Submission to the Review of the Mental Health Act Draft Exposure Bill 2006

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MHCC is the state peak body for non-government organisations working for mental health throughout NSW. MHCC represents the views and interests of over 160 NGOs in the formation of policy, and acts as a liaison between the government and non-government sectors. Our member organisations specialise in the provision of services and support for people with a disability due to mental illness.

MHCC represents the interests of its members on a number of National and State boards, committees and reference groups including:

National Organisations

- Consumer Health Forum of Australia Governing Body
- Department of Health and Aged Care Suicide Prevention Strategy
- Mental Health Council of Australia (MHCA)

State Organisations (NSW)

- ACROD Management Committee
- FONGA (Forum of Non-Government Agencies) NCOSS
- Health Care Complaints Commission (HCCC) Consumer Consultative Committee
- Institute of Psychiatry, Consumer Advocate Training Consultative Committee
- Mental Health Association (MHA), Mental Health Promotion Advisory Committee
- NCOSS Health Policy Advisory Group (HPAG)
- Office of the Protective Commissioner Disability Group Interagency
- Committee
- PIAC Forensic and Mental Illness in Prison Network
- Quality Management Services (QMS) Human Service Organisation
- Standards Steering Committee

State Government Departments (NSW)

- Attorney General's Department, Law Reform Commission, Flexible Service Delivery Consultative Committee.
- Community Housing Disability Consultative Committee, Office of Community Housing
- Department of Education & Training, Disabilities Community Consultative Committee
- Department of Housing – Port Jackson Housing Advisory Committee
- Department of Housing – NGO Advisory Group
- Dual Diagnosis (MISA) TAFE Training Project / Steering Committee
- NSW Community Housing Disability Consultative Committee
- NSW Mental Health Review Systems Committee
- NSW Health Mental Health Taskforce
- NSW Health Mental Health Priority Taskforce
- NSW Health, Housing and Supported Accommodation Initiative (HASI)
  – Steering Committee
  – Advisory Committee
  – Evaluation Committee

- NSW Health NGO Advisory Group
- NSW Suicide Prevention Committee
- NGO Advisory Group Accreditation Sub-committee
- Justice Health Consumer and Community Group
- NSW Health, Centre for Mental Health, NGO Partnerships Forum
- Services Industry Reference Group. (Mental Health Course Development)
- The New Joint Guarantee of Service (JGOS)

Background

In December 2002, The Legislative Council Select Committee Inquiry into Mental Health Services in NSW tabled its final report. MHCC in consultation with key stakeholders made numerous representations to the Committee. The final report made 120 recommendations. As a consequence, a 'Day of Participation and Action' was facilitated by MHCC in May 2003, which drew together members and stakeholders from across NSW to prioritise the recommendations and instigated the formation of networks and action plans to support the successful implementation of the most critical recommendations.

The level of interest was reflected in the 180 participants who attended the 'Day of Participation and Action', representing a diverse range of interests. Stakeholders included representatives of public sector agencies, area health services, peak body representatives, consumers, carers, non-government service-providers, police and members of a broad spectrum of the health professions.

As a consequence, MHCC established a number of working groups to address specific interests, such as: carer; forensic; housing; mental illness and dual diagnosis, Indigenous and youth issues. These groups met regularly to discuss the inquiry recommendations, and subsequently to deliberate the Government Response to the Select Committee Inquiry into Mental Health Services in NSW, published in December 2003.

In addition to the working groups, MHCC facilitated numerous workshops and consultations and during the following two years MHCC provided two submissions to the Review of the Mental Health Act 1990: Discussion Paper 1 – Carers and Information Sharing and Discussion Paper 2 – The Mental Health Act 1990, and provided independent submissions from the working groups. In August 2006, The Mental Health Act Draft Exposure Bill was released and MHCC facilitated a consultation in September, which was attended by 45 key stakeholders.

This submission identifies many of the views expressed at the consultation, and numerous discussions, written presentations, legal and clinical advice broadly collected. The submission includes perspectives some of which are do not reflect the position held by MHCC, and in these instances MHCC has stated their view.

General Comments

MHCC welcome the opportunity to respond to the Draft Exposure Bill, although they would like to express concern as to the haste with which submissions are required. Given the complexity of the bill, to convene consultations and gather comments, the time given to the sector to prepare submissions is glaringly inadequate, and insufficient to do justice to the material.

Contributions from the community to the development of best practice to be entrenched in the legislation, has engaged many people for three years. MHCC is of the opinion, that at this last and crucial stage of refining the bill, the urgency with which the government intends to proceed, represents a missed opportunity to produce a visionary piece of legislation that could be a leading example to Western democracies.

In addition to this, the final date for submissions, 2 November 2006, and the tabling of the bill in Parliament on 14 November 2006, appears to be unrealistic if it is to enable the Minister and those drafting the bill, to give due consideration to the many submissions we expect them to receive. If previous numbers are any indication, the government will receive many hundreds of submissions.

Whilst MHCC appreciate the complexity of the forensic system, we also express concern that this review, now under a separate process to be chaired by President of the Mental Health Tribunal, The Hon Greg James QC that these matters are to be delayed until after the election, with the report to be released in August 2007. MHCC suggest that in view of the many submissions already presented related to these matters and the work of the Law Reform Committee published over the last 10 years, that these issues should form part of government policy presented to the general public in their election manifesto.

Nevertheless, from our understanding of the Draft Exposure Bill, MHCC are pleased to see that to a large extent the bill now reflects a proper balance between carers' right to know, confidentiality and privacy, and the ability to make appropriate determinations on behalf of a person with a mental illness when necessary. The bill if passed will certainly recognise carers' rights in a much more substantial way.

The bill also provides clarity and balance around the training of professionals in all contexts to understand their obligations, to seek information from and disclose to carers, the implications for all other community based organisations, and the rights of consumers and carers under the various Mental Health and Privacy Acts.

The amendment that enables carers to obtain an Interim Court Order, to obtain confidential information and urgent assessment when an individual is at risk is now reflected throughout the Act, which we welcome.

MHCC note that in the two Discussion Papers, the key focus of the Objects of the Act was to incorporate the spirit and intent of the Act, to set overarching parameters, thus giving guidance and assistance as to how more detailed provisions of the Act should be interpreted, so that good practice is entrenched in the legislation. We do not feel that this has always been achieved.

MHCC recommends that the Act should be expanded to include core 'Principals,' supporting a concept of overarching guidance to provide for the care, treatment and protection of people with a mental illness, informed by UN Resolution 46/119, Principal 1: Fundamental freedoms and basic rights.

Our consultations suggested that there should be a complete set of definitions in the Preliminary, Chap 1.4, and that all definitions appearing throughout the chapters and sections of the Act should be listed in the Preliminary, Chap 1.4.

Whilst the Preliminary, Objects - Chap 1. 3(d) refers to the civil rights of those under the Act, there is broad consensus that the Act should recognise the needs of particular groups of people such as: Indigenous; culturally and linguistically diverse and people with an intellectual disability. There also needs to be recognition with regard to the rights of carers who may be under 18. We suggest that this acknowledgement be included in the overarching principals of the Act.

It was also felt that definitions in the Preliminary should be substantially expanded, and include for example:

Authorised person
Behaviour in relation to Psychosurgery
Capacity
Community Treatment Order (in the definitions but not adequately defined).
Involuntary patient
Least restrictive care
Least restrictive environment
Mentally disordered person - see section 15. Should be defined
Mentally ill person - see section 14. Should be defined
Psychosurgery
Serious harm

Widely expressed at the MHCC consultation, was the use of language and terminology throughout the Bill. Whilst the bill has gone a long way to improving on the Act as it stands, it was felt that the intent as expressed in The Report of the Review as **Themes for Change, 1.2** had not been met.[i]

Some examples were highlighted as of particular concern at consultations with regard to language and terminology:

- Consultation participants consider that the word 'control' repeatedly used throughout the bill is inappropriate. Whilst MHCC acknowledge that a person under the Act is a last resort, the intent expressed by Parliament in 1.3 and 68.1, focus on care, support, safety and protection and the term control, is not inline with those sentiments.

- The use of the term 'patient' is felt to exclude people living in the community with a mental illness, and various other terms are used throughout the Bill. It is thought that there should be more consistency.

  MHCC express the view that for the purposes of simplicity 'patient' refers to those under the Act receiving medical/psychiatric care, and is therefore appropriate.

- At consultations, aversion to the term 'mentally ill person' was consistently raised. It was suggested that this should be replaced by 'a person with a mental illness' as it better accommodates the episodic nature of many conditions and does not define an individual in terms of their mental illness or diagnosis.

- **S15** – Objections were raised to the use of language as expressed for example in Section 15 – that, "the person is suffering from mental illness." The alternative suggested was that a person 'has a mental illness.'

- **S16. j** – Some objections were raised by consumers as to the use of language as expressed for example in Section 16.j - "the person has developmental disability of mind." – The term 'intellectual disability' was suggested in preference.

MHCC agree with the view expressed by some service providers consulted that 'intellectual disability' is preferable terminology to "developmental disability of mind." However, we stress the necessity to pay attention to the context in which it is used, and make a distinction between 'developmental disability' and 'acquired brain injury.'

Comment on Sections

The following section comments are listed numerically.

- **S11 - Review of decisions made by medical officer to refuse or discharge voluntary patient** (cf 1990 Act, s19)

(1) This section applies to a decision made under this Chapter by an authorized medical officer (other than a medical superintendent) to refuse a person admission to a mental health facility as a voluntary patient or to discharge a person as a voluntary patient.

In rural, regional and remote areas, when (as often occurs) no authorised medical officer is available, inpatient staff express concern about voluntary patients wanting to discharge themselves, and frequently detain patients for assessment under common law and a duty of care.

MHCC understand that under the Act, a possibility exists for an accredited person to be authorised who is not a medical officer. However, in policy implementation it appears that an accredited person is not sufficiently defined in the Act as to bring this about, and concerns as to the level of responsibility that should be placed upon Clinical Nurse Consultants (CNC) due to insurance issues and professional imperatives, has resulted in only medical officers having authorisation.

MHCC note that Section 136 has been amended from Section 287(a) of the 1990 Act. The language has broadened as to become somewhat ambiguous as to the powers an accredited person might hold.

Recommendation

- That an accredited person be clearly defined in the Act, S136.1, stating that the Director General may appoint an accredited person who is other than a medical practitioner.
- That S136 include clarification as to the qualifications necessary for nomination of accredited person in the definitions, or in policy directives under the Act.
- That S136.2 clarify powers given to an accredited person under the Act.

- **12.1(b) – General restrictions on detention of persons**

(1) *A person must not be involuntarily admitted to, or detained in or continue to be detained in, a mental health facility unless an authorized medical officer is of the opinion that:*

(a) the person is a mentally ill person or a mentally disordered person, and

(b) no other care of a less restrictive kind is appropriate and reasonably available to the person.

There are many examples throughout the Act that require reference to another section of the Act. The Act has become unwieldy, necessitating a user move back and forth between chapters to find relevant sections that provide explanation to another section. In this instance, the section/clause is clarified by Chapter 4.1, Div 1, Section 68, which explains the intent of the Parliament with regard to Principals for Care and Treatment and should be noted.

Recommendations

- That clear reference is made to another section of the Act that clarifies a relevant section/clause.
- That S68, Div.1. Principals for Care and Treatment are included in the Preliminary, Objects of the Act.

- **S18. 1– When a person may be detained in mental health facility**

(1) A person may be detained in a declared mental health facility in the following circumstances:
(a) on a mental health certificate given by a medical practitioner or accredited person (see section 19),

Similarly, this clause requires clarification as to who is an accredited person, since other subheadings refer to police, ambulance officers, court transfer or on a written request of a primary carer S18.1 (b).

Recommendation

- A clearer definition of an accredited person to be included in Preliminary, Definitions, Chap 1.4 and a reference provided in S18.1 (b).

- **S19.1 – Detention on certificate of medical practitioner or accredited person**

(1) A person may be taken to and detained in a declared mental health facility on the basis of a certificate about the person's condition issued by a medical practitioner or accredited person. The certificate is to be in the form set out in Part 1 of Schedule 1.

Clinical Nurse Consultants in rural, regional and remote areas report that often there is no way in which to remove a schedule (when an authorised person is not available). Police have proved reluctant under the current Act (cf 1990 Act, s24) to transport patients many hundreds of miles to be assessed. As previously highlighted in this submission, alternative accredited persons should be authorised by the Director General to conduct assessments.

Recommendations

- That an accredited person be clearly defined in the Act, S136.1, stating that the Director General may appoint an accredited person other than a medical practitioner.
- That S136 include clarification as to the qualifications necessary for nomination of accredited person in the definitions, or in policy directives under the Act.

S19.2 (b) - Detention on certificate of medical practitioner or accredited person

(2) A mental health certificate may be given about a person only if the medical practitioner or accredited person:

(b) is of the opinion that the person is a mentally ill person or a mentally disordered person, and

Recommendation

- To take into account concerns regarding harm to reputation, and financial harm, by inserting S22.1 (b) as a clause under subsection 19.2 (b), *' it would be beneficial to the person's welfare to be dealt with in accordance with this Act, rather than otherwise in accordance with law. This would include concerns regarding harm to reputation and financial harm. '* [ii]

- **S19.2 (d) – Detention on certificate of medical practitioner or accredited person**

(2) A mental health certificate may be given about a person only if the medical practitioner or accredited person:

(d) is not the primary carer of the person.

MHCC note that Section 19.2(d) has been amended from the Section 21 in the current Act. We suggest that clause (d) include the words *'or relative,'* to circumvent the possibility of a relative (who is a medical practitioner or accredited person) issuing a certificate when they may be less able to make an objective assessment.

Recommendation

- That S19.2 (d) include the words *'or relative.'*

- **S22.1a – Detention after apprehension by police**

MHCC consultations raised questions as to what constitutes harm. MHCC suggested in their submission to Discussion paper 2, that the concept of harm should include harm to reputation and financial harm. Most consumers and carers agree.

MHCC are of the opinion that Section 22 (b) is a broad statement, which should include the wording suggested for Section 19.1 (b).

Recommendation

- To add the words to S22.1 (b), *' it would be beneficial to the person's welfare to be dealt with in accordance with this Act, rather than otherwise in accordance with law. This would include concerns regarding harm to reputation and financial harm. '*

- **S25.1 – Detention after transfer to another health facility**

(1) A person may be transferred from a health facility to a declared mental health facility and detained in the mental health facility if a responsible medical officer of the health facility, or the authorised medical officer of the mental health facility, considers the person to be a mentally ill person or a mentally disordered person.

MHCC suggest that use of the word 'responsible medical officer' is vague and suggests broad powers, since under Section 25.2, once transferred, the patient is scheduled under Section 19 of the Act.

Recommendation

- That S25.1clarify what is meant by, 'responsible medical officer.'
- That S25.2 clarify the powers a 'responsible medical officer' has to act.

- **S26.1 – Detention on request of primary carer, relative or friend**

(1) A person may be detained in a declared mental health facility on a written request made to the authorized medical officer by the primary carer or a relative or friend of the person.

The wording of the above section is very unclear.

Recommendation

- That the wording in S26.1 be altered to read, *'A person may be detained for the purpose of assessment on a written request by the primary carer or a relative or friend of the person to the authorised medical officer or accredited person.'*

- **S27 (d) – Step 4 Mental health inquiry or discharge**

(ii.d) The person must be brought before a Magistrate as soon as practicable after the authorised medical officer is notified of the relevant finding of the second or third examiner.

MHCC suggest that a time frame be specified rather than use the wording *'as soon as practicable.'*

Recommendation

- That the wording be altered to include a time frame of no more than 5 days.

- **S31. 4 – Limited detention of mentally disordered persons**

(*4) The person must not be further detained in the mental health facility if, on any such examination, the authorised medical officer is of the opinion that the person is not a mentally disordered person or a mentally ill person or that other care of a less restrictive kind is appropriate and reasonably available to the person.*

Consensus at consultations was that a definition of 'least restrictive care' was necessary in Chap1.4. This term is used throughout the Act, and it is felt that, a definition is particularly necessary to provide clarity to Section 68(a).

Appropriate wording suggested was that *'best possible care and treatment',* rather than, *"least restrictive alternative."* Least restrictive alternative may lead to early discharge, which may not necessarily be the best possible care and treatment, and in some instances has led to neglect.

Recommendations

- That the term *"least restrictive care or alternative*" be amended to read *'best possible care and treatment.'*

- That the term *'best possible care and treatment,'* be included in the Preliminary, Chap1.4, Definitions.

- **S32. 4(a) – Limited further detention of person's taken to a facility by police or after Magistrate's bail**

(a) detain a person for ***no more than 1 hour*** *pending the person's apprehension by a police officer.*

MHCC consultation participants expressed grave concerns that 1 hour was a far too restrictive a time frame, since circumstances frequently arise in which police unable to respond in time may result in putting a person at risk.

Recommendation

- That the wording of S32.4 (a) be amended to 4 hours.

- **S34 – Mental health inquiries to be held**

Concerns were raised during consultations with regards to rights of appeal to the magistrate, under Section 34. Both the Right of Appeal in Section 77 (Notification of appeal rights to new involuntary patients) and a Statement of Rights in Schedule 3, provide information pertaining to these concerns.

Recommendation

- That a note be included under S34 indicating that rights of appeal, and a statement of rights are available in S77 and Schedule 3.

S35 (4) - **Purpose and findings of mental health inquiries**
(4) The Magistrate may defer the operation of an order for the discharge of a person for a period of up to 14 days, if the Magistrate thinks it is in the best interests of the person to do so.

During MHCC consultations concerns were raised with regard to adjournment safeguards. MHCC suggest that only two adjournments could be ordered before an appeal process is permitted.

Recommendation

- That S35 (4) include clarification as to the appeal process for an adjournment, and to note clauses in S44 that detail a patient's right of appeal.

- **S38. 3 – Purpose and findings of reviews of involuntary patients**

(3) If Tribunal determines that person not mentally ill, they must be discharged…

Concerns were raised that even if a person is determined as not mentally ill, that some care should be taken as to the location from which they are being discharged and the place of origin from which they may have been transported.

Recommendation

- That the wording be added to S38.3, *'they must be discharged with due consideration to their circumstances.'*

- **S50 – Applications for and making of community treatment orders. Definitions.**

The definition of a CTO in the Preliminary, Chap 1.4 refers to Section 50, which does not adequately define a CTO.

Recommendation

- That a definition of a CTO be included in Chap 1.4 and in Part 3, in addition to Div.1 S50, Definitions, to cover all sections that refer to CTOs in that part, S51 – S56.

- **S53.3 (a) - Determination of applications for community treatment orders**

(3) The Magistrate or Tribunal may make a community treatment order for an affected person if the Magistrate or Tribunal determines that the patient is a mentally ill person and that:

(a) no other care of a less restrictive kind 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…

In Section 53.3(a) and (b) it is necessary to understand what is meant by *"least restrictive environment."* This is defined in Chap 4.1. Div.1, 68 a – j, as are the patients' rights.

Recommendations

- That S53.3(a) and (b) are clarified by cross-referencing to S68.
- That S68, Div.1. Principals for Care and Treatment are included in the Preliminary, Objects of the Act.

- **S56. 2 - Form and duration of community treatment orders**

(2) A community treatment order ceases to have effect on the date specified in the order or, if no date is specified, 12 months after the date of the order.

This amendment to the 1990 Act, states a time frame of 6 – months, which raises concern. MHCC in response to Discussion Paper 2, Questions 63, 64, and 65 stated that it is appropriate that, *"a medical practitioner should be required to give evidence that the affected person is likely to become a mentally ill person within 3 months if the order is not renewed,"* (p. 39).

MHCC reiterate that the Act should not be amended to extend orders from 6 to 12 months. A six-month order is regarded as an important safeguard for patients. This position received support at MHCC consultations.

Recommendations

- That a community treatment order ceases to have effect on the date specified in the order or, if no date is specified, 6 months after the date of the order.

- That S56 include a clause stating that legal representation before the Tribunal will be provided if requested.

- **S 57. 5 – Duties and functions of a person and mental health facility**

(5) A person implementing a treatment plan under an order may enter the land (but not the dwelling) on which an affected person's residence is situated without the person's consent for the purpose of implementing the community treatment order.

MHCC and those consulted deem this section/clause to be strangely worded. It posed the question as to how a person attempting to implement a breached CTO could possibly implement a treatment order in such circumstances.

It is suggested that this section requires amendment to include clarification that to enter the premises without permission would constitute trespass, and that legally a warrant must be obtained to enter premises if the breached person forbids entry.

If our understanding is correct, we suggest clarity on what is required in such an event, and that a carer could be nominated as a consenting agent, if such a nominated person exists.

Recommendations

- That S57.5 is modified to explain how the person implementing the treatment order would legally be able to carry out their function.

- That the person's nominated carer may be nominated as a consenting agent to agree to enter a dwelling.

- **S 58.3 (a) – Breach of Community Treatment Order**

(3) On a further refusal or failure by the affected person to comply with the CTO, the director may cause the person to be given a written notice (a breach notice):

(a) requiring the person to accompany a member of staff of the NSW Health Service employed at the declared mental health facility for treatment in accordance with the order or to a specified mental health facility.

Objections were raised to use of the term *"affected person"* (as it was throughout the bill) in S58.3 (a). A definition is deemed necessary to determine exactly which persons employed by NSW Health this requirement applies to.

MHCC are of the opinion that in general the term *"affected person,"* is appropriate, although in the context of S58.3 (a) it would be preferable to alter it as recommended.

Recommendations

- That the term *"affected person"* in S58.3 (a) should be altered to read *'person who is breached.'*

- That the wording in clause (a) be amended to read, *'requiring the person to accompany a member of staff of the NSW Health Service who has been so directed by the Medical Superintendent, employed at the declared mental health facility for treatment in accordance with the order or to a specified mental health facility.'*

- **S68 – Principals for Care and Treatment**

As previously referred to (e.g. Section 12.1(b)) MHCC stress that since Section 68 refers to the vision and intent of the Parliament with regard to Principals for Care and Treatment, it is vital that this Section be included to provide the unequivocal ethical foundation and overarching Objects of the Act.

Recommendation

- That S68 in addition to its position in the bill as drafted, be included in the Objects of the Act, Chap 1.3 Preliminary.

- **Chapter 4. Division 1 – 68 – 72.**

Participants at consultations were concerned that they were unable to find any statement in the Act regarding carer assessment safeguards.

It was also suggested that the Act specify the accredited organisation/ authorised person capable of making an assessment and taking 'reasonable steps' to identify any conflict of interest or whether a carer is capable.

Likewise, some reference requires inclusion under S 71.1, *' A primary carer for the purposes of this Act is …'* or under Section 72, Nomination of Carer.

MHCC are of the opinion that this could be an infringement of a consumer's right to nominate as they see fit, and that such an inclusion may therefore be an inappropriate inclusion in the Act.

Recommendation

- That the Act remain without inclusion of carer assessment, but that it be included in the overarching principals of the Act, that nomination of a carer is appropriate to the needs of the patient.

- **S69 – Offence to ill-treat patients.**

Service providers and consumers feel most strongly that the term *"ill-treatment,"* needs clarification, and that this broad statement should be specifically expressed as *'seclusion and restraint,'* in the Definitions.

A preference was indicated for the language used in the Victorian Mental Health Act 1986 (amended 2002, see Sections 81 & 82), with regards to seclusion and mechanical restraint:

> http://www.health.wa.gov.au/mhareview/resources/legislation/VIC_Mental_Health_Act_1986.pdf [Accessed 20.10.2006].

Recommendation

- o That the Victorian Mental Health Act 1986 (Amended 2002, Sections 81 and 82, shown in the endnote) be incorporated into the NSW Draft Exposure Bill. [iii]

- **S72 – Nomination of a carer**

MHCC were unable to locate in the bill details as to how nomination of a carer takes place. Whilst we acknowledge that implementation is a policy and procedures matter, we are of the opinion that within the Act is necessary to provide clarity as to how this process takes place. In this way, the bill will, *"recognise and support greater participation for carers and patients,"* as outlined in the Report of the Review, Themes for Change.

Recommendation

- o That a carer nomination form be included as a Schedule in Chapter 9, Miscellaneous.

- **S74.1 – Information to be given to persons to be detained**

This section refers to the obligations an authorised medical officer has to give a patient oral and written explanation of legal rights.

Suggestions were expressed that this information be stated under S75, and that under S73, it would be clearer if a subheading included S68 (j) – regarding carer rights. MHCC were unable to find a definition of carer rights and responsibilities in the bill.

MHCC are of the opinion that conveying such explanations to a patient are clearly the responsibility of staff and not a carer responsibility.

Recommendations

- o That the bill should not include a statement of carer obligations to explain rights to patients.
- o That the bill should include a definition of the function of a nominated carer; the process of nomination; duration of a nomination; the revoking of a nomination and where this nomination is to be recorded.
- o That the bill should include a statement defining nominated carer rights and responsibilities.

- **S77 - Notification of appeal rights of new involuntary patients**

MHCC were unable to find a clause in the bill that referred to the right of appeal in the case of an adjournment.

Recommendation

- o That S44 include a right of appeal in the case of an adjournment, which is noted in S 77.

- **S77.1 – Notification of appeal rights of new involuntary patients**

MHCC note that Section 44 (Appeals against discharge refusals) provides further detail on appeal rights, but Section 44(b) is unclear as to who this refers to as the person appealing on behalf of the patient.

Recommendation

- o That S44 (b) clarify whether the Tribunal can determine no further right of appeal on behalf of the patient even when instigated by a legal representative or carer.

- **S78.1 – Notifications to primary carer of events affecting patients or detained persons**

(1) An authorized medical officer of a mental health facility must take all reasonably practicable steps to notify the primary carer of a patient or person detained in the facility if any of the following events occurs:

Consultation participants highlighted concerns regarding the wording of this section emphasising the importance that, *"a primary carer is advised if any of the following events occurs* ***or are about to occur****."* This particularly applies to S78.1, Clauses 1(c); (d); (e); (f) and (g) and similarly S78.2.

Recommendation

- That S78.1 and S78.2 be amended to include the words, *'or are about to occur.'*

- **S79.3 – Discharge and other planning.**

(3) An authorized medical officer of a mental health facility must take all reasonably practicable steps to provide a patient (of any kind) who is discharged…

Similar sentiments were expressed to Section 79.3 as Section 78. We suggest that it is necessary to insert the wording, *'or to be discharged'* *"from the facility, and the patient's nominated carer, with appropriate information as to follow-up care."*

Recommendation

- That S79.3 is amended to include the words, *'or to be discharged.'*

- **S 80 – Transfer of patients to or from mental health facilities**

(2) A person who is a patient in a health facility other than a mental health facility may be transferred from the health facility to a declared mental health facility for the purpose of detaining the person under Part 2 of Chapter 3.

Recommendation

- That S80 include the wording, ' *for the purpose of detaining the person under Part 2 of Chapter 3, after assessment by an authorised medical officer.'*

- **S81.3 – Transport of persons to and from mental health facilities and other health facilities.**

(3) A person may be sedated, by a person authorised by law to administer the sedative, for the purpose of being taken to or from a mental health facility or other health facility under this Act if it is necessary to do so to enable the person to be taken safely to or from the facility.

> ***Note.*** *The Poisons and Therapeutic Goods Act 1966, and the regulations under that Act, regulate the persons who may prescribe and administer drugs (including sedative drugs).*

Clinicians and consumers raise concern with regard to sedation doses, which they believe frequently represent over medication, and propose that reference in the note to this section refer to, *"least harmful and appropriate doses,"* or be cross referenced to Section 85, Administration of excessive and inappropriate drugs.

"85 - Administration of excessive or inappropriate drugs *(cf 1990 Act, s198)*
A medical practitioner must not, in relation to any mental illness or mental condition or suspected mental illness or mental condition, administer, or cause to be administered to a person a drug or drugs in a dosage that, having regard to professional standards, is excessive or inappropriate. Maximum penalty: 50 penalty units."

Recommendation

- That S81.3 be amended to include the words, *'least harmful and appropriate doses,'* or cross-referenced to S85.

- **S83. 1 - Prohibited Treatments.**

Division 2 General provisions about mental health treatment
(1) Prohibited treatments (cf 1990 Act, s197)
(d) A person must not administer to or perform on another person any of the following: deep sleep therapy, insulin coma therapy, psychosurgery, any other operation or treatment prescribed for the purposes of this section.

Our consultation revealed that this issue is a technical one, not well understood by many in the community. MHCC are aware of arguments against the use of psychosurgery, but reiterate the view expressed in their response to Discussion Paper 2.

We note the conclusion reached by the Psychosurgery Review Working Group, that psychosurgery can be effective for, *"a very small and specific group of patients suffering from some chronic, disabling and treatment resistant psychiatric illnesses."*

This group of consumers should not be disadvantaged by the prohibition of a form of treatment that may give them relief from the severe, long-term distress caused by their mental illness.

Any consideration of psychosurgery would have to come with the proviso that rigorous measures are put in place to ensure that consumers are fully informed of their rights, options and possible consequences of the procedure and that any consent is a genuinely informed consent.

MHCC consulted RANZCP and support two submissions to the Legal Department from Dr Sid Williams and Prof Sachdev. We strongly recommend that their expertise be taken into consideration.

Apart from our objection to this amendment to the current Act, MHCC found the entire Section 83 extremely confusing. It is unclear whether these prohibitions refer to both voluntary and involuntary patients or only one or other patients.

Recommendation

- That psychosurgery should not be banned and that S83.1 be redrafted to reflect the expert clinical recommendations submitted.

- **S83.2 –** Definitions regarding *"behaviour in the definition of psychosurgery,"* and *"psychosurgery."*

MHCC propose that the wording *"behaviour"* used in Section 83.2 is unclear. We suggest that a definition be expanded to clarify what this includes. Likewise the term *"psychosurgery,"* requires similar attention.

Recommendation

- That S83.2 is re drafted to provide greater clarity.
- That the terms *'behaviour,'* and *'psychosurgery,'* be included in Chapter 1.4, Preliminaries.
- That S83 clearly state whether it refers to voluntary and involuntary patients, or only one or other types of patients.

- **S91.2 – Part 2 Mental Health Treatments. Division 3 Electro Convulsive Therapy (ECT) – Informed Consent Requirements.**

MHCC could find no reference in the Act to ECT as a treatment of last resort never to be used on children or young people under the age of 18.

Recommendation

- That S91.2 state that ECT is a prohibited treatment for people under age 18.

- **S96.3 – Purpose and findings of ECT inquiries**

(3) An ECT determination is a determination:

(a) that the patient is capable of giving informed consent to the electro convulsive therapy and has given that consent, or that:

(b) the patient is incapable of giving informed consent or is capable of giving informed consent to the electro convulsive therapy but has refused, or has neither consented nor refused, to have the treatment administered, and

Section 96.3 amended in the bill judges that a person might be capable of providing consent to ECT, but incapable of being able to refuse consent. MHCC are of the opinion that if a person is capable of consenting to psychosurgery then they should also be capable of refusing it.

It has been suggested that to detain a person under the Act is a last resort, and therefore such a judgement appropriate. However, we suggest that the wording is confusing and reads reminiscent of 'Catch 22.'

Recommendation

- That further consideration is paid to the wording of S96.3 to provide clarity to those using the Act who may not have legal background.

- **S96.4 – Number of ECT treatments approved**

Since ECT is normally given in 3 treatment sessions, it is recommended that the number stated is (not exceeding) 9 rather than 8.

Recommendation

- That S96.4 be amended to read that, *'in any ECT determination, the Tribunal must also specify the number of treatments approved (not exceeding 9).'*

- **S100.1 - Authorised medical practitioner may consent to surgery**
  (1) An authorised medical officer may apply to an authorised medical practitioner for consent to the performance of a surgical operation on an involuntary patient.
  and
- **S101.1 –Tribunal may consent to surgery**
  (1) An authorised medical officer of a mental health facility may apply to the Tribunal for consent to the performance of a surgical operation on an involuntary patient detained in the facility.

Regarding Sections 100.1 and 101.1, MHCC are of the opinion that the term *"authorised medical officer,"* is unclear. If the medical officer is the medical superintendent at the mental health facility, and the medical practitioner is authorised by the Director General, it would be more appropriate to go direct to the Tribunal for consent to surgery.

Lawyers who participated at MHCC consultations suggested that there needs to be greater clarity about when it is appropriate to get consent from the Tribunal and when to get it from an authorised medical practitioner. If external consent is required, then the Tribunal should be approached. It was suggested that one step too many has been included.

Recommendation

- That further consideration is given to the meaning of the two Sections 100 and 101.

- Sections 100.1 and 101.1 redrafted to provide greater clarity.

- **S99.1; S91.2– Emergency surgery for involuntary patients and S101.2 – Tribunal may consent to surgery**

(1) An authorised medical officer or authorised medical practitioner may consent to the performance of a surgical operation on an involuntary patient (other than a forensic patient not suffering from a mental illness) if of the opinion that:

MHCC were unable to understand what is meant by,*" a forensic patient not suffering from a mental illness."* Since the wording in these sections / clauses refer to patients who do not have the capacity to consent to an operation, we are unclear as to who this refers. Who is a forensic patient not suffering from a mental illness?

Recommendation

- That the bill be drafted to provide clarity to the words, *"other than a forensic patient not suffering from a mental illness."*

- **S103.2 – Tribunal may consent to special medical treatment**

(2) On an application, the Tribunal may consent to the carrying out of special medical treatment on a patient (other than prescribed special medical treatment) if the Tribunal is satisfied that it is desirable, having regard to the interests of the patient, to carry out the treatment on the patient.

Part 3, Section 103.2 refers to Section 98, Definitions: *"special medical treatment,"* as one likely to render the patient infertile. There is also a definition of *"prescribed special medical treatment,"* under Section 103(6). We assume this to mean to administer medication that may render the patient infertile. However, we suggest that a definition be also given in Section 98, as to what exactly this refers.

The confusion arises since Section 103 (6) provides the definition that *"prescribed special medical treatment means special medical treatment referred to in paragraph (b) of the definition of "special medical Treatment in section 98."* From this definition both prescribed and special seem to have identical meaning, so we question why the use of both words has been included in this section.

Recommendation

- That if the definition of, "special medical treatment," means something different to "prescribed special medical treatment," that the difference be explained.

- **S115.1 – Application for a licence to keep premises as a private mental health facility.**

Section 115.1 is unclear as to whether the application applies to gazetted beds or not.

Recommendation

- o That S115.1 specifies whether the application refers to gazetted beds.

- **S116.1 - Grant and refusal of licence.**

Section 116.1 is unclear as to the conditions under which the Director General can approve the licence. MHCC suggest more clarity around the aims of this section. Section 116.1 is also unclear as to whether the application applies to gazetted beds or not.

- o That S116.1 states the conditions under which a licence may be granted.
- o That S116.1specifies whether the application refers to gazetted beds.

- **S150.1 – Composition of the Tribunal**

Section 150.1 suggests that the Act would support use of a Tribunal conducted by one person.

MHCC and consultation participants are deeply concerned that a Tribunal of one is to become a reality entrenched in the law. We are of the opinion that it is imperative that Tribunals reflect a spectrum of clinical, legal and community expertise.

Recommendation

- o That S150.1 is amended to define the Tribunal composition to number at least **three** members.

- **S154 – Tribunal Procedures Generally**

MHCC were unable to find in the Act, a section dealing with capacity for involvement and patient rights to advocacy during Tribunal proceedings.

Recommendation

- o That a section /clause is added that supports capacity for involvement and ensuring patient rights to advocacy during Tribunal proceedings.

- **Schedule 2 – 8.1(c). Records of Proceedings (Page 95)**

MHCC suggest that a clause be added, subclause (d) *'unless requested / required by the legal representative of the mentally ill person,' (if they have one).*

MHCC were unable to find a clause in the bill that dealt with the provision of legal representation for patients coming before the Tribunal. Although it does state in Section 152 that patients may have representation, it does not state ensuring provision of legal representation:

> ***"152 - Legal representation of mentally ill persons and other persons***
> *The fact that a person is suffering from mental illness or a developmental disability of mind or is suffering from a mental condition that is not a mental illness or a developmental disability of mind is presumed not to be an impediment to the representation of the person by an Australian legal practitioner before the Tribunal."*

Recommendations

- That an additional clause (d) be added to Scedule2. 8.1, that unless: *' requested or required by the legal representative of the mentally ill person,' (if they have one).'*

- That S152 include a sentence that specifies that all patients are entitled to legal representation before the Tribunal, and the Tribunal must ensure legal representation if requested.

- **S156 – Appeals to the Court**

MHCC were unable to find detail as to safeguards under Section 156 in the event of an adjournment. Since there appears to be no right of appeal other than to the Supreme Court, a patient may be detained at the discretion of the Magistrate.

Recommendation

- That S156 include a time frame during which an appeal must be reconvened.

- **Schedule 3 – Statement of Rights**

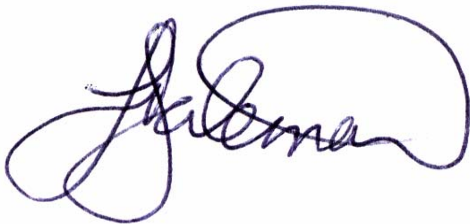
When is a Magistrate's mental health inquiry held?
"A Magistrate's mental health inquiry must be held as soon as possible after it is decided to keep you in a mental health facility against your will because you are a mentally ill person.

Recommendation

- That under Schedule 3, the words *"as soon as possible,"* be amended to include, *'no longer than 5 days.'*

MHCC thank the Department of Health for enabling us to participate in this consultative process and look forward to involvement in the future consultations with regard to the forensic matters.

For further information please direct any questions with regard to this submission to Corinne Henderson, Policy Officer at corinne@mhcc.org.au or Tel: 02 9555 8388 ext 101.



Jenna Bateman
Executive Officer.

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[i] **"1.2 Themes for Change**
While the submissions were supportive of much of the current content of the law, some clearly identified "themes for change" also arose, and these have informed the development of the Exposure Draft Bill:
First, recognising and supporting greater participation for carers and patients by revising the language of the Act into plainer English, overhauling and enhancing the recognition of patient rights and expectations and enhancing information sharing between clinicians, carers and patients.
Secondly, by making the 1990 Act more operationally relevant to current service models and needs, by recognising the role of service providers such as ambulance services, and improving the means by which persons with mental illnesses can obtain general and specialist medical care.
Thirdly, by ensuring there is sufficient flexibility in the legislative scheme to accommodate future changes and additions in service delivery by revising the way services are recognised by the legislation."

[ii] S22(b) is of the opinion that the person is a mentally ill person or a mentally disordered person, and is beneficial to the person's welfare to be dealt with in accordance with this Act, rather than otherwise in accordance with law.

[iii] **81. Mechanical restraint**

(1) Mechanical restraint of a person receiving treatment for a mental disorder in an approved mental health service can only be applied—

(a) if that restraint is necessary—

(i) for the purpose of the medical treatment of the person; or

(ii) to prevent the person from causing injury to himself or herself or any other person; or

(iii) to prevent the person from persistently destroying property; and

(b) if the use and form of restraint has been—

(i) approved by the authorized psychiatrist; or

(ii) in the case of an emergency, authorized by the senior registered nurse on duty and notified to a registered medical practitioner without delay; and

(c) for the period of time specified in the approval or authorization under paragraph (b).

(1A) In this section **"mechanical restraint"**, in relation to a person, means the application of devices (including belts, harnesses, manacles, sheets and straps) on the person's body to restrict his or her movement, but does not include the use of furniture (including beds with cot sides and chairs with tables fitted on their arms) that restricts the person's capacity to get off the furniture.

(1B) In the circumstances referred to in sub-section (1)(b)(ii) the senior registered nurse must notify the authorized psychiatrist of the application of mechanical restraint as soon as practicable.

(1C) It is not necessary to obtain a person's consent to the application of mechanical restraint to him or her.

(1D) If mechanical restraint is applied to a person, he or she must—

(a) be under continuous observation by a registered nurse or registered medical practitioner; and

(b) be reviewed as clinically appropriate to his or her condition at intervals of not more than 15 minutes by a registered nurse; and

(c) subject to sub-section (1E), be examined at intervals of not more than 4 hours by a registered medical practitioner; and (d) be supplied with bedding and clothing which is appropriate in the circumstances; and (e) be provided with food and drink at the appropriate times; and

(f) be provided with adequate toilet arrangements.

(1E) The authorised psychiatrist may vary the interval at which a person to whom mechanical restraint is applied is medically examined under sub-section (1D)(c), if the authorised psychiatrist thinks it appropriate to do so.

(1F) If a registered medical practitioner or the senior registered nurse on duty or the authorised psychiatrist is satisfied, having regard to the criteria specified in subsection (1), that the continued application of mechanical restraint to a person is not necessary, he or she must without delay release the person from the restraint.

(2) Any person who applies mechanical restraint to a person receiving treatment for a mental disorder in an approved mental health service in contravention of sub-section (1) is guilty of an offence against this Act.

(3) The authorized psychiatrist must at the end of each month prepare and send to the chief psychiatrist a report of the use of mechanical restraint specifying in each case—.

(a) the form of mechanical restraint used; and

(b) the reasons why that restraint was used; and

(c) the name of the person who approved or authorized the use of that restraint; and

(d) the name of the person who applied that restraint; and
(e) the period of time for which the person was kept restrained; and
(f) if the authorised psychiatrist varied the interval at which the person was medically examined, the reason for that variation— during that month.

82. Seclusion of person receiving treatment
(1) In this section, **"seclusion"** means the sole confinement of a person at any hour of the day or night in a room of which the doors and windows are locked from the outside.

(2) A person receiving treatment for a mental disorder in an approved mental health service may be kept in seclusion only—
(a) if it is necessary to protect the person or any other person from an immediate or imminent risk to his or her health or safety or to prevent the person from absconding; and
(b) if the use of seclusion has been—
(i) approved by the authorized psychiatrist; or
(ii) in the case of an emergency, authorized by the senior registered nurse on duty and notified to registered medical practitioner without delay; and
(c) for the period of time specified in the approval or authorization under paragraph (b).

(2A) In the circumstances referred to in sub-section (2)(b)(ii) the senior registered nurse must notify the authorized psychiatrist of the use of seclusion as soon as practicable.

(2B) It is not necessary to obtain a person's consent to keep him or her in seclusion.

(3) A person who is kept in seclusion must—
(a) be reviewed as clinically appropriate to his or her condition at intervals of not more than 15 minutes by a registered nurse; and
(b) subject to sub-section (3A), be examined at intervals of not more than 4 hours by a registered medical practitioner; and (c) be supplied with bedding and clothing which is appropriate in the circumstances; and
(d) be provided with food and drink at the appropriate times; and
(e) be provided with adequate toilet arrangements.

(3A) The authorised psychiatrist may vary the interval at which a person who is kept in seclusion is medically examined under sub-section (3)(b), if the authorized psychiatrist thinks it appropriate to do so.

(3B) If a registered medical practitioner or the senior registered nurse on duty or the authorised psychiatrist is satisfied, having regard to the criteria specified in subsection (2), that the continued seclusion of a person is not necessary, he or she must without delay end the keeping of the person in seclusion.

(4) Any person who keeps a person in seclusion in contravention of this section is guilty of an offence against this Act.

(5) The authorized psychiatrist must at the end of each month prepare and send to the chief psychiatrist a report specifying in each case—
(a) the reasons why seclusion was used; and
(b) the name of the person who approved or authorized the use of seclusion; and
(c) the name of the person who kept the person in seclusion; and
(d) the period of time for which the person was kept in seclusion; and
(e) if the authorised psychiatrist varied the interval at which the person was medically examined, the reason for that variation— during that month.