relation to ECT.

Feedback from public submissions & survey

Nineteen respondents commented on this matter. Submissions were received from six organisations, including RANZCP; five LHDs and associated speciality networks; four individuals; and four government bodies, including Legal Aid.

A majority of respondents supported the notion that medical practitioners should be required to disclose financial and commercial relationships. Only one respondent specifically stated that disclosure should include employment status, citing an example of a medical practitioner being a part-time public employee and contracted as a private practitioner.

A minority of respondents opposed the notion, with reasons put forward including:

- That this was inconsistent with other medical procedures carried out in public hospitals and was impractical to implement.
- That declaration of financial and commercial interests would be better dealt with in legislation that regulated the conduct of health professionals in conjunction with professional codes of conduct, including a method for statutory enforcement. For example, that non-disclosure would amount to ‘unsatisfactory professional conduct’ and potentially ‘professional misconduct’ under the NSW Health Practitioner Regulation National Law.

The discussion paper also asked whether the requirement for disclosure of financial relationships should be extended to other aspects of treatment like medication, surgical procedures, admission and treatment within private facilities.

Fourteen respondents commented on this matter with the majority supporting the notion. One respondent commented that this was in part already covered by the Trade Practices Act 1974 (Cth) which requires medical practitioners to disclose to their patients any actual or potential conflict of interest.

Advice from the Expert Reference Group

The ERG was asked to consider the following questions:

1. Are the requirements for medical practitioners’ financial and commercial disclosure sufficiently covered by other legislation – for example, the Commonwealth Trade Practices Act 1974 or the NSW Health Practitioner Regulation National Law – or is this something that needs to be retained in the NSW Mental Health Act?

The ERG provided the following advice about key issues that should be considered when making a decision about the legislation:

- There was consensus that the requirement for disclosure of financial relationships by both the person proposing the treatment and the medical practitioner who proposes to administer the treatment should be retained in the Act.
Summary

Taking into account all of the information and advice gathered during this review of the Act, it may be appropriate to undertake further consultation on whether, and how, the requirements for declaration of financial interest by medical practitioners prescribing and administering ECT should be amended to address the practical implication issues.
25. Psychosurgery

The current legislation / situation

The Mental Health Act 2007 states that psychosurgery is a prohibited treatment.

NSW is the only Australian state where the legislation specifically prohibits the use of psychosurgery.

Psychosurgery is defined in section 83(2) of the NSW Mental Health 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.

The current definition of psychosurgery in the Act incorporates both ablative neurosurgery for mental disorders which aims to produce an irreversible lesion in the brain for the purposes of alleviating specific mental disorders, and brain stimulation techniques, particularly deep brain stimulation (DBS) and vagus nerve stimulation (VNS), that involve surgical intervention, but in which the primary objective is not to produce an irreversible lesion in the brain but to stimulate one or more brain regions.

In line with this definition, the technique known as DBS has been considered a form of psychosurgery and cannot be performed on patients in NSW. DBS has emerged as an intervention for a number of neurological conditions and, Regulation 12 of the Act 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.

Prior to its prohibition in the current Act, there were strict statutory requirements and guidelines for psychosurgery in NSW.

Discussion paper

In relation to this issue, the discussion paper asked the following questions:
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.

**Feedback from community consultation forums**

The issue of psychosurgery was raised by one attendee during the course of the consultations. It is therefore not possible to assert any community view about psychosurgery based on this report of the consultations.

**Feedback from public submissions & survey**

Twenty submissions commented on the current prohibition of psychosurgery and DBS as treatments for psychiatric conditions. They included eight submissions from mental health clinicians/researchers, and LHDs. A further twelve submissions were received from carers, peak organisations representing consumers and service providers, government agencies, advocacy groups, OVs, and the MHRT.

The submissions from those with a medical background generally spoke to the potential benefits of psychosurgery for an extremely small number of mental health patients with intractable conditions. They also commented on the potential benefits of DBS treatment for the treatment of psychiatric conditions in a small number of cases, particularly for serious depression that does not respond to other treatments.

A further twenty submissions that commented on psychosurgery were received after the advertised submission period closed and within a 24-hour timeframe. All were opposed to psychosurgery, but provided only minimal rationale for their views, and are not included in the analysis below.

**Support for removing psychosurgery from the list of prohibited treatments**

Fourteen submissions considered that psychosurgery should not be identified in the Act as one of the prohibited treatments, or were open to amending the Act to allow psychosurgery under strict controls and guidelines. The majority of these also advocated for allowing DBS treatment in NSW for indicated psychiatric illness.

There was strong support for the Act to recognise mechanisms for the control and monitoring of psychosurgery and DBS should the legislation be relaxed to allow these procedures.

Reasons provided in submissions which supported removing prohibition included:

- NSW is the only Australian state where psychosurgery is prohibited by law.
- Although rarely performed in Australia, some psychosurgery techniques can be effective for a very small and specific group of patients suffering from some chronic, disabiling and treatment resistant psychiatric illnesses. This group of NSW mental health patients should not be disadvantaged by the prohibition of a form of treatment to which they wish to consent, and that may give them relief from the severe, long-term distress caused by their mental illness.
- The current prohibition of DBS prevents research into this potentially helpful treatment for very ill and disabled patients whose condition does not respond to other treatments.
- A growing evidence base supporting the use of DBS in some psychiatric disorders.
- To continue to outlaw the use of this procedure for psychiatric disorders, whilst continuing its use for neurological disorders, constitutes a form of discrimination.
Because DBS for severe psychiatric conditions that do not respond to any alternative treatment is available in VIC, some NSW patients have travelled to Melbourne for treatment. Providing for their follow care up in NSW is difficult.

Support for maintaining the general prohibition of psychosurgery

Six respondents, including the MHRT, considered the general prohibition of psychosurgery and/or DBS should be maintained until there is more evidence of its benefits and safety for psychiatric conditions.

Reasons provided in submissions which objected to amendments to the legislation to allow the use of psychosurgery and DBS for psychiatric conditions were:

- As yet, insufficient evidence of efficacy, for psychiatric conditions.
- The consumer’s peak organisation expressed concern with the suggestion that psychosurgery may be reintroduced and commented on the irreversible nature of the treatment.
- Maintain the general prohibition of psychosurgery for psychiatric conditions but allow ‘exceptions’ with controls.

Other comments made in submissions

- Consider amendments to permit psychosurgery and/or DBS, with controls, only after further consultation with consumers and other respondents.
- Several submissions that supported changes to legislation to allow the use of DBS for psychiatric conditions identified the need for a rigorous procedure around determining the suitability of patients for DBS, accreditation for services offering DBS, and consent processes in relation to this treatment.
- Any use of psychosurgery should be subject to approval by an independent tribunal in which the patient is represented by his/her own advocate whether or not the patient is refusing the treatment /has capacity to consent.
- There is a stigma associated with the term ‘psychosurgery’ and an outdated understanding of modern treatment techniques. An explanatory term such as ‘neurosurgery for psychiatric conditions’ was preferred to ‘psychosurgery’.
- Submissions referred to the RANZCP’s Position Statement 29 on Neurosurgery for Mental Disorders (2009) the checks and balances, and the external monitoring system recommended there (Note that this statement specifically excludes deep brain stimulation).
- Many submissions, both those in favour of relaxing the psychosurgery ban, and those that sought to maintain the ban on psychosurgery, acknowledged that DBS may present a new and beneficial treatment for people with certain intractable psychiatric conditions.

Advice from the Expert Reference Group

The ERG was asked to consider the following questions:

1. Should consideration be given to amending the Act to remove psychosurgery from the list of prohibited treatments?
2. If so, should the Act specify the regulatory and control mechanisms required for the use of psychosurgery as a treatment for psychiatric conditions?

3. Given the controversial nature of psychosurgery, should wider consultation with interested parties take place prior to any changes to the Act?

4. Should DBS and psychosurgery be defined as different types of procedures? Why?

5. Should DBS treatment for certain psychiatric and neurological conditions be permitted under strict controls to be specified in the Act? Why?

The ERG provided the following advice about key issues that should be considered when making a decision about the legislation:

At the first ERG meeting:

- Psychosurgery should be renamed neurosurgery for psychiatric conditions, and should be considered separately to brain stimulation techniques such as DBS.
- Members generally supported the removal of psychosurgery from the list of prohibited treatments, but supported restrictions being placed on it (e.g. having a review board or MHRT, second opinions etc).
- Members considered that psychosurgery should only be conducted on voluntary patients and not under coercion, and that informed consent should be mandatory.
- Members considered that there was potential argument for cross border cooperation with Victoria to utilise Victorian Psychosurgery Review Board.

At the second ERG meeting:

- Following further consideration of relevant evidence, members supported:
  - maintenance of the prohibition on ablative neurosurgery for psychiatric conditions, but
  - removal of the prohibition on non-ablative brain stimulation techniques such as DBS subject to strict regulation and oversight (e.g. having a review board or MHRT, second opinions etc).

Summary

Taking into account all of the information and advice gathered during this review of the Act, it may be appropriate to undertake further consultation on this issue, including:

- whether psychosurgery should be renamed ‘neurosurgery for mental disorders’ and non-ablative brain stimulation techniques should be excluded from the definition of this term;
- whether the Act should continue to prohibit ablative neurosurgery;
- whether to allow non-ablative brain stimulation techniques with robust regulation and oversight and mandatory informed consent by the patient;
- whether a review process similar to the previous Psychosurgery Review Board provisions should be reinstated to regulate use of non-ablative brain stimulation techniques;
- whether an independent multidisciplinary body comprising doctors, lawyers and lay people should be established to review individual applications for consent for treatment, the merits of new procedures and the skills and qualifications of the clinicians involved, and whether this function could be undertaken by the MHRT.
# APPENDIX ONE:
## LIST OF PUBLIC SUBMISSIONS RECEIVED

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<thead>
<tr>
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<th>Submission Details</th>
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<tr>
<td>1</td>
<td>Assoc Prof Julian Trollor (UNSW Department of Developmental Disability Neuropsychiatry &amp; Council for Intellectual Disability Mental Health)</td>
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<td>2</td>
<td>Australian Medical Association (NSW)</td>
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<td>Australian Salaried Medical Officers' Federation of NSW (ASMOF)</td>
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<td>Carers NSW</td>
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<td>Commission for Children and Young People</td>
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<td>Council of Social Service of NSW (NCOSS)</td>
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<td>7</td>
<td>Department of Attorney General and Justice (DAGJ)</td>
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<td>8</td>
<td>Department of Family &amp; Community Services NSW</td>
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<td>9</td>
<td>Edwina Light (The Centre for Values, Ethics and the Law in Medicine – University of Sydney)</td>
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<td>10</td>
<td>Emergency Care Institute (part of the ACI)</td>
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<td>Illawarra Forum Inc</td>
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<td>Inner South West Community Development Organisation</td>
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<td>Medical Services Committee</td>
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<td>Mental Health Carers ARAFMI NSW Inc. (ARAFMI)</td>
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<td>Mental Health Coordinating Council</td>
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<td>MH-Kids</td>
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<td>21</td>
<td>Ms Sascha Callahan &amp; Dr Christopher Ryan (The Centre for Values, Ethics and the Law in Medicine – University of Sydney)</td>
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<td>National Mental Health Commission</td>
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<td>New South Wales Nurse and Midwives' Association</td>
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<td>Northern Beaches Mental Health Support Group (Schizophrenia Fellowship of NSW)</td>
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<td>NSW Branch of the Faculty of Child and Adolescent Psychiatry</td>
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<td>NSW Carers Advisory Council (FACS)</td>
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<td>NSW Trade &amp; Investment Cross-Border Commissioner</td>
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<td>38</td>
<td>Official Visitors Program (NSW)</td>
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<td>39</td>
<td>Prof Perminder Sachdev &amp; Dr Adith Mohan (Neuropsychiatric Institute - UNSW)</td>
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<td>Public Interest Advocacy Centre (PIAC)</td>
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<td>Individual (Member of the Legislative Council)</td>
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APPENDIX TWO: REFERENCE WEBLINKS

Western Australia (WA)

Mental Health Act Review website -

Current Mental Health Act -


First draft Mental Health Bill (2011) -

Victoria (VIC)


(Archived Mental Health Act Review website -

Current Mental Health Act -

Draft Mental Health Bill (2010) –

Tasmania (TAS)


Current Mental Health Act -
http://www.thelaw.tas.gov.au/tocview/index.w3p;cond=;doc_id=31%2B%2B1996%2BAT%40EN%2B20130206000000;histon=;prompt=;rec=;term=
Mental Health Bill (second reading Jun 2012) –
http://www.parliament.tas.gov.au/ParliamentSearch/isysquery/18f2cc5e-b095-4fb2-b703-d5759c82ae92/2/doc/

**Australian Capital Territory (ACT)**


Draft Mental Health Bill – see link on website page

**Queensland (QLD)**


**South Australia (SA)**

Current Mental Health Act -

**Northern Territory (NT)**


**New Zealand**

Mental Health (Compulsory Assessment and Treatment) Act 1992 -

**United Kingdom**


**Scotland**

Mental Health (Care and Treatment) (Scotland) Act 2003 -
APPENDIX THREE:
MEMBERS OF THE EXPERT REFERENCE GROUP

David McGrath, Director, Mental Health and Drug & Alcohol Office (MHDAO), NSW Ministry of Health

A/Prof. John Allan, NSW Chief Psychiatrist

Gemma Broderick, Senior Legal Officer, Legal and Regulatory Services, NSW Ministry of Health

Gaby Carney, Assistant Director, Legislation, Policy and Criminal Law Review Division, Department of Attorney General and Justice

Peter Dodd, Solicitor, Health Policy and Advocacy, Public Interest Advocacy Centre (PIAC)

Charles Doutney, Staff Specialist, Medical Services Committee

Jonathan Harms, CEO, ARAFMI (Association of Relatives And Friends of the Mentally Ill)

Denise Heddle, Principal Policy Officer, Health and Justice Branch, Department of Premier and Cabinet

Prof. Daniel Howard, President, Mental Health Review Tribunal (MHRT)

Hon. Greg James QC

Dr. Adrian Keller, Royal Australian and New Zealand College of Psychiatrists and Clinical Director, Forensic & Long Bay Hospitals

Prof. Karin Lines, Executive Director, Forensic Mental Health and Youth Health Services

Dr. Simon Longstaff, Executive Director, St James Ethics Centre

Anne Mortimer, CEO, The Northside Group at Ramsay Health Care

Leanne O’Shannessy, Director, Legal and Regulatory Services and General Counsel, NSW Ministry of Health

Dr. Peri O’Shea, CEO, NSW Consumer Advisory Group

Karen Price, Associate Director, Mental Health Clinical Policy, Mental Health and Drug & Alcohol Office (MHDAO), NSW Ministry of Health

Dr Russell Roberts, Director of Mental Health, Drug & Alcohol Services, Western NSW LHD

Harold Sperling QC, NSW Law Reform Commission

Robert Wheeler, Solicitor in Charge, Mental Health Advocacy Service, Legal Aid NSW

Secretariat: Regulatory Team, Mental Health and Drug & Alcohol Office (MHDAO), NSW Ministry of Health