



July 2004

REVIEW OF THE MENTAL HEALTH ACT 1990

Discussion Paper 2: The Mental Health Act 1990

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Part 1: Review of the Mental Health Act 1990

1.1 Background to the Review

The Mental Health Act 1990 was passed by the NSW Parliament in May 1990 and commenced shortly thereafter. At the time it was passed the Act was considered by some to be a high water mark in Australian mental health legislation in relation to the recognition it gave to the rights and liberty of persons with a mental illness. Prior to its introduction, the legislation had also been the subject of extensive consultation with both those with a direct interest in its provisions – most notably consumers, carers and health professionals – as well as the broader community.

Seeking the involvement of the community has always been a key feature of legislative reform in this area. The 1990 Mental Health Act was one of the first pieces of legislation in NSW to include a time limited review clause, with section 304 requiring the Minister to review the new legislation and report on that review to Parliament within 2 years of the commencement of the Act. The Mental Health Act Implementation Monitoring Committee was established by the then Minister to undertake the review in accordance with this provision. The Committee, which was chaired by Anne Deveson¹ included wide ranging membership from service provider and community groups to ensure consultation with the community remained a central part of the review process.

The Committee conducted the first and to date, only comprehensive review of the current legislation, focusing on issues arising from its implementation. The Final Committee Report was provided to the then Minister in August 1992². The recommendations in the Report provided the basis for a series of amendments to the Act passed in 1994 and 1997. There has been no substantive amendment of the Act since.

The Act has now been operational for thirteen years, and remains largely as passed in 1990. In the years since however there have been changes in the NSW Health system, changes in the way mental health services are organised and provided, and new regulatory developments such as privacy laws, which have directly impacted on the legislation. Given these changes, it is now appropriate to revisit the Act and consider whether amendments are necessary to make it more effective and more responsive to the current needs of patients and the community.

Clearly, some of the changes described above raise questions which go beyond the statutory confines of the Mental Health Act itself, to the manner in which mental health services are provided, funded and administered by government. Many of these broader questions have been subject to recent comprehensive consideration and discussion, through the work of the NSW Parliamentary Select Committee on Mental Health which reported to Parliament in December 2002.

The Committee was established by the Legislative Council in December 2001, with extensive terms of reference to review provision of mental health services including funding, quality, staffing levels and community participation in those services.³ Over the following twelve months, the Committee received 303 submissions and heard evidence from 91 separate witnesses⁴. The Final Report, and its 120 recommendations represents a detailed picture of community concerns in relation to mental health services. It therefore provides an important context to this legislative review. In addition, while the focus of the Committee's inquiry was on service delivery, it made some

recommendations for changes to the Mental Health Act, primarily based around its community participation terms of reference.

It is recognised a comprehensive review of the Mental Health Act must involve extensive consultation with consumers, carers, and health service providers. To ensure this, in October 2003 the Department of Health wrote to a range of stakeholders seeking their views on issues to be included in the review. The issues raised as part of this consultation have provided a useful tool in guiding the work to date. The review is occurring by way of two issues papers, each focusing on a key aspect of the legislation:

- Paper 1:** **Carers and Information Sharing**
February 2004 *addressing information sharing issues identified by the Parliamentary Select Committee and the impact on mental health services of developments in privacy law.*
- Paper 2:** **Operation of the Mental Health Act**
July 2004 *looking at the general terms of the Act, including current admission processes, to consider mechanisms to improve access and care as well as looking at the forensic system, including the structure for review and release of forensic patients.*

1.2. Issues Paper 2

The current Paper is designed to look at the general terms of the Mental Health Act 1990, focussing on operational and treatment issues. The Paper has separate sections on each Chapter of the Act, and seeks general comments on all aspects of the legislation as well as identifying specific areas where suggestions for reform have arisen in the past, or as part of preliminary consultation on this Paper.

In addition to considering recent reviews and submissions made in response to both issues papers, the Review will also have regard to the Model Mental Health Legislation prepared for Australian Health Ministers' Council in December 1994⁵. The Model Mental Health Legislation, which is based on *The United Nations Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care* provides a useful touchstone in relation to international and national standards in this area⁶.

Comments sought by 31 October 2004.

Comments on the issues raised here are sought by 31 October 2004. It is proposed that once comments have been received and considered on both Issues Papers in the Review, a draft Bill will be developed. Further consultations will then occur on this draft prior to introduction into Parliament.

Comments should be directed to

Legal Branch
Department of Health
LMB 961 NORTH SYDNEY 2059
e-mail: legal@doh.health.nsw.gov.au.

Part 2: Objects of the Mental Health Act 1990

The objects clauses in Chapter 2 of the Mental Health Act are an important part of the Act. They set out the general spirit and intent of the legislation and provide guidance to assist in the interpretation of the powers, rights and obligations contained there. They also provide direction on the role and functions of the Department of Health and the Director General under the Act. It is therefore important to ensure that these provisions remain relevant and properly reflect current approaches and issues in mental health.

2.1 Care treatment and control of mentally ill and mentally disordered persons

Section 4 of the Act sets out the objects applicable to the care treatment and control of mentally ill and mentally disordered persons, as follows-

- (1) *The objects of this Act in relation to the care, treatment and control of persons who are mentally ill or mentally disordered are:*
 - (a) *to provide for the care, treatment and control of those persons, and*
 - (b) *to facilitate the care, treatment and control of those persons through community care facilities and hospital facilities, and*
 - (c) *to facilitate the provision of hospital care for those persons on an informal and 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.*
- (2) *It is the intention of Parliament that the provisions of this Act are to be interpreted and that every function, discretion and jurisdiction conferred or imposed by this Act is, as far as practicable, to be performed or exercised so that:*
 - (a) *persons who are mentally ill or who are mentally disordered receive the best possible care and treatment in the least restrictive environment enabling the care and treatment to be effectively given, and*
 - (b) *in providing for the care and treatment of persons who are mentally ill or who are mentally disordered, any restriction on the liberty of patients and other persons who are mentally ill or mentally disordered and any interference with their rights, dignity and self-respect are kept to the minimum necessary in the circumstances.*

The objects are designed to set a balance between an individual's need to receive appropriate care and treatment for their illness and their rights to liberty and self-determination. The question arises as to whether the balance set on these issues in 1990 remains appropriate, or whether experience since the Act commenced operation suggests a revision should occur. Comments are therefore sought on the contents of section 4 including, whether the objects remain relevant, should be revised or added to.

The use of the concepts of "least restrictive environment" and "least restrictive alternative", used both in the objects and elsewhere in the legislation⁷ have often been the subject of discussion, with arguments that the legislative emphasis on "least restrictive" options has led to the Act being interpreted in a way that results in people who require ongoing care being discharged too early.

The concept of "least restrictive environment" is well established in mental health law, being recognised in both the United Nation's Principles For The Protection Of Persons With Mental Illness⁸ and the Model Mental Health Legislation developed for Australian governments. The principle is not intended to operate as an overriding obligation, and is required to be balanced against other considerations. Thus the NSW Act qualifies the

provision, requiring it to be the least restrictive environment in which the “best possible care and treatment ... can be effectively given”. This restriction was recognised when the section was considered by the Mental Health Sentinel Events Review Committee⁹, which concluded that the need for patients at a higher risk of self harm to be held in a more secure environment was “consistent with the letter and intent of the Mental Health Act”. The problems identified above may therefore arise more from the administration of the Act, than the actual words of the Act itself. This will need to be considered in deciding if amendment to the Act is the best way to address such problems.

COMMENTS SOUGHT

1. **SHOULD THE OBJECTS LISTED IN SECTION 4 BE REVISED?
IF SO, HOW?**
2. **DOES THE “LEAST RESTRICTIVE ALTERNATIVE” OBJECT CAUSE PROBLEMS IN MANAGING THE CARE OF PERSONS WITH A MENTAL ILLNESS? IF SO, HOW?
ARE THE PROBLEMS A RESULT OF THE LEGISLATION, OR PROBLEMS WITH HOW IT IS APPLIED?**
3. **SHOULD THE PRINCIPLE BE REVISED OR AMENDED?
IF SO, HOW?**

2.2 Administrative Objects, Objectives of the Department and Functions of the Director-General

Sections 5 to 7 of the Act also contain further administrative objects and objectives which direct the Department to support the provision of comprehensive and accessible services, permit early intervention and support the patient in the community, and other functions of the Director General which range from ensuring the provision of appropriate care to education and the promotion of research¹⁰.

In this regard, the Department has already received a range of suggestions for “additional objects” to be inserted into the Act. These cover a wide range of areas, including:

- An object dealing with the policy and design of specialist services, similar to that included in the Commonwealth Disability Services Act 1986 and Disability Services Act 1993;
- A statement of general principles and standards similar to those included in the Disability Services Act and the Guardianship Act;
- Recognition of the right of a consumer to participate in all aspects of their own care or treatment as far as is practicable;
- Recognition of the specific needs of children and young people and parents with mental illness;
- Definition of agency and interagency responsibilities for acute, rehabilitation and community based services for people with mental illness and psychiatric disability, including people with dual diagnosis (both other impairment and substance abuse), and people with brain injury, in particular, organic brain injury.

Comments are sought on the above suggestions, as well as any other suggestions for matters which should be included in this part of the Act. In calling for these suggestions, it should be recognised that the key focus of the objects clause is to set the general parameters of the Act, and give assistance in how the more detailed provisions of the Act

should be interpreted. As such, a clear distinction needs to be drawn between matters which could be included as objects, and matters which may better sit in the body of the Act as operational provisions.

COMMENTS SOUGHT

- 4. SHOULD ADDITIONAL OBJECTS, OBJECTIVES AND FUNCTIONS BE INCLUDED IN THIS PART OF THE ACT?
IF SO, WHY? WHAT SHOULD THEY ADDRESS?**

Part 3: Mentally Ill and Mentally Disordered Persons

The definitions of “mental illness”, “mentally ill person” and “mentally disordered person” used in the Act determine whether a person can be involuntarily admitted and treated for a mental illness or condition. They are therefore three of the critical concepts used in the NSW Mental Health Act.

3.1 Definition of mental illness

The definition of “mental illness” used in the Mental Health Act 1990 is as follows:

mental illness means a condition which 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).

Prior to 1990 mental health legislation had sought to define the broad condition of mental illness. This approach had led to extensive litigation, ongoing redefinition and confusion at an operational level as to what could and could not be considered a “mental illness” and when patients could be treated involuntarily¹¹. The 1990 Act successfully resolved these confusions and uncertainty by establishing, for the first time in Australia, a definition determined by reference to observable symptoms, rather than an all encompassing definition of the concept of mental illness itself. The current definition is also in line with the UN Principles and generally reflects the model definitions provided in the Model Mental Health Legislation.

This definition has operated well since 1990 and has provided much needed clarity. Nevertheless comments are sought as to whether the definition could be improved. Specific comments are also requested on two specific conditions raised from time to time in discussion of the definition.

3.1.1 Anorexia Nervosa

One concern which has arisen is that persons with anorexia nervosa may not be able to be treated under the Act, as anorexia nervosa is not specifically covered by the definition of “mental illness”. These concerns do not however appear to have been borne out at an operational level, where it is understood that individuals with anorexia are scheduled and held for care and treatment under the Act. The Mental Health Review Tribunal considered the issue and concluded that a person with anorexia can fall within the definition on the basis that they may suffer “a severe disturbance of mood”, which (when accompanied by evidence of risk of serious harm¹²) would allow them to be detained and treated. Nevertheless, it is understood there remains some ongoing uncertainty on this issue, so the issue is raised for comment.

3.1.2 Personality Disorders

The question of whether personality disorders should be covered by the definition was raised for discussion in 1996 when the Department of Health issued a paper entitled

“Caring for Health : Proposals for Reform - Mental Health Act 1990”. That Paper argued it was not appropriate to extend the definition in this way, as a personality disorder is not a condition for which treatment is both available and effective¹³. The Paper argued that including personality disorder in the Act’s definitions:

“would effectively allow the Mental Health Act to cover persons who merely because of their life long, habitual ways of thinking, acting and feeling, are brought to notice, usually in the context of antisocial activity or other activity which distresses the community. Such a radical expansion is simply not appropriate, as it would run counter to the very purpose and objects of the Act to deal exclusively with the care and treatment of the mentally and psychiatrically ill.”¹⁴

The conclusions reached in this paper remain valid. From a practical perspective, the inclusion of “personality disorder” would also present difficulties in developing appropriate criteria to include in the definition, given it describes mental illness via symptoms.

3.1.3 Discussion

Over the years since the Act commenced operation, there have also been suggestions that the definitions of mental illness in the Act should be extended to include other conditions, such as dementia and drug induced psychosis. What appears to be common to each of these suggestions (as with those discussed above) is the wish to cover groups of clients who may often fall between services, or who may be difficult to manage in general hospital and community settings. The statutory regime of mandatory treatment and control offered by the Mental Health Act may be seen as an attractive option for ensuring care and treatment of these groups.

While recognising some of these concerns, it should be emphasised that the Mental Health Act is not primarily a mechanism for controlling and detaining all categories of individuals with challenging conditions, but provides a treatment regime for the mentally ill, allowing them to recover and return to the community.

As such, the definitions were designed to be confined to what are readily accepted as “mental illnesses”. Some other conditions while not “mental illnesses” may benefit from a consideration of management or rehabilitation regimes involving some element of compulsion, but this does not automatically render them appropriate for inclusion in the therapeutic regime of the Mental Health Act¹⁵.

COMMENTS SOUGHT

5. DOES THE DEFINITION OF “MENTAL ILLNESS” USED IN THE ACT REMAIN APPROPRIATE? SHOULD IT BE REVISED? IF SO HOW?
6. SHOULD CHANGES BE MADE TO INCLUDE “PERSONALITY DISORDERS” IN THE DEFINITION? IF SO, WHY? IF SO, HOW SHOULD THEY BE INCLUDED?
7. SHOULD CHANGES BE MADE TO INCLUDE “ANOREXIA NERVOSA” IN THE DEFINITION? IF SO, WHY? IF SO, HOW SHOULD THEY BE INCLUDED?

3.2 Definition of mentally ill person

The term “mentally ill person” is defined in section 9 of the Act, as follows:

- (1) *A person is a mentally ill person if the person is suffering from mental illness and, owing to that illness, there are reasonable grounds for believing that care, treatment or control of the person is necessary:*
 - (a) *for the person’s own protection from serious harm, or*
 - (b) *for the protection of others from serious harm.*
- (2) *In considering whether a person is a mentally ill person, the continuing condition of the person, including any likely deterioration in the person’s condition and the likely effects of any such deterioration, are to be taken into account¹⁶.*

There are two key elements to this definition, first, that care, treatment or control is needed to protect the person or others from “serious harm” and secondly, that a person’s “continuing condition”, and the possibility that this condition may deteriorate over time can be taken into account. The NSW approach is consistent with the UN Principles and the National Model Mental Health Legislation although the language used in NSW takes the definition somewhat wider than those used in the two models.

While definitions of “mentally ill person” and its reference to “continuing condition” have been generally supported, criticisms have been made that the term is not sufficiently clear. For example, some concerns have been raised that people are being discharged from mental hospitals prematurely, and that the definition of “mentally ill person” should be amended to prevent this occurring, notwithstanding, as noted above, the NSW definition is already quite broad in this respect.

At the same time, separate concerns have been raised that the definition may allow people to be detained longer than appropriate, as there is insufficient clarity as to the point at which a patient can assert that, due to the absence of symptoms, they are no longer a mentally ill person and accordingly are entitled to be discharged. Given these disparate views, it may be that the concerns raised again go more to practice and the mechanisms available to a patient to assert they are no longer a mentally ill person, than to the use of the language in the definition.

COMMENTS SOUGHT

- 8. DOES THE DEFINITION OF MENTALLY ILL PERSON REMAIN APPROPRIATE?
IF NOT, WHY? HOW SHOULD IT BE CHANGED?**

3.3 Mentally disordered persons

The Act also allows persons to be detained in a psychiatric hospital for a short period of time if they are a “mentally disordered person”. Mentally disordered is defined in section 10 of the Act as:

- A person (whether or not the person is suffering from mental illness) is a mentally disordered person if the person’s behaviour for the time being is so irrational as to justify a conclusion on reasonable grounds that temporary care, treatment or control of the person is necessary:*
- (a) *for the person’s own protection from serious physical harm, or*
 - (b) *for the protection of others from serious physical harm.*

These provisions, which reflect a similar term used in the Model Mental Health Legislation¹⁷, are generally used to detain highly distressed and often suicidal individuals at high risk to themselves or others.

One concern that is raised by some clinicians is that increasingly broad interpretations are being given to this term to use the Mental Health Act as a tool to control difficult or dangerous individuals who, for various reasons, cannot be dealt with by other agencies. One example often given is persons who are at chronic risk due to a personality disorder. Against this concern, operational experience is that the provision provides a useful tool to address individuals in high risk states, who may otherwise do serious harm to themselves or others.

COMMENTS SOUGHT

9. DOES THE PROVISION FOR SHORT TERM DETENTION OF “MENTALLY DISORDERED PERSONS” REMAIN APPROPRIATE?
10. IS THE DEFINITION OF MENTALLY DISORDERED PERSON APPROPRIATE? IF NOT, WHY? SHOULD IT BE REVISED? IF SO, HOW?

3.4 Words and conduct that do not indicate mental illness or disorder

Section 11 of the Act sets out a list of behaviours and conduct which will not indicate a person is a mentally ill or mentally disordered person. This list includes such conduct as expressing a particular political opinion or belief, a religious opinion, a particular philosophy or sexual preference, or that a person has taken alcohol or any other drug. The provision makes it clear that this conduct *of itself* cannot be used to treat a person as a mentally ill or mentally disordered person. The original rationale was based partly on a concern that otherwise some of these actions could in fact be used to inappropriately infringe a person’s liberty and treat him or her as a mentally disordered person, the concern being the Act could otherwise be used as a means of “controlling” persons who may have views or exhibit behaviours which are socially unacceptable. It was also developed in response to the ongoing litigation around the definition of mental illness prior to 1990. As that litigation raised doubts as to the legal parameters of the definition, section 11 was designed as a clear statutory statement of what should not, on its own, be considered mental illness.

Suggestions have been made that section 11 should be deleted as some of the concerns, including the prospect of ongoing litigation, are no longer relevant. It has been argued that 14 years experience with the Act shows that the “mentally ill person” definition has of itself proved sufficiently robust. At the same time however, it might also be considered that the content of section 11 in the Act over this time frame may well have had an effect on how the definition is viewed and interpreted, suggesting that it should in fact be retained. Comments are therefore sought on this issue.

COMMENTS SOUGHT

11. DOES SECTION 11 REMAIN RELEVANT? SHOULD IT BE CHANGED OR REVISED? IF SO, WHY? IF SO, HOW?

Part 4: Admission To and Care in Hospitals

Chapter 4 of the Mental Health Act deals with the processes for admission and review of persons who are treated in psychiatric hospitals. While the Chapter deals with both voluntary and involuntary admissions, it is important as it sets the parameters for how a person can be taken to a hospital and treated against their will, as well as the protections available to ensure the powers of detention are not used inappropriately.

Voluntary admission to gazetted hospitals

Part 1 of Chapter 4 allows a person to admit themselves to a gazetted hospital, or be admitted on application of their guardian¹⁸. Such voluntary admissions can only continue if the medical superintendent deems the person is “likely to benefit from care or treatment as an informal (ie voluntary) patient”¹⁹. A voluntary admission to a psychiatric unit is thus more like an admission to a general hospital for medical treatment, and does not rely on the “mental illness” criteria in the Act, as that definition, along with the definition of “mentally ill person” is directed at ensuring forced admissions only occur when a person’s illness places them at risk to themselves or others.

Some concerns have arisen however that the provisions allowing a person to be admitted by their guardian suggest a de facto involuntary status, meaning they cannot be discharged (irrespective of their own wishes) without the approval of the guardian. While this is not the case, concerns have arisen that this does occur, and runs counter to the purpose of the voluntary admission scheme established under Part 1 of the Act.

While acknowledging this issue, it may also be said that the position of a person subject to guardianship can be quite different from that of other voluntary patients. A person under guardianship has been recognised as lacking capacity to make important life decisions, and may also lack the capacity to properly care for themselves in the community without some assistance. In these circumstances, it has been argued it is reasonable to provide a process where the person will remain in hospital until their guardian can be contacted, and proper arrangements made for their discharge into the community.

COMMENTS SOUGHT

- 12** SHOULD DIFFERENT DISCHARGE ARRANGEMENTS APPLY FOR VOLUNTARY PATIENTS UNDER GUARDIANSHIP?
IF SO, WHY? WHAT SHOULD THESE ARRANGEMENTS BE?

Involuntary admissions to gazetted hospitals

4.1 Taking a person to a hospital

Part 2 of this Chapter of the Act deals with the process whereby a person can be involuntarily admitted to a psychiatric hospital. There are six ways this can be initiated:

- a person can be taken to and detained in a hospital on the basis of a certificate written by a medical practitioner or accredited person (under section 21, this certificate is generally known as known as “a schedule”²⁰)

- a court can authorise entry onto premises to allow a schedule to be filled out (section 27);
- a person can be taken to and detained in hospital by a police officer, if the officer is concerned the person appears to the officer to be mentally disturbed (section 24);
- a person can be taken to and detained in a hospital by order of a court who may be hearing criminal charges involving the person (section 25);
- a person can be detained at request of a relative or friend (but only if the urgency of the circumstances and the lack of availability of a medical practitioner are sufficient to justify such “direct” admission, section 23);
- a person can be detained in a hospital on the information of a welfare officer, although this provision does not empower the welfare officer to take the person to the hospital against their will (section 26).

The most common form of involuntary detention is by way of a Schedule filled out in accordance with section 21²¹. Other provisions regularly used include admissions by the Police (section 24), or through the criminal justice system (section 25).

Comments are sought as to the ongoing application and effectiveness of these admission provisions. Comments are also sought on a number of specific issues which have arisen in this area.

4.1.1 Detention on certificate of medical practitioner or accredited person

The main features of a Schedule are that:

- it must be filled out by a medical practitioner or “accredited person”²²
- the person who fills it out must have personally examined the person and be satisfied they meet the criteria of a “mentally ill person” or a “mentally disordered person”²³;
- police assistance can be obtained for transporting the person if “there are no other means of taking the person to hospital reasonably available”;
- A person cannot be detained as a mentally ill person on the basis of a schedule which is more than 5 days old²⁴.

(a) Requesting the assistance of Police

Ever since the Act was commenced in 1990, there has been ongoing debate about when Police should be requested to assist in transporting a person under a schedule. The intention of the Act was to enable such assistance to be sought when a person’s illness or state of mind is such that without Police assistance both the patient and those transporting them may be placed at risk of harm. While NSW Health and NSW Police have worked together to introduce procedures to ensure Police are not called unnecessarily, concerns have arisen that police are used routinely to provide general transport of persons who have been scheduled to a hospital, even when there is little or no risk of harm. This led the Parliamentary Select Committee to recommend:

That the Minister for Health seek to amend section 22 of the Mental Health Act 1990 to incorporate criteria with which medical practitioners must comply before they can request police escort of mental health patients under Section 22(1)(a)²⁵.

In response to this recommendation, the Government has recently amended the criteria applied under section 22, so that now Police assistance may only be requested where the medical practitioner or accredited person is of the opinion that:

“there are serious concerns relating to the safety of the person or other persons if the person is taken to a hospital without the assistance of a member of the Police Force”

NSW Police have however raised a further concern with section 22. Section 22(2) currently *requires* a police officer to provide assistance when indicated in the Schedule. The concern is that this effectively allows a medical practitioner to dictate the use of police resources, rather than allowing the Police to weigh up the competing law enforcement priorities which they may be facing at any particular time. Suggestions have been made that the sections should simply authorise police to take part in the transport, rather than require them to. This is the model adopted in both the South Australian and Victorian mental health legislation²⁶.

(b) Risk assessments of persons scheduled under the Act

Given ongoing concerns relating to security issues, violence and occupational health and safety, suggestions have been made that the Schedule should also require a medical practitioner or accredited person to provide a formal “risk assessment” of the person. This could provide the Police, Ambulance Service and the admitting hospital with guidance on precautions which may be necessary when transporting or examining the person. There are concerns however as to whether medical practitioners would be qualified to provide such an assessment, particularly where limited information is available. Complications also arise as to the reliability of such assessments in such circumstances, and the implications in relying on them. It might also be argued that the changes to section 22 of the Act, outlined above, may well address this concern. One option may be to require a practitioner filling out a Schedule to consider the issue of how the person may be safely transported, including the question of whether restraint or sedation may be required.

(c) Restraint, Sedation and Transport

Currently the NSW Mental Health Act is silent on a range of issues which may arise as part of the transport of a patient, with the Act considered to imply the power to undertake necessary action through the general provisions on detention. Legislation in some other states does address a number of these issues explicitly, so they are raised to seek comment on whether they should also be addressed in the NSW Act. The areas raised are:

Use of restraint and sedation in transport: Establishing such provisions provides both a clear authority for the use of transport, restraint and sedation, and would also allow some constraints to be placed upon when and how restraint and sedation could be applied. For example, forced medication could be authorised to ensure safe transport of the person. It would also allow clear definition of who is entitled to use restraint (for example health system employees) or provide medication (for example ambulance paramedics).

Who can transport a patient: The NSW Act does not explicitly indicate who is entitled to undertake transport of a patient, either to a hospital as part of an admission, or as part of an interhospital transfer. The Act could be clarified to recognise that health staff or ambulance officers can assist in such transportation, where appropriate.

Searching a patient: Concerns can arise that a patient being admitted from the community may have drugs, weapons or other materials which they may use to injure themselves or those involved in transporting them. Ambulance Officers and Police have indicated that clarification of their ability to search patients and remove such objects will assist in ensuring transport occurs as safely as possible, for all involved.

(d) Role of Ambulance Officers

The NSW Ambulance Service is one of the key agencies involved in transporting mentally ill persons both to and between hospitals. The Service and the role it plays is not however recognised under the Act. Ambulance officers have raised concerns as to the extent of their powers to participate in transportation under the Act, and in using restraint as part of the transport. This covers not only admission, but where a person has absconded or is simply being transported between facilities. Ambulance officers are also generally recognised as part of the treatment team under mental health laws in other states, and their recognition in NSW law may assist in addressing a range of other issues, such as the question of appropriate restraint and sedation, outlined at point (c) above.

A further suggestion made by both the Ambulance Service and NSW Police is that Ambulance Officers should also be authorised to take a person to a hospital, if they have reasonable grounds to believe the person is mentally disturbed and may be about to cause serious bodily harm to themselves or others. This suggestion recognises that Ambulance Officers may often be called into situations where a person on the scene is suffering from a mental illness requiring urgent care. At present, no further action can arguably be taken until and unless police are present, or a medical practitioner is available to write a schedule.

(e) Other suggestions for reform

A number of other suggestions for changes to the use of a Schedule have been raised with the Department, largely arising from concerns about difficulties in accessing mental health services in rural and remote areas. It is recognised that some of these proposals would have substantial implications for the way care is provided, and the rights of individual patients. They are therefore raised here for comment and discussion.

- should a phone (rather than a personal) examination by a medical practitioner or accredited person be allowed in emergency situations?
- should medication be able to be authorised by phone, on the evidence of a nurse or a police officer?
- should a general practitioner be required to seek advice from a mental health service before completing a schedule? (This would require a 24 hour advisory service to be available in every area)

COMMENTS SOUGHT

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| 13 | DO THE PROVISIONS RELATING TO POLICE ASSISTANCE REQUIRE CHANGE? SHOULD THE PROVISIONS BE AMENDED TO AUTHORISE, BUT NOT REQUIRE POLICE ASSISTANCE TO BE PROVIDED? IF SO, WHY? IF NOT, WHY NOT? |
| 14 | SHOULD THERE BE A REQUIREMENT FOR A RISK ASSESSMENT WHEN FILLING OUT A SCHEDULE? IF SO, WHY? |

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| 15 | SHOULD THE ACT BE AMENDED TO PROVIDE SPECIFIC POWERS FOR RESTRAINT AND SEDATION WHILE A PERSON IS BEING TRANSPORTED TO HOSPITAL? IF SO, WHY? |
| 16 | SHOULD THE ACT BE AMENDED TO RECOGNISE THE ROLE OF THE NSW AMBULANCE SERVICE AND AMBULANCE OFFICERS? IF SO, WHY? |
| 17 | SHOULD ANY OTHER CHANGES BE MADE TO THE PROVISIONS RELATING TO SCHEDULES UNDER SECTIONS 21 AND 22 OF THE ACT? IF SO, WHY? |

4.1.2 Detention on request of relative or friend or a welfare officer

As noted above, sections 23 and 26 allow respectively for the detention of a person at the request of a relative or friend, or a welfare officer. The terms of section 23 are extremely restrictive, and neither section 23 or 26 authorise involuntary transport of the person to the hospital, prior to detention. It is understood these provisions are rarely used. It may also be argued that now the option exists to allow persons other than medical practitioners to write a schedule under the accredited person provisions, the immediate need in rural areas recognised by section 23 has diminished. Comments are therefore sought as to whether these provisions need to be retained.

COMMENTS SOUGHT

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| 18 | SHOULD SECTIONS 23 AND 26 BE RETAINED IN THE ACT? IF SO, WHY? |
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4.2 Detention on arrival at a hospital

The original scheme of mental health legislation in NSW, going back to the 19th century, was to provide for admission and care of mentally ill persons in large asylums where general medical care and treatment was available in addition to treatment for mental illness. Over the years however, service models have changed. Now most psychiatric units are placed within larger general hospitals and rely on those general facilities to provide any medical assessment or treatment required for patients admitted under the Mental Health Act.

The terms of the 1990 Mental Health Act however still reflect the old “asylum” system, and only provide for admission and treatment in hospitals that are psychiatric hospitals or “gazetted units” under the Mental Health Act²⁷. There is only limited recognition of a patient’s needs for more general medical treatment. Thus, while the current Act’s leave provisions provide a basis to transfer admitted patients in hospital for urgent medical care²⁸, the legislation is less clear in providing for comprehensive medical assessment and treatment of a person at the point they are initially detained or admitted.

Ideally, such persons should be admitted via a general emergency department, to allow a comprehensive examination of their overall health, including medical, psychiatric and behavioural issues. This would also ensure life-threatening conditions (such as head trauma, poisoning, delirium, or endocrine or metabolic disorders) are identified as *medical* rather than *psychiatric* conditions, and ensure sufficient time for appropriate treatment. In recognition of this, emergency departments are increasingly incorporating purpose built rooms for assessing, treating and observing mental health patients. NSW Health is also developing guidelines for mental health areas within emergency

departments to promote consensus on the best design, location, staffing or number of these rooms.

While the needs of a mentally ill person may be best met by admission via an appropriate emergency department, the structure of the Act is focussed on admission to a gazetted unit, where appropriate medical (as opposed to psychiatric) assessment may not be readily available. Question therefore arises as to whether a statutory solution is required to this issue. For example, should emergency departments also become “gazetted units” under the Act, or should a more comprehensive scheme be introduced to provide for initial detention and assessment in specially designated “psychiatric emergency centres” (ie identified emergency departments with appropriate resources and facilities) whereby persons admitted under a Schedule (or any other of the involuntary provisions) can be properly triaged before formal admission to a specialist gazetted unit for care and treatment of their mental illness.

Some issues which might arise from such a proposal include:

- Should criteria be established for what type of premises can be a “psychiatric emergency centre”?
- Should there be a time limit on the length of time a person can be kept for initial assessment?
- At what stage would the examinations required under sections 29 and 32 of the Act be undertaken?
- If a person is admitted for ongoing care via a “psychiatric emergency centre”, how would the process for the magistrates review required under the Mental Health Act operate?
- Should Official Visitors be able to inspect such centres?

COMMENTS SOUGHT

19 SHOULD EMERGENCY DEPARTMENTS BE MADE GAZETTED UNITS?
IF SO, WHY?

20 SHOULD THE ACT BE AMENDED TO ALLOW ADMISSION VIA A PSYCHIATRIC EMERGENCY CENTRE?
IF SO, WHY? IF SO, WHAT SORT OF ISSUES SHOULD BE ADDRESSED?

4.3 Examination on Detention at Hospital

4.3.1 Who should conduct the initial examination?

Once “detained” under the Act, the legislation requires a person must be examined by a medical officer within 12 hours²⁹. If this examination finds the person is not mentally ill or disordered, the person must be discharged. If they are found to be mentally ill or disordered, the person must then be examined by another medical practitioner (or where the first examination was not performed by a psychiatrist, by a psychiatrist) as soon as is practicable³⁰. If this second examination contradicts the first and concludes the person is not a mentally ill or disordered person, a third examination by a psychiatrist must be undertaken.³¹

The Department has received diverse comments and views on who should conduct these examinations. At one end of the spectrum, there have been strong criticisms in a number of recent coronial and other cases over the practice of allowing often junior registrars to conduct examinations. The criticism is that the lack of experience of and

lack of support for such practitioners has led to poor judgement as to the risk posed by a person presenting to hospital. In a number of these cases, discharge of the patient followed shortly thereafter by the patient's death or the death of a close family member. The outcome of these cases suggests that the critical examinations, such as the first examination on entry to hospital, should be conducted by a senior, experienced, psychiatrist. Similar concerns have also been raised by forensic psychiatrists who deal with people admitted via the Local Court³².

This raises other difficulties however, specifically the limited number of psychiatrists working in the public health system, particularly in rural areas. While the above issues suggest bringing a higher level of medical specialist expertise to the examination process, other suggestions have also been made to the Department that some non-medical professional groups with specialist mental health knowledge may also have the appropriate skills to conduct such examinations³³.

The answer to both concerns may well be to reconsider this issue through assessing the skills necessary to make a proper evaluation of a person's mental state, rather than starting from a perspective of professional boundaries. While it may well be that the skills required to provide adequate assessments will ultimately fall along similar lines to those professional boundaries, as has been shown by the experience with "accredited persons", focussing on the skill set necessary to undertake a particular activity – in the case of accredited persons, the writing of a schedule 2 admission document - has produced positive results. Consideration of this option is particularly important when recognising that there will be an ongoing shortage of psychiatrists, psychiatry registrars and doctors who are skilled and knowledgeable in psychiatry in the coming years, particularly in rural areas. If other professionals or professional groups with appropriate skills can be utilised to improve assessment decisions, the opportunity should be considered.

The 12 hour time frame for the initial examination on admission imposed by section 29 of the Act also imposes additional difficulties in this regard as it necessitates access to a skilled professional in a relatively short time frame. The most obvious response to this would be to extend this period. At the same, lengthening the time frame further makes inroads into the liberties of the patient. Given however, the serious issues raised in respect of the availability of practitioners to provide assessments, the issue of the length of the time frame is raised for comment.

4.3.2 ensuring examination recognises cultural and lingual diversity

It has been suggested to the Department that in cases where a person is from a non English cultural or linguistic background a bicultural mental health consultant should be used, as such a person can provide information about cultural, political or religious aspects of the diagnosis, and make an assessment from a cultural point of view and clarify cultural issues. The Transcultural Mental Health Centre offers a free of charge specialist cultural and clinical consultation assessment service through a pool of qualified bilingual/bicultural sessional staff speaking approximately 55 languages.

Using such "bicultural" consultants would no doubt improve care for people of different cultural backgrounds, however issues of their broad availability across NSW would need to be considered in any decision to amend the Act to recognise or require use of such consultants.

COMMENTS SOUGHT

- 21** WHO SHOULD CONDUCT THE INITIAL EXAMINATION AT HOSPITAL?
- 22** SHOULD THE ACT REQUIRE MORE INVOLVEMENT OF PSYCHIATRISTS AS OPPOSED TO PSYCHIATRIC REGISTRARS?
IF SO, WHY? IF NOT, WHY NOT?
- 23** SHOULD THE ACT ALLOW SPECIALIST ACCREDITED PERSONS TO CONDUCT ASSESSMENTS?
IF SO, WHY? IF NOT, WHY NOT? WHAT SORT OF QUALIFICATIONS SHOULD THEY HAVE?
- 24** SHOULD THE PERIOD WITHIN WHICH THE INITIAL EXAMINATION MUST BE CONDUCTED BE LONGER THAN 12 HOURS?
IF SO, WHY? IF NOT, WHY NOT?
- 25** SHOULD THE ACT REQUIRE THE USE OF A BICULTURAL MENTAL HEALTH CONSULTANT WHEN PERSON IS FROM A CULTURALLY AND LINGUISTICALLY DIVERSE BACKGROUND?

4.4 Medical Treatment

Under section 31(2) the medical superintendent of a hospital has very broad powers to provide medical treatment to involuntary patients without their consent. Section 31(2) reads:

The medical superintendent of a hospital may, subject to this Act, give, or authorise the giving of, such treatment (including any medication) as the medical superintendent thinks fit to a person detained in the hospital in accordance with this Act.

The provision is wide enough to cover any treatment necessary for ongoing medical care or treatment, as well as treatment for mental illness³⁴.

Some issues have arisen around this provision and the breadth of its coverage. First the powers are not expressly restricted to treatment for a medical or clinical condition affecting a person's health, nor do they expressly limit the care to what may be therapeutically necessary or appropriate. It may be argued that such limitations are imposed by the use of the word "treatment". Questions however have been raised, particularly as to whether the section would allow a medical superintendent to authorise contraception or other care not directly necessary to the patient's ongoing health and whether these powers should be expressly constrained, or limited to what is necessary for therapeutic care.

The Department has also been informed that recent studies show that people of different ethnic backgrounds react differently to different levels of medication. While part of a normal medical assessment would address such matters, a suggestion has been made that the Act specifically require such an "ethnopsychopharmacological" assessment.

COMMENTS SOUGHT

- 26** SHOULD THE POWERS TO AUTHORISE TREATMENT BE REVISED?
IF SO, WHY? IF SO, HOW?
- 27** SHOULD A GUARDIAN RETAIN ABILITY TO CONSENT TO MEDICATION FOR THE PERSON, WHILE THE PERSON IS INVOLUNTARILY DETAINED IN A HOSPITAL?

4.5 Time Limitation on Detention of Mentally Disordered Persons

A person who can be held as a "mentally disordered person" under the Act, can only be detained in the hospital for a continuous period of up to 3 days (not including weekends and public holidays), and may only be detained 3 times in any one month. This effectively permits any mentally disordered persons to be held for a continuous period comprising nine consecutive days and any intervening weekends and public holidays. These provisions were introduced because people experiencing temporarily irrational behaviour, who may otherwise have been excluded from the definition of mental illness, may still be in need of care and protection. This might include people who suffer a traumatic crisis in a close personal relationship and who, overwhelmed by emotional turmoil, are unable to control their actions and emotions, becoming suicidal or otherwise seriously out of control for a brief period.

A suggestion has been made that the current "3 x 3" time restrictions do not provide sufficient time to properly treat such individuals, and that the time limits should be extended or indeed removed. This suggestion would clearly substantially expand the categories of people who can be held for lengthy periods in psychiatric units, and would effectively supersede the current definitions of "mentally ill person". Given this, very strong evidence would be required to justify and pursue such a suggestion.

Questions have also arisen as to why section 35(1) specifically excludes weekends and public holidays from the "3 x 3" day calculation. The argument has been made that this can regularly automatically extend the detention by a further 2 days, and in some cases (such as over Easter and Christmas periods) by as many as 4 days. If, as has been suggested, such additional periods of detention are considered clinically appropriate, they should be recognised under the Act, and not arise randomly, as a result of the day on which the person was admitted.

COMMENTS SOUGHT

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| 28 | SHOULD THE TIME LIMITATIONS FOR THE DETENTION OF MENTALLY DISORDERED PERSONS BE ALTERED OR REMOVED?
IF SO, WHY? |
| 29 | SHOULD THE EXEMPTION FOR WEEKENDS AND PUBLIC HOLIDAYS BE REMOVED? IF SO, WHY? |

4.6 Review of Patients under the Act

The need for judicial review of ongoing detention has been recognised under NSW law since the 1958 Mental Health Act, and is also in line with key provisions of the *United Nation's Principles For The Protection Of Persons With Mental Illness*. Judicial review of detention is one of the key aspects of the Mental Health Act, and determines when and how decisions on individual liberty are made. They are therefore among the most important provisions of the Act.

Currently, the review function is split between two different bodies. When a person is initially admitted to a hospital (most commonly under a Schedule 2) their condition must be assessed by at least two medical practitioners. If these examinations determine the person is a "mentally ill person", they must be brought before a Magistrate 'as soon as practicable'³⁵. Their case is then reviewed by a Magistrate sitting alone, who must determine if, on the balance of probabilities, the person is a mentally ill person³⁶.

In reaching this decision, the Magistrate is entitled to take into account information presented to him or her, and any cultural factors which may be relevant to the issue³⁷. At the end of the inquiry, the Magistrate can:

- discharge the person (either immediately or by deferred discharge);
- order the person to be released subject to a community treatment order;
- order the person to be held as a temporary patient for up to 3 months;
- order an adjournment.

Where a person is made a temporary patient further detention is subject to review by the Mental Health Review Tribunal, a body with specialist legal and mental health expertise. The Tribunal, which generally sits with a three person panel (made up of a lawyer, a psychiatrist and a community member), will usually review a patient immediately before the end of their “temporary patient” period. In such a review, the Tribunal has the power to:

- discharge the person (either immediately or by deferred discharge);
- order the person to be released subject to a community treatment order;
- order the person’s continued detention as a continued treatment patient for up to 6 months;
- order an adjournment.

Where a person is made a continued treatment patient, the Tribunal is required to review their case once every 6 months. The Tribunal also hears and determines any renewals of community treatment orders. The initial questions of detention and treatment are therefore reviewed through the Local Courts, whereas ongoing detention and enforced community care are reviewed by the Tribunal³⁸.

4.6.1 Comments sought on procedural matters

As a first question, this Paper seeks comments on the ongoing effectiveness of procedures relied on during the initial review of detention. Comments are sought in respect of all aspects of procedure, including

- the requirements for information to be given to patients;
- the provisions allowing information to be withheld from patients;
- the requirement to have hearings recorded;
- the right to legal representation;
- the use of telephone hearings and videoconferencing;
- processes for and lengths of adjournments;
- processes for an appeal.

4.6.2 Comments sought on current structure of the review process

The Paper is also seeking comments on the broader structure of the review process, with a view to assessing whether the current structure is the most effective way of providing for review of patients in the mental health system. The question is whether the current structure, which divides the review process between the Local Court and the Mental Health Review Tribunal, can or should be revised to make it more effective or more sensitive to the needs of patients and those who care for them. Comments are therefore sought on the current process, its effectiveness and how it could be improved.

In order to help generate comments on this issue, and the alternatives which may be available, the following options are offered for comment. Submissions are also welcome on any other models which are considered of merit:

1. Retain the current system: This would retain the role for Magistrates to review the initial detention, and the Mental Health Review Tribunal to conduct the longer term reviews, as well as continue its function to order community orders and review forensic patients. There is no doubt the current system has worked well over the last 13 years. In recent years, the Chief Magistrate has assigned specific magistrates to hear mental health matters, a move which has allowed a degree of specialist expertise to be developed by the court in the mental health area. The comprehensive network of local courts throughout NSW also means patients can be assured of a quick and timely review of their case.

2. Transfer of Magistrate's Role to the Mental Health Review Tribunal: This would allow the specialist mental health expertise of the Tribunal to be applied at the initial review stage, and would also release Magistrates currently involved in such matters for general court work. At the same time, this proposal would mean a substantial increase in the current workload of the Mental Health Review Tribunal, with consideration required as to mechanisms for ensuring ready statewide access to the Tribunal, at least equal to that currently available through the local courts. In this regard, consideration may need to be given to whether it would be appropriate for the Tribunal to hear initial reviews as a three person panel or by the legal member sitting alone, and if an appeal process to the "full" tribunal would be appropriate.

3. Removal of Requirement for Initial Review: NSW is somewhat unique in Australia in requiring review by a judicial officer "as soon as practicable" after admission. A number of other states do not have such strict requirements, allowing the first review to be conducted by the equivalent of the Mental Health Review Tribunal around 14 days after the initial admission. It should be noted however, that such a proposal would substantially dilute the protections the Act currently provides for review of involuntary detention, and could only be considered if there are strong public interest grounds to support it. It would also mark a substantial change in approach in NSW, and, if pursued, consideration would need to be given to other mechanisms which might then be employed to protect patients rights over this period.

The above options need to be considered in relation whether, and to what extent, they may improve current processes, as well as being a cost effective use of public resources. Consideration also needs to be given to the forensic review function and the executive discretion over release of forensic patients. Currently, the Tribunal reviews the cases of forensic patients, and makes recommendations to the Executive Government, which then determines if release should occur. Chapter 5 discusses this issue. If the executive discretion were to be removed, any model would need to factor in which body (ie court or tribunal) should make these determinations instead.

COMMENTS SOUGHT

PROVISIONS RELATING TO REVIEW

- 30** COMMENTS ARE SOUGHT ON THE CURRENT PROCEDURES AND PROVISIONS APPLYING IN RESPECT OF MAGISTRATES HEARINGS
ARE THEY ADEQUATE? IF NOT, WHY?
HOW COULD THEY BE MADE MORE EFFECTIVE?
- 31** COMMENTS ARE SOUGHT ON THE CURRENT PROCEDURES AND PROVISIONS APPLYING IN RESPECT OF MENTAL HEALTH REVIEW TRIBUNAL HEARINGS
ARE THEY ADEQUATE? IF NOT, WHY?
HOW COULD THEY BE MADE MORE EFFECTIVE?

STRUCTURE OF THE REVIEW PROCESS

- 32 SHOULD THE SEPARATION OF REVIEW PROCESSES BETWEEN MAGISTRATES AND THE MENTAL HEALTH REVIEW TRIBUNAL BE RETAINED?
IF SO, WHY? WHAT ARE THE ADVANTAGES OF THE CURRENT SYSTEM?
IF NOT, WHY NOT? WHAT ARE THE DISADVANTAGES OF THE CURRENT SYSTEM?**
- 33 WHAT ALTERNATIVE STRUCTURES ARE SUGGESTED?
IN PARTICULAR COMMENTS ARE SOUGHT ON:**
- (i) TRANSFERRING THE INITIAL REVIEW TO THE MENTAL HEALTH REVIEW TRIBUNAL RELYING ON THE JUDICIAL MEMBER SITTING ALONE;**
- (ii) OTHER STRUCTURES
WHICH STRUCTURE IS PREFERRED? WHY? WHAT ARE THE ADVANTAGES OR DISADVANTAGES SEEN IN THE DIFFERENT MODELS?**

4.7 Leave and Transfer

Providing patients with leave is an important part of the care and rehabilitation process. Leave may be needed for medical treatment, to visit family, or attend court, or for compassionate reasons, such as attending a family funeral. Leave is also used to assist the graduated return to the community for someone who has been acutely unwell.

Provisions for transfer of patients play an important part in care, as they allow a patient to be moved to a facility which may better reflect their care needs, or which is closer to their family or friends.

The main provisions relating to leave and transfer are:

- **Section 71** Allows the medical superintendent to grant leave, subject to conditions, to any patient held in a hospital if of the opinion that it “will benefit their health”.
- **Section 77** Allows the medical superintendent to grant leave subject to conditions for the purposes of “receiving medical treatment”. The section only applies to “temporary patients” and “continuing treatment” patients, that is patients who have been seen by a Magistrate, and been found to be mentally ill persons;
- **Section 78** Allows the medical superintendent or an authorised officer to direct the transfer of a patient. The Act imposes no criteria which the medical superintendent must use when deciding to transfer a patient, and again the provision is limited to “temporary patients” and “continuing treatment” patients. It is also restricted to transfers between psychiatric units, so cannot be used to transfer a patient to obtain medical care in a general hospital.

The current provisions in the Act dealing with leave and transfer contain a degree of inconsistency between patients who are awaiting a magistrate’s hearing and those who are being held after a determination that they are mentally ill persons. There is therefore limited recognition that a patient who has yet to be seen by a magistrate may need to be transferred for medical care and treatment. At the moment the general leave provisions in section 71 must be used for this purpose, placing a patient in something of a legal limbo during the course of such leave, in relation to their status under the Mental Health Act, and whether they can be reviewed by a Magistrate.

While some of the issues surrounding the need for patients to obtain appropriate medical care at the time of admission have already been raised in Part 4.2 of this Paper, it has also been suggested that the question could be addressed by revising the leave and transfer provisions to recognise these issues, for example:

- To establish greater consistency between the treatment of all persons who are involuntarily detained, whether before or after their appearance before a magistrate;
- To establish specific provisions allowing a patient to be transferred for medical care or treatment, with such provisions applying to all involuntary patients, and allowing transfers to general as well as psychiatric hospitals;
- To ensure persons transferred for medical care have the same access to a magistrate's review as persons who remain in a gazetted unit;
- To require a medical superintendent to address specific criteria before transferring a patient.

COMMENTS SOUGHT

- 34** ARE THE CURRENT LEAVE PROVISIONS ADEQUATE? SHOULD THEY BE CHANGED? IF SO, HOW?
- 35** SHOULD THE TRANSFER PROVISIONS SPECIFICALLY RECOGNISE MEDICAL TRANSFERS? IF SO, HOW? IF SO, SHOULD THESE PROVISIONS ALSO COVER PERSONS WHO HAVE NOT YET BEEN BEFORE A MAGISTRATE?
- 36** SHOULD THE GENERAL TRANSFER PROVISIONS INCLUDE CRITERIA WHICH MUST BE ADDRESSED BEFORE A DECISION IS MADE TO TRANSFER A PATIENT?

4.8 Apprehension of Absconding Patients

The Act contains straightforward provisions allowing the apprehension of a patient who has absconded from hospital. Section 76 provides that the absconder may be apprehended at any time by:

- the medical superintendent or any other suitably qualified person employed in the hospital, or
- a member of the Police Force, or
- a person authorised by the Minister or the medical superintendent, or
- a person assisting that medical superintendent, other suitably qualified person so employed, member of the Police Force or person so authorised,

While the authority to apprehend is clear, some questions have arisen over the power to enforce this provision. In this regard, the NSW Police have noted that while the initial detention provisions in section 22(3) of the Act specifically allow the use of "reasonable force", the apprehension provisions in section 76 are silent on this issue.

There is also a question as to whether the power should explicitly allow the forced entry of premises. As a result, police have on occasion indicated they are powerless to act, particularly in situations where the patient has barricaded themselves in their home. The

question has therefore arisen whether section 76 should be brought into line with section 22(3).

A further point arising under section 76 relates to concerns of NSW Police already outlined in relation to section 22(2) (see discussion at 4.1.1), that is, the need to amend the provision to simply authorise police to take part in the transport, rather than require them to.

COMMENTS SOUGHT

- 37** SHOULD SECTION 76 BE AMENDED TO ALLOW APPREHENDING AUTHORITIES TO USE “REASONABLE FORCE”?
IF SO, WHY? IF NOT, WHY NOT?

4.9 Discharge of patients – notification of Police

In December 2003, the first Mental Health Sentinel Events Review Committee Report, “Tracking Tragedy: A systematic look at suicides and homicides amongst mentally ill inpatients”, was released. Recommendation 29 of the Report proposed that by April 2004

Area Health Services shall ensure that high risk mental health patients will not be discharged subsequently (from the mental health unit), if it is known that they have access to firearms, until police have acknowledged that the firearms have been removed from the patient's access.³⁹

In response to the Report, NSW Health introduced procedures to require a responsible clinician who is concerned about a patient’s access to firearms, to contact the duty police officer at the nearest Local Area Command to discuss the situation.

Further implementation of this recommendation would, however, require legislative change. The recommendation refers to “high risk mental health patients” not being discharged if they are known to have access to firearms. Whether a person can be discharged or not is a question determined by the Mental Health Act. Under those provisions, the Act already allows discharge to be refused if a person is considered to be a “mentally ill person”, that is a person with a mental illness who is in need of care treatment or control for their protection, or the protection of others from “serious harm”. Given this, it would appear the Act would already allow a mentally ill person at “high risk” due to possible access to firearms (or indeed, any other weapon) to be detained.

The proposal also requires a patient to be held pending advice from Police that the firearms have been removed from the patient’s access. Concerns arise as to whether police currently have the necessary legislative power to seize a weapon on this basis, as well as the possible impact on Police resources if officers are required to be diverted to attend to such issues on a regular basis.

While noting these difficulties, the important concerns which led to the recommendation remain. As such, comments are invited on the recommendation, whether legislative changes should be considered or alternative means by which the issue may be addressed.

COMMENTS SOUGHT

38 ARE THE PROVISIONS OF THE ACT VIS A VIS RISK OF HARM SUFFICIENT TO DETAIN PERSONS WHO MAY HAVE ACCESS TO FIREARMS?

39 IF NOT, WHY NOT? HOW SHOULD THE PROVISIONS BE CHANGED?

40 WHAT ROLE SHOULD POLICE HAVE? WHY?

Part 5: Management of Forensic patients under the Act

Forensic patients are dealt with under two separate pieces of legislation. The Mental Health (Criminal Procedure) Act 1990 deals with the criminal process and provides for the criminal courts to consider questions of a person's fitness to be tried and defences of not guilty on the grounds of mental illness. Chapter 5 of the Mental Health Act generally operates after the criminal processes have been concluded, and provides for the management, review and release of persons who are then designated as "forensic patients".

5.1 Categories of Forensic Patients

The legislation provides for five categories of forensic patients

1. people found "not guilty on the grounds of mental illness";
2. people who have been determined to be "unfit to be tried", that is incapable of being tried for the criminal offence they are charged with;
3. people who have been found "unfit to be tried" and who have been through a 'special hearing' in relation to the offences they are charged with and have had a limiting term of detention imposed on them;
4. inmates of correctional centres who become mentally ill while in prison and who are then transferred to a mental hospital for care and treatment;
5. inmates of correctional centres (generally on remand) who have been referred for assessment by a magistrate to determine whether they should be formally transferred as per 4 above;

The majority of forensic patients are those found "not guilty on the grounds of mental illness". This means that a criminal court has found that while the person committed the act, due to mental illness they did not understand the quality and nature of the act. As such, they were incapable of forming the necessary intent to be found guilty of a crime.

The NSW legislation currently makes no distinction between those people who may have had a mental illness at the time they committed the crime, or whose mental illness affects their ability to properly defend themselves on charges (ie, categories 1 to 3) and those who have been remanded in custody or sentenced through the normal criminal justice processes, but become ill while in prison and require treatment while incarcerated (categories 4 and 5). This approach is different from that taken in other states such as Victoria. These states rely on two types of classification: first, "forensic patient", which covers categories 1 to 3 above, and secondly "security patient" to cover persons transferred for treatment of their mental illness while in prison (ie, categories 4 and 5).

Establishing these two separate classifications allows different approaches to be taken to the management and care of these groups in respect of security, leave, release, status as a prison inmate, and provisions for transfer to other jurisdictions. Establishing similar categories in NSW law would allow the same differential arrangements to be made. Such a proposal would however, also need to consider the situation of persons who are held on remand, who have not been to trial. They may well start as "security patients"

transferred for care, but may well end up as “forensic patients”, if they are later found not guilty on the grounds of mental illness or unfit to be tried when their cases come to court.

COMMENTS SOUGHT

- 41 SHOULD THE ACT BE AMENDED TO PROVIDE FOR TWO DIFFERENT CATEGORIES OF FORENSIC PATIENT, BASED ON HOW THE PERSON CAME INTO HOSPITAL IF SO WHY? IF NOT, WHY NOT?**

5.2 Executive Discretion in relation to the Release of Forensic Patients

When a person commits a crime, is charged and found guilty, the length of time they must remain in custody is determined by their sentence, which in turn is determined by the criminal courts, that is, the judiciary. Where concerns arise about the length of sentences, they are dealt with via appeal process through the court system. The Executive, being the Governor and the Ministers who make up the Government of the day have no role in determining the length of time a particular individual will be detained.

Where the offender has a mental illness, the situation is quite different. First, in most cases, the person will be found not guilty of the crime, on the basis of the defence of not guilty on the grounds of mental illness. This means that a court finds that due to their being mentally ill at the time of the offence, the person lacked the capacity to appreciate the nature or wrongfulness of their act, and therefore lacked the necessary intent to have committed the crime. As a result, the person will be found not guilty and no sentence will be imposed. The person will instead be referred for assessment, care and treatment, often on an involuntary basis in a gazetted psychiatric unit. The other main category of forensics, those people who lack even the requisite capacity to respond to the charges they face, will go through a “special hearing” to determine if they committed the acts in question, and can have a “limiting term” as opposed to a sentence imposed. This group to will also generally be detained in a gazetted unit for ongoing care and treatment.

The law in NSW however, also imposes a further difference on the way persons with mental illness are treated. Once a person is detained as a ‘forensic patient’ the decision on the length of time the person will thereafter be held moves away from the court system, and is instead made by the executive. While the executive will have advice from the Mental Health Review Tribunal, that body’s role is only to make recommendations on the basis of its regular reviews. The final decision rests with the executive. The process for review and release of forensic patients in NSW is therefore said to be subject to an “executive discretion”. The antecedents of the executive discretion go back to 19th century lunacy legislation, when patients found not guilty on the grounds of mental illness were also referred to as “Governor’s pleasure” patients, in that they remained in detention at the open discretion of the Governor.

The retention of the executive discretion in NSW has been controversial. Since the Act was introduced in 1990, most states and territories in Australia have removed the discretion and placed decisions relating to the release of such individuals in the hands of the court system. These changes reflect the National Statement of Principles for Forensic Mental Health⁴⁰ which provides that persons found unfit for trial or not guilty on the grounds of mental illness should not have decisions to detain, release or transfer them made by “a political process or the Governor/Administrator in Council”, but by

courts or independent statutory bodies of competent jurisdiction. The approach taken at a national level also reflects international standards⁴¹.

In addition, practically every review of this issue since 1990 has recommended that the executive discretion be removed, including:

In 1992, the Mental Health Act Implementation Monitoring Committee⁴² concluded it was inappropriate for the executive to make the final decision in these cases. Some of the Committee's concerns related to practical problems, including the time delays that can arise where more than one body considers the same matter. Other concerns related to the fact that the decision maker does not hear the evidence on which the relative assessments and recommendations are made, patients do not have the right to present their evidence directly to the decision maker retention of the executive discretion may be in breach of the International Covenant on Civil and Political Rights.

In 1993, The Human Rights and Equal Opportunity Commission Report on its National Inquiry into the Human Rights of People with Mental Illness specifically referred to NSW law, and recommended that the final determination for forensic patients should be made by an independent body, separate from the executive.

In 1996, the NSW Law Reform Commission Report on "People with an Intellectual Disability and the Criminal Justice System" recommended the removal of the executive discretion, citing additional concerns that the decision maker did not have to give a reason for the decision.

The reasons for the retention of the executive discretion in NSW were summed up in the 1996 *Caring for Health Paper*⁴³, issued by the Department of Health, as a basis for consultation on a number of the MHAIMC Report recommendations from 1992. That paper stated:

*"While the issues raised by the MHAIMC are persuasive, other issues must also be considered. Ultimately, decisions in relation to forensic patients require consideration of a number of issues, including the clinical state of the patient, their dangerousness, as well as community attitudes and concerns. While the Mental Health Review Tribunal deals with issues of a clinical nature, it is not constituted to look at the broader community issues, which is really the province of the executive arm of government"*⁴⁴.

Comments are therefore sought as to whether the executive discretion should be retained.

Clearly, in considering this question, a critical issue is how the system would work if the executive discretion were removed, and who the final decision maker on issues of release would be. Options would include:

- vesting the power to determine questions of release with the Supreme Court of NSW. This recognises both the serious issues involved and the close linkage of forensic matters to the criminal justice process. Other powers to vary conditions could remain vested in the Mental Health Review Tribunal, or be vested in the Local Court, given their role in the civil detention system;
- vesting the power to determine questions of release in the Mental Health Review Tribunal. This recognises the considerable expertise of the Tribunal in the area of

forensic review. However, given the serious nature of the issues arising, it may be considered more appropriate for a judicial body to perform this role.

- establish a two tier structure for management of forensic patients, whereby routine matters such as transfer and review are dealt with by the Tribunal and questions of release or reduction of conditions imposed on a conditional release are referred to a superior court, such as the Supreme Court.

COMMENTS SOUGHT

- 42** SHOULD THE “EXECUTIVE DISCRETION” TO DETERMINE THE RELEASE OF FORENSIC PATIENTS” BE REMOVED?
IF SO, WHY?
IF SO, HOW SHOULD DECISIONS ABOUT A FORENSIC PATIENT’S RELEASE BE MADE? BY WHAT BODY?
- 43** WHAT ROLE SHOULD THE MENTAL HEALTH REVIEW TRIBUNAL PLAY IN ANY REVISED SYSTEM?

5.3 Public safety criteria for recommendations of the Tribunal

Currently, when the Mental Health Review Tribunal considers whether to recommend the release of a forensic patient from custody, it is required to consider if:

“the safety of the person or any member of the public will be seriously endangered by the person’s release.”⁴⁵

Concern has been raised that this test may not be adequate as it does not factor in a broader “public safety” test, (arguably being limited to harm to an identifiable individual). There is also a concern that the requirement of “*seriously* endangered” is too high a test. Comments are sought on this issue, and whether the legislation should be amended to address it. Quite separately from the issue of release, the Tribunal also has the power to consider questions of leave for forensic patients, with the same test applied⁴⁶. If any change in the public safety test were to be considered appropriate, it would also necessarily flow on to these provisions as well.

COMMENTS SOUGHT

- 44** SHOULD THE PROVISIONS REQUIRING CONSIDERATION OF THE LEVEL OF RISK OF A PATIENT WHEN DECIDING ON A RECOMMENDATION FOR RELEASE BE VARIED? IF SO, HOW?
- 45** SHOULD SIMILAR CRITERIA BE IMPOSED WHEN CONSIDERATION IS BEING GIVEN TO LEAVE?

5.4. Notification required of Recommendations for Release

The forensic provisions also include specific legislative requirements for certain office holders to be notified of a proposal to order the release of a person, whether conditionally or unconditionally. There are three such provisions:

1. Notification of the Attorney General is designed to allow the Attorney General to raise an objection if the Attorney considers the person has spent insufficient time in custody or and because further unrelated criminal charges may be pending.
2. Notification of the Director of Public Prosecutions is designed to allow the DPP to raise an objection if further unrelated criminal charges may be pending.

3. Notification of the Commissioner of Police is to provide the Police with an indication of the proposed date of that person's release.

5.4.1 Notification of the Attorney General and Director of Public Prosecutions

The notification of these two office holders has been an issue of debate since the Act was first commenced. Strong arguments have been put by agencies such as the NSW Law Reform Commission⁴⁷ that as the provisions do not apply to all persons who have passed through the criminal justice system they are unfair and discriminatory against persons who have a mental illness, or who have been found not guilty on the grounds of mental illness. There have also been arguments that the power of the Attorney General to veto a person's release on the basis of "insufficient time spent in custody", has in any event limited relevance to persons who have not first been sentenced to a term of imprisonment, suggesting it should not apply to those who have been found not guilty on the grounds of mental illness⁴⁸.

Finally, the process for notification and objection to release fit within a system whereby final release is subject to the executive discretion. If it is ultimately proposed to place the decisions on release in the hands of the courts, consideration would also need to be given to whether, and how, these notice provisions would continue to operate. It may be, for example, more appropriate in such cases to grant the Attorney General or Director of Public Prosecutions a right to appeal a decision to release.

5.4.2 Notification of the Minister of Police

The notification to the Minister for Police has been identified as a provision which can allow NSW Police to be kept informed of possible releases, and thus take any protective action which may be necessary. This is considered particularly relevant where there may be some fear for the safety of other individuals. As a result, the provision has often been seen as a "victim protection" provision. That said, it also needs to be recognised that it pre-dates the NSW Victims' Rights Charter and various reforms implemented in NSW to recognise the interests of victims of crime, which include provision to keep victims informed of possible releases and allow them to make submissions about the proposed release. In this regard, NSW Health has also developed comprehensive processes to support victims of crime where affected by the forensic system.

The question arises as to whether this notification provision has been overtaken by these other developments in this area, and should be reviewed or replaced. The question also arises as to whether issues relating to forensic patients should be subsumed into the general victims' provisions dealing with all crime, or whether more specific recognition be given to the issue under the mental health legislation.

On the one hand, it may be argued that now that the wider issue of the rights of victims of crime is comprehensively addressed through the Attorney General's Department, it is more appropriate that persons who have been victims of actions taken or crimes committed by forensic patients be covered by those general provisions. In this regard, the Law Reform Commission concluded the issues concerning victims "should be governed by the procedures which apply to *all* victims, not just victims of forensic patients"⁴⁹. On the other hand, the extensive administrative scheme established within NSW Health recognises that there are specific issues arising in relation to forensic matters, which may well be better addressed through special provisions recognising the role of victims under the Mental Health Act.

COMMENTS SOUGHT

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| 46 | SHOULD THE PROVISIONS RELATING TO NOTIFICATION OF THE ATTORNEY GENERAL, DIRECTOR OF PUBLIC PROSECUTIONS AND MINISTER FOR POLICE BE REVISED?
IF SO, HOW? |
| 47 | SHOULD THE FORENSIC PROVISIONS IN THE ACT BE AMENDED TO INCLUDE SPECIAL PROVISIONS RECOGNISING VICTIMS OF CRIME?
IF SO, WHAT SHOULD THEY INCLUDE? |

5.5 Transfer and Review of Mentally ill Prisoners in Hospitals

Sections 97 and 98 provide a process whereby the inmates of correctional centres who become mentally ill, or require mental health care, can be transferred to a secure psychiatric unit for treatment. The process adopted to authorise such a transfer is similar to the “scheduling” process for civil patients except that:

- the process requires two distinct forms of documentation, those being certificates from two medical practitioners (one of whom is a psychiatrist) and the authority of the Chief Health Officer;
- there is no time limit specified in the legislation vis a vis the length of time the certificates or the CHO’s authority remains valid (unlike a Schedule 2 which is operative for only 5 days);
- the Chief Health Officer must notify the Mental Health Review Tribunal in writing when such an order is made;
- the Mental Health Review Tribunal (rather than a Magistrate) must review the patient as soon as practicable or within 14 days if the transfer has not occurred.

While these differences can generally be justified on the basis that the situation to be addressed is different where a person is already being detained in a prison, as against situations when they are at large in the community and civil detention is being sought, some issues have arisen.

5.5.1 Time frame on the transfer documents.

The reason for a five day limit on a civil schedule is the recognition that a person’s mental condition may change over time so that the opinion given at one point as to their mental state is unlikely to be valid five days later. While this would appear to apply equally within the correctional system, in the latter case, it can also be argued that concerns such as inaccurate certificates being used to initiate detention, simply do not arise. It may however, still be appropriate to include a time limit on these documents, or a process for medical staff to cancel them. This latter option would be rather like the authority of a medical superintendent in the civil system to discharge a person from the need for psychiatric care at any time.

5.5.2 Review of Individuals not Transferred

As noted above, inmates who are not transferred to hospital within 14 days of the Chief Health Officer’s order must be reviewed by the Tribunal informally every month. The Mental Health Review Tribunal has raised a concern with this requirement, noting that lack of beds is often the reason a person has not been transferred, rather than any question about their need for care. It has been suggested that provisions to allow a

medical practitioner to cancel the order for transfer (noted above), may also address this issue.

5.5.3 Review of Transferees

The Mental Health Review Tribunal is also required to conduct informal monthly reviews of :

- inmates who have been transferred and whose trials have not been completed ;
- persons who have been found unfit to plead but who have not had a “special hearing” conducted.

Section 86 states that the purpose of the review is “to determine whether the legal proceedings pending in respect of the person are delayed and, in the event of any delay, to take such action as the Tribunal or member thinks fit”. The Tribunal has advised that this purpose stands somewhat at odds with the overall role and functions of the Tribunal in forensic matters, which are to assess the person’s mental state and level of risk and make appropriate recommendations for their ongoing care. As such, the Tribunal is ill-equipped to respond to delay caused by the legal process, a matter arguably better addressed by the person’s legal representative in any proceedings. Given this, the suggestion has been made that this requirement for review be removed.

5.5.4 Juvenile offenders

The transfer provisions will apply equally to juveniles, as juvenile detention centres are considered “correctional centres” for this purpose. Recently, there have been a number of cases where a young person held in a juvenile detention centre was transferred being in need of psychiatric care. There are concerns that the special needs of juveniles may be overlooked or not properly met by the general system. Suggestions have therefore been made that there should be specific recognition of the special needs of juveniles in the forensic mental health system in the Act. The question is whether this is the most appropriate manner of addressing the issue, or whether having facilities and programs available to juveniles is the real key to addressing this issue.

COMMENTS SOUGHT

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| 48 | SHOULD TIME LIMITS BE PLACED ON THE PERIOD OF TIME A CERTIFICATE OR CHO AUTHORITY UNDER SECTION 97 REMAIN VALID?
IF SO, WHY? IF NOT, WHY NOT? |
| 49 | SHOULD THERE BE A PROCESS IN PLACE TO ALLOW TRANSFER AUTHORITIES TO BE CANCELLED?
IF SO, WHY? WHO SHOULD HAVE THIS POWER? |
| 50 | SHOULD THE MENTAL HEALTH REVIEW TRIBUNAL CONTINUE TO INFORMALLY REVIEW CASES OF PERSONS WHO HAVE NOT BEEN TRANSFERRED?
IF SO, WHY?
IF NOT, COULD THIS ISSUE BE ADDRESSED VIA A PROCESS TO “CANCEL” AN ORDER, NOTED ABOVE? |
| 51 | SHOULD THE REQUIREMENT FOR THE TRIBUNAL TO REVIEW CASES OF DELAY IN LEGAL PROCEEDINGS BE RETAINED OR REMOVED?
IF SO, WHY? |
| 52 | SHOULD THERE BE SPECIFIC RECOGNITION OF THE SITUATION OF JUVENILES IN THE FORENSIC SYSTEM? |

5.6 Conditions which can be imposed in a conditional release

Under the Act, the Mental Health Review Tribunal cannot recommend the release of a forensic patient unless it is satisfied that the safety of the patient or any member of the public will not be seriously endangered by the person's release. Part of the process of meeting this test, and gradually rehabilitating forensic patients into the community is to rely initially on "conditional release". This allows the Mental Health Review Tribunal to recommend a range of restrictions on the activities and lifestyle of the person in question as conditions of any release into the community.

The type of conditions will generally reflect the person's circumstances, and the stage they have reached in their recovery, and can include such things as taking medication, not using drugs or alcohol, regular reporting to a psychiatrist or case manager, and residing in a particular place. There are however, no guidelines for the content of the conditions of release in the legislation, and ultimately what conditions will be imposed is a matter for the Minister and Governor, who currently determine the issue of conditions, as part of the executive discretion.

In 1996, the NSW Law Reform Commission⁵⁰ recommended the legislation should be amended "to include a non-exhaustive list of release conditions which may be imposed", the aim being to prevent political factors being part of any consideration of conditions. The Commission also considered that the list would act as an educative process for the public as to the types of conditions imposed on forensic patients and would also make decisions more openly structured. Clearly, if the executive discretion is removed and decision making is transferred to a court, the concerns raised by the Commission would be diminished.

COMMENTS SOUGHT

- 53** SHOULD A NON-EXHAUSTIVE LIST OF CONDITIONS FOR THE CONDITIONAL RELEASE OF FORENSIC PATIENTS BE SET OUT IN THE LEGISLATION? IF SO, WHY? IF SO, HOW SHOULD THEY BE INCLUDED?
- 54** SHOULD THE POWER TO IMPOSE CONDITIONS BE RESTRICTED TO THE MENTAL HEALTH REVIEW TRIBUNAL?

5.7 New Forensic Facility

In 2003 the Government announced the development of a new facility for forensic patients, to be built outside the grounds of the Long Bay Prison complex. It is proposed the facility will come on line in 2006/07. The most important aspect of this proposal is that unlike existing forensic facilities, the new hospital will operate separate from the prison system, be administered by NSW Health and staffed by health professionals and non-corrections personnel⁵¹.

Given the new facility will operate separately from the correctional system, a number of adjustments may be required to the Act to recognise the non-inmate status of persons held there, including provision for admission of persons direct from court both after trial and as part of the assessment process. Provisions to facilitate this new facility are intended to be included in the revisions to the Mental Health Act arising from this review.

5.8 Management of Conditionally Released Forensic Patients in the Community

5.8.1 Liaison between Government Agencies

A number of agencies have important roles in planning for the future of forensic patients as they are released into the community. These include Justice Health⁵², the Mental Health Review Tribunal and NSW Health, and may also include a range of other agencies such as the Department of Ageing, Disability and Home Care, the Department of Housing and the Department of Community Services⁵³. It is vital that there is interagency planning for the progression and release of forensic patients as early as possible. Currently however there are no formal mechanisms requiring such interagency cooperation.

Questions have been raised as to whether there should be a more formal mechanism to ensure this planning occurs, either through protocols or memorandums of understanding between the agencies in question, or via a mandatory legislative requirement. In this regard, the NSW Select Committee recommended:

That the Minister for Health implement a formal agreement with the Mental Health Review Tribunal for the supervision and management of released forensic patients, including:

- *clarification of the responsibility of clinical services in the monitoring and reporting of clinical supervision, including the role of the Mental Health Review Tribunal in monitoring progress and*
- *clarification of formal procedures for managing breaches of release conditions⁵⁴.*

There is also precedent for legislative recognition of the need for co-operation of different agencies in the area of child protection. The Children and Young Persons (Care and Protection) Act 1998 recognises this and the need for assistance and co-operation between such agencies. A similar provision in the Mental Health Act would also provide a sound basis for any administrative agreement or protocol as suggested by the Parliamentary Select Committee.

5.8.2 Action taken on Breach of Conditional Release

Section 93 of the Act contains clear provisions to deal with a situation when a person breaches a conditional release order. These provisions allow the Minister to issue an order for the person to be apprehended and detained “in the place (being a hospital, prison or other place) and in the manner specified in the order”.

Some confusion appears to have arisen in respect of this provision, with some service providers being reluctant to seek an order under section 93 for what are non-serious or technical breaches of conditions of release or where they consider the patient is only in need of short term hospital stay to recover from an exacerbation of their mental illness.

The reason for this reluctance appears to be twofold. First a concern that the need for a Ministerial order means there may be time delays and difficulties in obtaining an order, and secondly, a misapprehension that an order under section 93 will require the person to be returned to a correctional centre. As an alternative, patients may admit themselves as voluntary patients, or be admitted under a schedule as an involuntary civil patient.

Reliance on the voluntary provisions of the Act provides no difficulties, as it would be no different from the patient attending a hospital for other care or treatment. The view taken of section 93 and the use of the civil detention provisions as an alternative are however problematic for a number of reasons:

- As can be seen from the terms of section 93, it does not require a person be returned to prison. The broad scope of the order allows a person to be taken to the most appropriate place care can be provided;
- While the power is currently vested in the Minister, action on breaches is generally taken promptly, and no specific circumstances have been identified where there has been an inappropriate delay in the Minister issuing a necessary order.
- The alternative of scheduling a person as a civil patient is legally questionable. As the Mental Health Review Tribunal has recently noted, the overall scheme of the Act clearly implies that a forensic patient should be dealt with in accordance with the forensic provisions, meaning the civil scheduling provisions may well not be available.
- Use of the civil provisions in such cases also increase confusion over the patient's status and the conditions they are required to operate under.

These issues indicate the current process is not clear to those working with patients, suggesting it may be appropriate to amend the Act to clarify that civil scheduling is not available, and to address more directly any operational concerns which might be identified with section 93 through the revision of the forensic provisions themselves.

COMMENTS SOUGHT

- 55** SHOULD THE ACT BE AMENDED TO REQUIRE OR RECOGNISE THE NEED FOR INTERAGENCY COOPERATION IN THE PLANNING FOR THE FUTURE OF A FORENSIC PATIENT
IF SO, WHY?
- 56** SHOULD THIS INCLUDE MECHANISMS TO ENSURE THAT EXIT AND TRANSITION PLANNING IS PROVIDED FOR FORENSIC PATIENTS?
IF SO, WHY
- 57** SHOULD THE PROVISIONS RELATING TO BREACH OF RELEASE BE REVISED TO RECOGNISE THAT CIVIL DETENTION IS NOT AVAILABLE?
- 58** SHOULD THE BREACH PROVISIONS ALSO BE REVISED TO ALLOW ALTERNATIVE PROCESSES FOR LESS SERIOUS BREACHES?
IF SO, WHY? HOW SHOULD 'LESS SERIOUS' BE DEFINED? WHAT PROCESS WOULD APPLY?

Part 6: Care and Treatment Outside Hospitals

6.1 Making Orders for Care in the Community

The Mental Health Act provides two means whereby a person can be ordered to receive care and treatment while in the community, these being Community Treatment Orders and Community Counselling Orders. These orders have a number of common features, including:

- The orders are issued by a Magistrate or the Mental Health Review Tribunal;
- They require a person to comply with a written treatment plan issued by a “health care agency” (being a body specifically recognised in the Act);
- Orders operate for a period of up to 6 months with provision to extend for further periods of 6 months;
- Provisions are included to enforce an order when a breach occurs.
- Orders expire if the person is admitted as an involuntary patient under the general admission provisions discussed in Chapter 4⁵⁵.

There are however, some quite important differences between the two types of orders which reflect the original intention of the legislation that most of the Orders to be made under the Act would be Community Counselling Orders, with Community Treatment Orders being limited to persons with more serious and chronic conditions. The differences include:

- A treatment order can only be made when the person has been detained in a hospital as a mentally ill person, whereas a counselling order can be made in the community;
- A person must be a “mentally ill person” under the Act⁵⁶ before a treatment order is made, but a counselling order requires evidence that the person is “likely to become” a mentally ill person within 3 months;
- Treatment orders can be renewed in the client’s absence, but the patient (or their legal representative) must be present at a hearing to renew a counselling order;
- The ultimate sanction for a breach of a treatment order is to be taken to a psychiatric hospital for involuntary review, (and possibly treatment), whereas this option is not available under a counselling order.

6.1.1 Community Treatment vs Community Counselling Orders

The original intention of the Act in relation to the use of counselling vs treatment orders has not been borne out in operation. About 95% of all orders issued under the Act are Community Treatment Orders. Counselling Orders are rarely used. Anecdotal evidence suggests health staff prefer seeking treatment orders, as the counselling orders are difficult to obtain, easily avoided and have insufficient enforcement powers to be effective. Some of the criticisms raised in respect of counselling orders include:

- The fact that a counselling order does not provide for a person to be involuntarily detained in a hospital as a sanction for a breach of the order makes them a less useful tool for community treatment as they have “no teeth”;

- The requirement for the client to be present at a renewal hearing means they can avoid future orders (and hence their obligation to obtain care) by simply refusing to attend the hearing;
- The requirement that medical or psychiatric evidence be given that the person is likely to become a mentally ill person within 3 months is excessively onerous. It can often be difficult to obtain such evidence when the person has not been in care, and some psychiatrists have indicated that it is almost impossible to make such a prediction over so long a period of time.

Comments are therefore sought on the relative effectiveness of the two types of orders, including whether they should be revised or indeed, whether the provisions for counselling orders should simply be deleted from the Act altogether, given they have been used so infrequently.

6.1.2 Initiating Orders in the Community

If the Act were to be amended to allow only for community treatment orders, consideration may also need to be given to whether those orders should be able to be initiated in the community. This is already the case in Victoria. A number of practical issues would need to be considered however, including what criteria would be imposed before such an order could be initiated in the community, and how evidence would be obtained in the absence of the sort of comprehensive assessment available at a hospital. The apparent failure of community counselling orders to properly address these very issues appears to have led in large part to their limited use. This in turn may suggest that community orders are best commenced through the hospital admission process. Clearly, any such change would need to have due regard for the civil liberties of a patient to ensure the standard applied is not lower than that which operates when a CTO is made in an institutional setting.

6.1.3 Initiating Orders for Inmates of Correctional Centres

A question has arisen in relation to prisoners who have been treated in a correctional centre for their mental illness. Where an inmate becomes a forensic patient there are extensive provisions for staged release into the community subject to conditions which can be similar (if not more extensive) to the conditions imposed on civil patients under community orders. Inmates will not however be classified as “forensic patients” unless they are formally held in the gazetted psychiatric hospital in Long Bay. For the same reason, they cannot be made subject to a CTO. Many inmates however can receive ongoing care for their mental illness in prison, without needing to be transferred to a gazetted unit. While these inmates may be willing to comply with their medication in the highly regulated environment of a prison, they may become non-compliant once released. It has therefore been suggested that a community order should be able to be initiated for such individuals as a precursor to release.

COMMENTS SOUGHT

- 59** SHOULD PROVISION FOR BOTH COMMUNITY COUNSELLING ORDERS AND COMMUNITY TREATMENT ORDERS BE RETAINED, OR SHOULD THEY BE CONSOLIDATED INTO ONE ORDER? IF SO, WHY?
- 60** IF THE ACT PROVIDES FOR ONE TYPE OF ORDER, SHOULD IT BE ABLE TO BE INITIATED IN THE COMMUNITY?

	IF SO, WHY? WHAT WOULD BE THE BASIS OF SUCH AN ORDER? HOW WOULD EVIDENCE TO SUPPORT THE MAKING OF THE ORDER BE COLLECTED?
61	SHOULD THE ORDERS BE EXTENDED FROM 6 TO 12 MONTHS? IF SO, WHY?
62	SHOULD COMMUNITY ORDERS BE ABLE TO BE INITIATED FOR A PERSON WHO IS IN PRISON? IF SO, WHY? HOW WOULD THIS BE ACHIEVED?

6.2 Length of time a person can be subject to an order

6.2.1 Limits on Renewals

As outlined at 6.1, both types of community orders are made for a period of 6 months, but can be renewed for periods of up to 6 months thereafter. Since the Act commenced, anecdotal evidence suggests that a substantial group of patients has been subject to ongoing orders, over 2, 3 or even 4 years.

The ability to make “rolling orders” in respect of an individual patient was tested in 1994 before the NSW Court of Appeal⁵⁷. The court held such orders could continue to be made notwithstanding there was no explicit finding a person was a mentally ill person, provided the Tribunal considered that the person benefited from the order and it is the least restrictive care appropriate and available. Concerns have been raised with the Department that the outcome of this case, accompanied by current practice, makes it extremely difficult for a person to demonstrate to the Tribunal that an order is no longer justified or necessary.

It has therefore been suggested that some separate objective test for *renewal* of orders be included in the Act. One suggestion is 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. It should be noted that this criteria is the same as that imposed before a community counselling order can be made, with the attendant problems identified at 6.1.1.

6.2.2 Duration of Orders

The duration of community orders has also been raised as in some jurisdictions they can be made for periods longer than 6 months. In Victoria for example, orders can be made for a period of up to 12 months. Concerns have been raised that such a lengthy order, without an appropriate appeal mechanism would be unduly harsh and unfair.

6.2.3 Discharge Reports

Both sections 126 and 136 provide for a “discharge report”, at the end of an order, with section 126 also requiring a written report to the Director General of the Department of Health vis a vis the efficacy of an order. Questions have been raised as to the value this process adds to the CTO process. Discharge planning and assessment should form an ongoing part of care and be readily demonstrated in the medical notes. It is also unclear what is intended by the report to the Director General. It may be that this provision could be revised to more appropriately link into planning for the person after the order expires, to provide a useful tool for ongoing management.

COMMENTS SOUGHT

- 63** SHOULD THERE BE A SEPARATE TEST FOR “RENEWAL” OF A COMMUNITY ORDER? IF SO, WHY? WHAT SHOULD THE TEST BE?
- 64** HOW LONG SHOULD COMMUNITY ORDERS BE MADE FOR? SHOULD THEY BE EXTENDED FROM 6 TO 12 MONTHS? IF SO, WHY?
- 65** SHOULD SPECIFIC APPEAL PROVISIONS BE INCLUDED TO ALLOW CHALLENGE OF A LENGTHY ORDER? IF SO, WHAT SORT OF APPEAL SHOULD BE ALLOWED?
- 66** SHOULD THE REQUIREMENTS FOR REPORTS UNDER SECTIONS 126 AND 136 BE REVISED OR REMOVED?

6.3 Breach of Community Treatment Orders

Action available on the breach of an order is set out in sections 137 to 139 of the Act. Breach action is only available if the health care agency has taken all reasonable steps to implement the order and considers that there is a significant risk of deterioration in the mental or physical condition of the affected person if they do not obtain the care provided for under the order. The breach provisions then provide health care agencies with a series of three escalating responses to persuade a person to comply, before they are ultimately “breached”:

First, a notification that a further refusal to comply will result in the person being taken to the health care agency or an appropriate hospital and treated;

Second, where the person still refuses to comply, a written notice requiring the person to accompany a member of the staff of the health care agency for treatment in accordance with the order or to a specified hospital;

Third, where the person still refuses to comply, an order will be issued for their detention, and Police can be requested to enforce the order.

Two issues have been raised for comment in relation to the breach provisions.

6.3.1 process for issuing a breach order

Concerns arise that this series of actions may be ineffective where a patient is an itinerant or has moved without informing their case manager of their new address. In such a situation, the person may not be able to be located in order to give them the written notice, and without that notice being given, further breach action is precluded. Suggestions have been made that the notice requirements should be able to be dispensed with, and an order issued directly, in certain circumstances. This may include where there is serious concern over the welfare of the person in question.

6.3.2 Use of Police to Enforce a Breach Order

The concerns raised by NSW Police vis a vis the inappropriate use of police officers to transport involuntary patients has already been discussed at some length in Chapter 4 of this paper. Similar concerns have also been raised over the use of police to action a

breach order under section 139⁵⁸. Comments are therefore sought on whether these provisions should be amended along similar lines to those suggested in relation to sections 22(2) and 76.

COMMENTS SOUGHT

- 67** SHOULD A HEALTH CARE AGENCY BE ABLE TO DISPENSE WITH NOTICE REQUIREMENTS? IF SO, WHY? IF SO, IN WHAT CIRCUMSTANCES?
- 68** SHOULD THE OPTION TO OBTAIN POLICE ASSISTANCE TO ENFORCE A BREACH ORDER BE AMENDED? IF SO, WHY? IF SO, HOW?

6.4 Detention following Breach of a Community Order

A number of questions have arisen as to the process for reviewing a person brought to a hospital as a result of a breach:

- *Should the person be examined within 12 hours of their arrival?* Examinations are required within 12 hours of initial detention, so suggestions have been made for a similar timeframe for persons who come in on a breach of a community order.
- *Should the person be reviewed as soon as practicable by the Tribunal?* As the Act stands a person is not entitled to be reviewed by the Tribunal for three months after their initial detention, unless they request such a review under the appeal provisions. Concerns have been raised that this timeframe is too lengthy, and that a review should occur as soon as practicable after the person is brought to hospital.

In considering these issues, it should be noted that a person under an order has already been found to be a mentally ill person prior to the order being made. In addition, their detention on a breach has resulted from a fairly onerous review process. It might be argued that in such cases the need for a quick review is less urgent than cases where a person has been brought in directly from the community, in some cases (eg when brought in by police) without any professional psychiatric assessment at all.

COMMENTS SOUGHT

- 69** SHOULD THE ACT REQUIRE A PERSON ADMITTED ON BREACH OF A COMMUNITY ORDER TO BE REVIEWED WITHIN A SET PERIOD OF TIME? IF SO, WHY? WHAT TIME FRAME SHOULD BE IMPOSED?
- 70** SHOULD THE ACT REQUIRE A PERSON ADMITTED ON BREACH OF A COMMUNITY ORDER TO BE REVIEWED BY THE TRIBUNAL AS SOON AS PRACTICABLE? IF SO, WHY?

6.5 Effect of involuntary admission on a community order

Sometimes a person under a community treatment order may be involuntarily detained under the general involuntary admission provisions of the Act, rather than via the breach process. This can occur for a number of reasons, including the person issuing the Schedule 2 or police being unaware of the community order. In such cases, section 135 of the Act provides that the order automatically expires. The rationale for this provision was that a further involuntary admission must indicate their situation has changed so markedly that a community order is no longer appropriate.

Concerns have been raised, however, that this is not always in fact the case, and that often, severing of the order will not be conducive to the person's ongoing care in the community. In particular, they may be released from hospital after a short stay, on the basis they are not a "mentally ill person". Because of section 135 however, this release will be without the safety net the community treatment order represents. Suggestions have therefore been made that while the presumption that the order expires be retained, the medical superintendent should have the power to overturn it if of the view retention of the order will be of benefit to the client.

COMMENTS SOUGHT

- 71** **SHOULD THE AUTOMATIC EXPIRY OF A COMMUNITY ORDER ON INVOLUNTARY ADMISSION BE RETAINED OR REMOVED?**
IF RETAINED, WHY?
IF REMOVED, HOW WOULD THE SCHEME OPERATE?

Part: 7 Medical and Therapeutic Treatments

Chapter 7 of the Act sets out a series of provisions designed to regulate, and in some cases prohibit, certain forms of treatment. The Chapter also provides for the carrying out of general medical treatment on persons held under the Act.

While comments and views are sought on all aspects of this part of the Act, a number of specific issues have been raised with the Department in relation to the provisions dealing with psychosurgery and electro convulsive therapy.

7.1 Psychosurgery

The Mental Health Act adopts quite a technical definition of “psychosurgery”⁵⁹, but in lay terms the procedure can be described as “any surgery on the brain carried out with the primary intention of ameliorating a psychiatric disorder”, excluding surgery for epilepsy, movement or pain disorders⁶⁰.

The Act prevents such surgery being carried out unless:

- the patient has given informed consent to the operation; and
- the medical officer proposing to carry out the operation has obtained the prior approval of the Psychosurgery Review Board.

In determining an application, the Board must be satisfied that the patient is capable of giving informed consent, the patient has given that consent and the psychosurgery has clinical merit. The Board also needs to be satisfied that the procedure will be carried out by qualified doctors and at a suitable hospital.

7.1.1 Psychosurgery Now and in the Future

Psychosurgery has not been carried out in NSW since 1994, largely due to the fact that the Psychosurgery Review Board was not reappointed when the members terms of appointment expired in that year. The change was in accordance with a government pledge at that time that it would ban psychosurgery. In a sense, this response reflects an Australia wide trend over recent years, with Victoria now the only place in Australia where psychosurgery is performed. Even in that state, it is understood only very few operations have been performed recently.

This fact, along with the fact that there appear to be no surgeons in NSW currently willing to perform these procedures, suggests there may be good grounds for removal of these specialist provisions, instead making psychosurgery a “prohibited treatment” under section 197 of the Act.

In considering this suggestion, however, reference should be made to the work of the Psychosurgery Review Working Group established by the Department of Health in 1996. In its final report⁶¹ in 1997 that group concluded “as it is currently practised, psychosurgery is a safe and effective procedure for a very small and specific group of patients suffering from some chronic, disabling and treatment resistant psychiatric illnesses⁶² and recommended it continue to be offered as a form of treatment in NSW.

It has been suggested that renewed interest overseas in pursuing some new forms of psychosurgery (which may provide benefits for mentally ill people) suggests there is also a need to retain some legislative basis to recognise and regulate these procedures in the

future. Pursuing regulation on this basis would however require strong and robust evidence of the effectiveness of these procedures, evidence which is not currently available.

7.1.2 Should the provisions relating to psychosurgery be revised?

The question of how psychosurgery provisions should look in the legislation was also addressed by the Psychosurgery Review Working Group Review. As such, if psychosurgery provisions were to be retained in the Act, the Working Group's work provides a good starting point. The Working Group recommended:

- Persons incapable of giving informed consent and patients under the age of 18 should be ineligible for psychosurgery;
- Psychosurgery should not be available to treat involuntary patients;
- Psychosurgery should only be offered as a treatment of last resort, after patients have received a full range of alternative treatments which have been demonstrated to have failed;
- The Psychosurgery Review Board should “facilitate mandatory comprehensive standardised independent psychiatric and neuropsychological follow up of each patient for at least 12 months post psychosurgery”;
- An additional member representing consumers should be added to the Board;
- The term psychosurgery should be replaced by the phrase neurosurgery for severe psychiatric disorders, in order to more accurately reflect the reality of the procedure and to reduce stigmatisation.

COMMENTS SOUGHT

72 SHOULD PSYCHOSURGERY BE MADE A PROHIBITED TREATMENT?
IF SO, WHY?
IF NOT, WHY NOT?

73 IF PSYCHOSURGERY IS RETAINED, WHAT CHANGES SHOULD BE MADE TO MAKE THE PROVISIONS MORE EFFECTIVE?

7.2 Electro Convulsive Therapy

Electro Convulsive Therapy (or ECT) cannot be carried out on involuntary patients unless:

- the treatment is considered by clinicians to be a reasonable and proper treatment for the person;
- the clinicians consider ECT is necessary or desirable for the safety or welfare of the patient; and
- where the Tribunal concludes that the person has not given informed consent or has neither consented or refused, the Tribunal must be satisfied it is a reasonable and proper treatment and is necessary or desirable for the safety or welfare of the patient.

Section 185 also sets out separate provisions allowing other persons, who are not involuntary patients under the Act, to have ECT where they are capable of giving consent.

Whilst ECT is controversial in the community, many clinicians see it as a useful and necessary form of treatment for some intractable conditions. It is said to have successful outcomes for certain individuals who have been unsuccessfully treated with medication. With modern improved equipment, better monitoring and more sophisticated techniques and safety measures, ECT offers a safe, reasonable alternative to other therapies.

One issue which has arisen relates to what is known as “maintenance ECT”. Generally approvals given by the Tribunal relate to a course of treatment, generally 8-12 treatments. The Tribunal will, however, also give approval for ongoing treatment, known as “maintenance ECT”. This is usually provided to involuntary patients on leave who are brought back to hospital on a fortnightly or monthly basis for treatment. Without the maintenance course the person’s “continuing condition” will deteriorate to such a degree that they require immediate hospitalisation.

The current Act provides no special recognition for maintenance ECT, nor does it limit the period of time over which ECT can be given. As a person’s situation is likely to change over time, the question arises as to whether the Act should in fact include such a restriction.

Questions about ECT and community treatment orders also arise from the above scenario. The situation of providing maintenance care while ensuring some oversight on compliance really reflects the substance of a CTO. Currently, ECT cannot be given under a CTO. The question therefore arises as to whether this issue should be reconsidered, and administration of “maintenance ECT” be dealt with by revised CTO type arrangement.

COMMENTS SOUGHT

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|-----------|--|
| 74 | DO THE CURRENT PROCESSES FOR ECT REMAIN RELEVANT AND APPROPRIATE?
IF NOT, HOW SHOULD THEY BE CHANGED? WHY? |
| 75 | SHOULD THE ACT MAKE SPECIFIC REFERENCE TO A TIME LIMIT WITHIN WHICH A COURSE OF ECT SHOULD BE CONDUCTED?
IF NOT, WHY?
IF SO, WHY? HOW LONG? |
| 76 | SHOULD SPECIFIC PROVISIONS BE INSERTED TO ALLOW, UNDER STRICTLY LIMITED CONDITIONS, A CTO TO BE MADE FOR ‘MAINTENANCE ECT’ IN THE COMMUNITY? |

7.3 Surgery Provisions

Chapter 7 of the Act also contains provisions for consent to general surgery. These provisions do not apply to special treatments such as psychosurgery or ECT, but deal with more general medical treatment which may be required while a person is in hospital. Issues have arisen about the current efficacy of the provisions. In particular, the requirements for notice to relatives prevents any hearing of an application for surgery occurring until 14 days after notice is provided to relatives. There is no provision for this to be shortened by receipt of the relative’s consent, or recognition of a situation where relatives cannot be contacted. Surgery, which may be urgent, or to relieve a painful condition, can thus be needlessly delayed.

Comparisons have also been made between these provisions and those in the Guardianship Act which authorise medical treatment, noting that the latter provide a much simpler and more straightforward system for decision making. It should be noted however, that there is a substantial difference between persons regulated by the two Acts, with persons under the oversight of the Mental Health Act also being held in detention. Arguments could be made that in such a situation, a person is more vulnerable, and a more substantial system of oversight and review of decisions about medical care is therefore appropriate.

COMMENTS SOUGHT

- 77** SHOULD THE NOTICE PROVISIONS RELATING TO SURGERY BE CHANGED? IF SO, WHY? IF SO, HOW?
- 78** SHOULD THE APPROVAL OF MEDICAL TREATMENT PROVISIONS BE BROUGHT INTO LINE WITH THOSE RELIED ON IN THE GUARDIANSHIP ACT? IF SO, WHY? IF NOT, WHY NOT?

Part 8 : Establishment of Hospitals and Official Visitors

Chapter 8 of the Act provides for the recognition of hospitals to provide treatment and care for persons with a mental illness. The Chapter also establishes the role of Official Visitors.

8.1. Hospitals

There are two main categories of such hospitals:

Gazetted hospitals: being public hospitals which provide services, and where a person can be admitted for voluntary care or detained for involuntary treatment; and

Authorised hospitals: which are private hospitals⁶³ authorised under the Mental Health Act and which provide care and treatment but cannot generally detain a person involuntarily.

The issue has been raised from time to time since the Act commenced, as to whether private authorised hospitals should also be able to admit and detain patients involuntarily. To date, there has been resistance to such an approach, on the basis that the accountability mechanisms offered in the public sector, and the lack of a profit motive, means the involuntary provisions are less vulnerable to abuse. This view has also been influenced by failings encountered in the private system in cases such as Chelmsford Private Hospital and more recent overseas experience.

COMMENTS SOUGHT

79 **SHOULD PRIVATE HOSPITALS BE ALLOWED TO ADMIT AND DETAIN PEOPLE FOR INVOLUNTARY TREATMENT?
IF SO, WHY?**

8.2 Official Visitors

Official Visitors have been recognised in mental health law in NSW since the mid 19th century⁶⁴, and the Official Visitors Program has always provided important safeguards for the rights and care of mental health patients. This role has gradually been strengthened through the legislative changes leading to the current Mental Health Act. Despite advances in quality assurance over the past decade, the scrutiny of Official Visitors, as a group independent of the administrative and clinical structures of the health system, continues to provide protection to what is a vulnerable group of health consumers. Official Visitors continue to identify and address issues such as poor physical environments, inappropriate procedures or staff behaviour and matters for clinical review.

While some minor changes were made to the Official Visitor provisions in 1997, there has been no substantial review of their operation since the Act came into force in 1990. Comments are therefore sought on the provisions which apply to Official Visitors, and whether changes could be made to increase their effectiveness.

In preparing this Paper, the Department has also had the benefit of a Discussion Document prepared by the Official Visitor Program, which raises a range of proposals for change to the Act. These provide a valuable insight into the issues from the perspective of Official Visitors, and have provided the basis for much of the following discussion.

8.2.1 Qualifications required for Principal Official Visitor and Official Visitors

There are two sets of provisions which deal with the qualifications necessary to be appointed an Official Visitor.

(a) Principal Official Visitor

Section 226 requires the Minister to appoint a Principal Official Visitor (or POV) who is “a medical practitioner, barrister, solicitor or other suitably qualified person.” While the provision does not *require* the POV to be a barrister solicitor or medical practitioner, it has been suggested that listing these professional groups sends the wrong message, and that it may be better to provide a description of qualifications necessary, focussing more on relevant clinical background or experience. It has also been noted that reference to legal qualifications is less relevant than in the past when Official Visitors were the agency responsible for reviewing the cases of involuntary and forensic patients. Now that this role is undertaken by the specialist Mental Health Review Tribunal, the need for legal qualifications to be highlighted in respect of the POV seems to have less relevance.

(b) Official Visitors

Section 228 of the Act provides for the Minister to appoint official visitors for each area health service in NSW. The section requires that “at least one” of the OV’s appointed for each area must be a medical practitioner. Concerns have been raised that the requirement to have at least one medical practitioner is problematic, and that a range of other health professions, such as clinical psychologists or nurses, would be equally suitable to provide the health background necessary to properly perform OV functions. Some of the issues raised in this regard include:

- The functions of both the POV and OV’s do not demand medical training. While a clinical background in mental health would be an advantage, there are other professions which will have this grounding;
- The principal area of expertise contributed by medical practitioners lies in their familiarity with medical records and procedures, but this expertise is shared with many other clinicians, such as psychiatric nurses and psychologists;
- The duties of an official visitor are generally fairly onerous and time consuming, meaning few currently practising medical practitioners are in a position to commit their time to the Official Visitors’ Program;
- The Program’s capacity to provide regular coverage of all hospitals and health care agencies has been compromised by a shortage of medical official visitors. This is particularly acute in rural areas⁶⁵;
- The difficulty in attracting medical practitioners is compounded by the fact that very often in rural areas, interested local practitioners cannot be appointed as they will often hold appointments with NSW Health facilities, that may create a conflict of interest under the Act.

These concerns are compounded by the terms of section 230, which require that the medical practitioner OV must be present at all OV visits. The Official Visitors program

reports complaints from both consumers and health care providers, where regular visits have not taken place due to the lack of a medical practitioner.

Given these issues, a suggestion has been made that the medical practitioner provisions be expanded to allow use to be made of the experience of a wider range of clinicians. In the NSW health system, many clinical disciplines provide skills and knowledge for the provision of mental health services. For some years now, the Program has already been attracting registered nurses, social workers, occupational therapists and psychologists as Official Visitors⁶⁶. These Official Visitors bring a wealth of expertise in health care generally and familiarity with mental health in particular. Revised provisions would allow these professional groups to provide the specialist health role currently restricted to medical practitioners.

8.2.2 Functions of Principal Official Visitor

The functions listed in the Act for the POV are specifically focussed, dealing with:

- assisting Official Visitors to exercise their functions under the Act;
- exercising the functions of an Official Visitor;
- reporting to the Minister on the exercise of the functions of Official Visitors.

The functions of the Principal Official Visitor in practice have moved well beyond this, with material developed as part of the recruitment program for the POV including descriptions of functions such as:

- To fulfil the requirements of the *Mental Health Act, 1990* by advising and assisting Official Visitors in the exercise of their functions, overseeing the operation of the Official Visitors' Program and reporting to the Minister as required;
- To advocate on behalf of consumers of mental health care, to ensure that issues of importance to their welfare are addressed properly in the hospital and health systems;
- To act as a resource person to Official Visitors with respect to current issues and developments in the mental health field; and
- To refer matters raising a significant issue of public health or safety, or raising a significant question as to the appropriate care or treatment of a client by a health service provider to appropriate authorities (such as for example, the HCCC).

A suggestion has therefore been made that the current functions be revised to recognise this broader role.

8.2.3 Visits to health care agencies every six months

Official visits to health care agencies deal in the main with inspection of records maintained at the facility and discussions with staff. Clients on community treatment orders are not residential, and so will not necessarily be present during an official visit. This suggests that there may not be a need for Official Visitors to visit these kinds of agencies so regularly. Suggestions have also been made that the requirement for six monthly visits be lifted to a longer period such as 12 months.

8.3 Patient Access to Official Visitors

Ensuring patient access to OV's is clearly a critical part of the OV provisions working successfully. Currently, section 234 allows a person detained in hospital or a person under a community order administered through a health care agency to notify the medical superintendent (or the Director in the case of a health care agency) that they wish to contact an Official Visitor. The Medical Superintendent or Director is then required to pass on that request within 2 days.

The Official Visitors Program has indicated that it is often the carer or family member of a patient who identifies the need to discuss issues with an Official Visitor. Since the establishment of a Freecall Official Visitors Phone Line, it is often the family member who makes the initial contact to draw attention to a problem that the patient is experiencing, such as not having seen a psychiatrist for an inappropriately long time. The suggestion has therefore been made that the Act should recognise the role of families and carers in obtaining support from the Official Visitors Program. This proposal would also be in line with the greater recognition for carers and family canvassed in the first issues paper of the Review, *Carers and Information Sharing*.

COMMENT SOUGHT

80 SHOULD THE ACT BE AMENDED TO ALLOW FAMILIES AND CARERS TO ARRANGE FOR A PATIENT TO HAVE ACCESS TO AN OFFICIAL VISITOR?

Part 9 : Proceedings of the Mental Health Review Tribunal

The Mental Health Review Tribunal is established under the Act as the main decision maker in a range of matters affecting patient care, detention and ongoing treatment both in hospital and in the community. The Tribunal is also tasked with reviewing and making recommendations on the detention and release of forensic patients.

This paper has already raised a number of issues for discussion which could affect both the scope of the Tribunal's role and how it does business, in particular the possibility of using the Tribunal to conduct the initial review of involuntary admissions (see 4.6) and the removal of the executive discretion over forensic patients (see 5.2).

9.1 Proceedings of the Tribunal

Chapter 9 of the Act deals with a wide range of procedural matters related to the Tribunal's operation, such as the constitution and composition of the Tribunal when exercising its various roles, procedures to be used at its meetings and rights of appearance before it. Irrespective of how the Review of the Act deals with the general questions raised in Chapters 4 and 5, ensuring the processes applied to the Tribunal are appropriate and efficient remains an important issue, and comments are sought on those matters.

As a first question, this paper seeks comments on the ongoing effectiveness of procedural processes before the Tribunal. Comments are sought in respect of all aspects of procedure, including

- provisions relating to assistance by interpreters;
- the requirement to have hearings recorded;
- the right to legal representation;
- provisions relating to access by patients to documents to be put before the Tribunal;
- representation at hearings, in particular whether victims of crime should have a right to representation at forensic reviews;
- processes for adjournments.

In addition, a number of issues have been raised in relation to some aspects of these provisions, and are discussed in more detail below.

COMMENTS SOUGHT

**81 ARE ANY CHANGES NECESSARY TO THE PROVISIONS GOVERNING THE PROCEEDINGS OF THE MENTAL HEALTH REVIEW TRIBUNAL?
IF SO, WHAT CHANGES ARE PROPOSED? WHY?**

9.2 Use of videoconferencing and teleconferencing

By using phone and video conferencing to conduct many of its reviews, the Tribunal and local mental health agencies have been able to improve access to Tribunal hearings, particularly for people living in rural and remote locations. Conferencing is also useful for emergency hearings, as they can be arranged more promptly than a full face-to-face hearing.

The introduction of videoconferencing in 1996, has been a particularly useful development for the Tribunal, as it allows the parties to see each other and interact live via a TV monitor. Video equipment includes a TV screen, a camera and microphone, which allow each end to see and hear the people at the other end of the line clearly. In the Tribunal's 2002 Annual Report, it was reported that there was 885 videoconference hearings out of the total of 7613 Tribunal hearings for that year.

While videoconferencing is used in many courts and other tribunals without specific legislative provision, in some cases, such as the Supreme Court, special provision is made to recognise the court may use this option⁶⁷. A question has been raised as to whether a specific power should be included for the Tribunal's use of such facilities (or indeed, more broadly, to cover future developments in technology). A secondary issue which has also arisen is whether such a provision should in effect *limit* when options such as video and telephone conferencing can be used. Some issues to be considered in addressing this issue include:

- The Tribunal is often making decisions which will lead to the detention or continued detention of a patient, as such consideration needs to be given to whether alternative arrangements such as tele- and video conferencing are sufficient to allow full consideration of all the necessary issues;
- In rural and remote areas, offering the option of a tele or video conference will also involve more prompt access to the Tribunal, meaning decisions on the patients future can be made in a more timely manner. Videoconferencing may also be of assistance to victims of crime who may otherwise have to travel long distances and incur expenses to attend repeated hearings;
- A study done by the MHRT⁶⁸ concluded that consumers prefer video conferencing to phone hearings. Concerns were raised that teleconferences were generally less satisfactory as the parties had no face-to-face contact and the telephone technology used by some community services did not provide the clarity required for a good hearing;
- The MHRT study also showed no substantial difference between the outcome of a face to face hearing and those conducted by videoconferencing.

COMMENTS SOUGHT

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|-----------|---|
| 82 | SHOULD THE ACT BE AMENDED TO SPECIFICALLY RECOGNISE THE USE OF VIDEO AND TELEPHONE CONFERENCING?
IF SO, WHY? |
| 83 | SHOULD THE MENTAL HEALTH REVIEW TRIBUNAL BE REQUIRED TO CONSIDER CERTAIN CRITERIA PRIOR TO DECIDING WHETHER TO PROCEED BY WAY OF TELECONFERENCE OR VIDEOCONFERENCE?
IF SO, WHY? WHAT CRITERIA SHOULD BE APPLIED? |

9.3 Requirement to give Reasons

Currently, section 280 of the Act only imposes limited obligations on the Tribunal to provide reasons in civil cases. Section 280 provides:

- Every determination or recommendation of the Tribunal must be recorded and formally signed off by the chairperson of that meeting of the Tribunal;
- The determination or recommendation must, include the reasons for the decision, but only if a party to the proceedings requests reasons to be included;
- Copies of such determinations are required to be made available to the person affected by the decision or their representative (subject to payment of a prescribed fee⁶⁹).

While the Act thus allows a right to obtain reasons for any decision of the Tribunal, it does not impose an obligation on the Tribunal to supply reasons in every case. Reasons will only be included in its written determination if a party to the proceedings (which would clearly include the patient) requests them. In practice few people have exercised this right to obtain reasons.

The question has arisen as to whether the Act should be amended to automatically require reasons to be given in every determination or recommendation of the Tribunal. Some issues to consider when addressing this question include:

- Most of the decisions made by the Tribunal involve deprivation or containment of a person's liberty, which is a serious matter. Written reasons ensure the rights of people are protected and there is transparency and accountability in the decisions of the Tribunal. This would also bring the Tribunal into line with the Guardianship Tribunal;
- While the Model Mental Health Legislation⁷⁰ provides for reasons to be given in such cases, it only does so where the person affected by the hearing, or their representative, requests the reasons, recognising that the human rights issues may be addressed sufficiently by ensuring the person has access to the reasons should he or she so choose. The Model also imposes a timeframe within which such a request should be met⁷¹, arguably equally important to protecting the individual's rights;

Consideration also needs to be given to the resource implications of such a change. The Tribunal conducts around 8,700 hearings year, 600 of those being forensic matters, in which reasons are generally given. Requiring written reasons to be automatically provided in every case would be a substantial cost impost on the Tribunal.

COMMENTS SOUGHT

- 84** SHOULD THE ACT BE AMENDED TO REQUIRE THE MENTAL HEALTH REVIEW TRIBUNAL TO PROVIDE A PERSON WITH A COPY OF ITS REASONS IN EVERY CASE?
IF SO, WHY? WHO SHOULD THE REASONS BE PROVIDED TO?

9.4 Power to Close Hearings

Section 272 of the Act gives the Tribunal the power to order a hearing to proceed in the absence of the public where a request is made to "close" the hearing by the person before the Tribunal or their representative. This provision does not however give the Tribunal the power to make such a decision of its own motion.

Sometimes people coming before the Tribunal are not legally represented. In such situations their illness may impair their ability to identify situations where hearing the matter confidentially in a closed hearing may be to their benefit and may protect their privacy. It has therefore been suggested that the Tribunal should have the power to close a hearing on its own motion.

COMMENTS SOUGHT

85 SHOULD THE ACT BE AMENDED TO ALLOW THE MENTAL HEALTH REVIEW TRIBUNAL TO CLOSE A HEARING OF ITS OWN RIGHT?
IF SO, WHY? SHOULD ANY LIMITATIONS BE IMPOSED ON THIS POWER?

Part 10 Cross Border Arrangements and other issues

10.1 Cross Border Arrangements

10.1.1 Need For Cross Border Arrangements

Each Australian State and Territory has its own legislative scheme to provide for the care, treatment and detention of mentally ill persons. The laws necessarily only apply within the borders of the state which enacted them. As a result, difficulties can arise in applying the involuntary detention laws across state and territory borders, for example:

- *Providing services under a community treatment order across a State or Territory border.* This becomes an issue in areas such as Albury-Wodonga and Tweed-Coolangatta where a person may live in one state but be under the care of a community team in another state;
- *Admitting persons from one state or territory to a hospital across the border.* Again, this can lead to persons being sent long distances to the closest “local” facility, when the nearest major psychiatric facility may be a short distance across the border;
- *Transferring a person detained in one state to a facility in another jurisdiction.* This can arise not only in border communities, but also where a person becomes ill and is admitted as an involuntary patient while on holiday in one state, and needs to be transferred back to their “home” state, to be near family, friends and ongoing care providers;
- *Apprehending involuntary patients who abscond across state borders.* While NSW has provisions that allow warrants to be issued and enforced in other states to apprehend an absconding NSW forensic patient who leaves this jurisdiction, these provisions do not extend to civil patients, nor are they available where the patient is from another state. Situations could thus arise whereby a patient can avoid apprehension simply by crossing a state or territory border.

In order to overcome these difficulties, state laws need specific provisions allowing the recognition and application of the mental health laws of other States. One of the main amendments made to the Mental Health Act in 1997⁷² was to introduce a new Chapter i to provide such a mechanism. As a result, Chapter 10A of the Act allows the Minister for Health to enter into agreements with other States and Territories to recognise interstate laws and allow them to apply in NSW.

To date, NSW has entered agreements with Victoria, the ACT and Queensland⁷³ to provide for the care and treatment of patients between these states. The Agreements provide a structure which also allows for the more comprehensive co-ordination of care across these State and Territory borders.

10.1.2 Community Treatment Orders

The current Interstate Agreements have generally only been in place for a short time⁷⁴. As such, there has only been a limited period to evaluate their operation. Two specific

provisions deal with community treatment orders under the cross border provisions of the NSW Act, namely:

Section 286M: which allows a community treatment order to be made under the NSW Act even though the affected person does not reside in NSW.

Section 286N: which allows staff of interstate health services to treat a person under an interstate community treatment order in this State

These provisions allow NSW community treatment orders to be made even though the person to whom they relate lives in another state. They also allow an order made in another jurisdiction to be administered in NSW allowing, for example, staff from Victoria to administer and enforce Victorian orders for patients living in NSW. While the Act recognises existing orders it does not allow an order covering a NSW person to be initiated in another state, or allow the NSW Mental Health Review Tribunal to make orders under an interstate mental health law where the person is in another state.

If a person's ongoing care is to occur in another state, it may be more effective to have the NSW Tribunal make an order in accordance with the other state's law. For example, a person may be in a NSW facility but will, on release, receive ongoing care in Victoria. This would be facilitated if the NSW Tribunal could make an order under the Victorian legislation, which could thereafter be administered in Victoria, by the Victorian authorities.

Similarly, if a person is admitted to a Queensland facility, but it is known their ongoing community care will take place across the border in NSW, it will arguably be more effective to have the relevant tribunal make an order under the "home state" law, ie, the NSW Mental Health Act, which can thereafter be administered under the NSW Act. In both cases, it would also be appropriate to include further amendments, to allow an order made in one state to be "deemed" an order of another state, to allow the tribunal in that latter state to make renewals of the orders.

In order to allow this to occur, a range of issues would have to be considered, including ensuring there is appropriate transfer of information to the relevant tribunal and how to ensure co-operation of health services across the border. This would include careful consideration of the differing criteria which may apply in other state laws, including recognising in some states, such as Victoria, a CTO can be issued in the community.

COMMENTS SOUGHT

86 COMMENTS ARE SOUGHT ON THE OPERATION OF CHAPTER 10A OF THE ACT;

87 SHOULD THE PROVISIONS BE EXPANDED TO ALLOW THE RELEVANT TRIBUNALS TO MAKE AN ORDER UNDER INTERSTATE LAWS?

10.2 Appeals to the Supreme Court

Currently the Mental Health Act contains a special section to deal with the jurisdiction of the Supreme Court. A person can seek the direct intervention of the Supreme Court. In addition, the Act makes decisions of both the Magistrate and the Mental Health Review Tribunal in relation to ongoing care and detention appealable to the Supreme Court⁷⁵. Since 1990 there have only been a handful of cases that have gone to the Supreme

Court, with some anecdotal evidence that this may relate to the cost of taking such proceedings.

In addition, since the Act was commenced, NSW has introduced an Administrative Decisions Tribunal, which has taken over much of the appellate work relating to NSW tribunals. The question arises as to whether the appellate role should be taken over by this Tribunal. It has been argued that the serious nature of the decisions made by these bodies, ie, the detention of an individual under civil law against their will, requires review by the most senior state court.

At the same time however, it should also be recognised that the ADT already has jurisdiction in similar cases of civil detention, in particular in relation to ongoing public health orders made under the NSW Public Health Act⁷⁶. In addition, a venue such as the ADT may well be a more accessible forum for review than the Supreme Court.

COMMENTS SOUGHT

- 88** SHOULD APPEALS ABOUT DETENTION UNDER THE MENTAL HEALTH ACT CONTINUE TO LIE TO THE SUPREME COURT?
IF SO, WHY?
- 89** SHOULD SOME OTHER BODY, SUCH AS THE NSW ADMINISTRATIVE DECISIONS TRIBUNAL HEAR APPEALS UNDER THE MENTAL HEALTH ACT?
IF SO, WHY?

10.3 Discharge Planning

Another important issue raised by the Parliamentary Select Committee related to discharge planning. Section 293 of the Act already requires a medical superintendent to do “all such things as are reasonably practicable” to ensure that the person discharged is provided with appropriate information on follow-up care which may be available.

The Parliamentary Select Committee however, heard extensive evidence that lack of appropriate follow up was having a major impact on patients’ ability to live in the community, with sometimes tragic consequences in cases of suicide. As a result, the Committee recommended:

That the Minister for Health, in relation to people who have attempted suicide and been admitted to hospital as mentally disordered:

- *propose the Mental Health Act 1990 be amended to require a post-discharge assessment appointment;*
- *the appointment be allocated and the patient informed of the appointment, and the assessment be conducted within five days of discharge.*⁷⁷

Comments are sought on this recommendation and whether it should apply more broadly.

COMMENTS SOUGHT

- 90** SHOULD SECTION 293 OF THE ACT BE AMENDED TO PROVIDE GREATER DIRECTION ON FOLLOW UP AFTER DISCHARGE?
IF SO, WHY? WHAT SHOULD BE REQUIRED?

¹ Ms Deveson chaired the Committee through its initial stages. On her resignation from the chair, Professor Ian Webster was appointed to bring the work of the Committee to a conclusion;

² *Report to the Honourable R A Phillips MP Minister for Health on the NSW Mental Health Act 1990*, Mental Health Act Implementation Monitoring Committee (August 1992);

³ The key terms of reference of the Committee were to “inquire into and report on mental health services in New South Wales and in particular: (a) the changes which have taken place since the adoption of the Richmond Report; (b) the impact of changes in psychiatric hospitalisation and/or asylum; (c) levels and methods of funding of mental health services in NSW, including comparisons with other jurisdictions; (d) community participation in, and integration of, mental health services; (e) quality control of mental health services; (f) staffing levels in NSW mental health services, including comparisons with other jurisdictions; (g) the availability and mix of mental health services in NSW, (h) data collection and outcome measures”. *Legislative Council*, 11 December 2001, 2nd Session, Minutes No.139, Item 19;

⁴ *Inquiry into Mental Health Services in New South Wales Final Report* Legislative Council Select Committee on Mental Health (December 2002), Chair’s Forward at XV;

⁵ *Report to the Australian Health Ministers Advisory Council*, National Working Group on Mental Health Policy (Model Mental Health Legislation) December 1994.

⁶ *Id.*, at p.26. The *Report* concluded that the NSW Mental Health Act directly or indirectly addressed 86% of the identified legally enforceable rights, and 68% of the “aspirational statements”.

⁷ See for example section 20, which provides an involuntary admission or ongoing detention of a person with a mental illness must also meet the criteria that “there is no other care of a less restrictive kind that is appropriate and reasonably available to the person”.

⁸ United Nations Principles for the Protection of Person’s with Mental Illness and for the Improvement of Mental Health Care (1991).

⁹ *Tracking Tragedy A systematic look at suicides and homicides amongst mentally ill inpatients*, First Report of the NSW Mental Health Sentinel Events Review Committee (December 2003) p.viii.

¹⁰ These additional provisions are:

5 Additional administrative objects of Act

- (a) to establish the Mental Health Review Tribunal, and
- (b) to provide for the appointment and functions of official visitors, authorised officers and welfare officers, and
- (c) to complement the operation of the Guardianship Act 1987, but not, except as provided by that Act, to affect the operation of that Act, and
- (d) to ensure that persons who are mentally ill or mentally disordered are informed of the provisions of this Act, and
- (e) to provide, as far as practicable, for proceedings under this Act before the Tribunal, a Magistrate or the Psychosurgery Review Board to be conducted with as little formality and legal technicality and form as the circumstances of the case permit.

6 Objectives of the Department

- (1) The objectives of the Department of Health under this Act in relation to mental health services are to establish, develop, promote, assist and encourage mental health services which:
 - (a) develop, as far as practicable, standards and conditions of care and treatment for persons who are mentally ill or mentally disordered which are in all possible respects at least as beneficial as those provided for persons suffering from other forms of illness, and
 - (b) take into account the various religious, cultural and language needs of those persons, and
 - (c) are comprehensive and accessible, and
 - (d) permit appropriate intervention at an early stage of mental illness, and
 - (e) support the patient in the community and liaise with other providers of community services.

- (2) It is also an objective of the Department of Health under this Act to ensure that patients and other persons who are mentally ill or mentally disordered are, in accordance with this Act, informed of their legal rights and other entitlements under this Act and, in so doing, to make all reasonable efforts to ensure that the relevant provisions of this Act are explained to those persons in the language, mode of communication or terms that they are most likely to understand.

7 Functions of the Director-General

- (a) to ensure that provision is made for the care, treatment, control and rehabilitation of persons who are mentally ill or mentally disordered, and
- (b) to promote the establishment of community mental health services for the purpose of enabling the treatment in the community wherever possible of persons who are mentally ill or suffering from the effects of mental illness or who are mentally disordered, and
- (c) to promote research into mental illness, and
- (d) to assist in the training and education of persons responsible for the care and treatment of persons who are mentally ill or mentally disordered, and
- (e) to make recommendations and reports to the Minister with respect to matters affecting the accommodation, maintenance, care, treatment, control and welfare of persons who are mentally ill or mentally disordered, and
- (f) to submit recommendations to the Minister concerning amendments to this Act or the regulations, and
- (g) to promote informed public opinion on matters relating to mental health by publishing reports and information concerning mental health and to promote public understanding of and involvement in measures for the prevention, treatment and care of mental illness and the care, protection, control and rehabilitation of persons who are mentally ill or who are mentally disordered

¹¹ It should be recognised that there will always be a distinction between definitions used in mental health legislation, which are designed to create a basis for determining when involuntary care and treatment can occur, and clinical definitions which are likely to be wider, being relevant to general psychiatric care and treatment, generally encompassed by the Diagnostic Statistical Manual (DSM IVR) and the International Classification of Disease (ICD 10)

¹² ie, meets the criteria of a mentally ill person"

¹³ *Caring for Health : Proposals for Reform - Mental Health Act 1990*, Discussion Paper, NSW Department of Health (1996) pp.12-13

¹⁴ id, p.12

¹⁵ It may be that different legislative regimes should be considered for these groups. In this regard, it is noted that the Legislative Council Standing Committee on Social Issues is currently reviewing the terms and effectiveness of the Inebriates Act 1912.

¹⁶ the definition was amended in 1997 by the *Mental Health Legislation Amendment Act 1997* to make reference to the continuing condition criteria clearer.

¹⁷ Section 9, Model Mental Health Legislation.

¹⁸ Section 12 of the Mental Health Act states

- (1) A person may be admitted to a hospital as an informal patient on an oral or a written application made by the person to the medical superintendent.
- (2) A person under guardianship within the meaning of the *Guardianship Act 1987* may be admitted to a hospital as an informal patient on an oral or a written application made by the person's guardian to the medical superintendent that is approved in writing by the Guardianship Tribunal constituted under that Act either before the application is made or as soon as practicable after it is made.

¹⁹ Section 17.

²⁰ So called as the form of the certificate is set out in Schedule 2 of the Mental Health Act 1990.

²¹ Approximately 55% of admissions are made by way of a Schedule 2, with the next most common admissions (24%) being by Police; *Annual Report 2001-2002 Mental Health Review Tribunal* p.44.

²² Provision for suitably qualified "accredited persons" to be appointed to write a schedule were inserted into the Act in 1997. In mid-2003 the Director-General of Health appointed 70 people as accredited persons for the purposes of being able to complete a Schedule 2 certificate. Persons so appointed have qualified for such appointment by attending a training course conducted by the Institute of Psychiatry. Preliminary feedback indicates that a higher than expected number of

Schedule's completed by these accredited persons have led to the person, the subject of the Schedule, being confirmed to be a mentally ill person on examination in hospital.

²³ See discussion of these terms at 3.2 and 3.3.

²⁴ In relation to a "mentally disordered" schedule, it must be acted on within 24 hours.

²⁵ Recommendation 97, *Inquiry into Mental Health Services in New South Wales Final Report* Legislative Council Select Committee on Mental Health (December 2002), p. 238.

²⁶ For example, section 9(4) of the Mental Health Act 1986 (Victoria) states a "request and recommendation" (by an appropriate practitioner) is "sufficient authority" for police to give assistance.

²⁷ These units are known as "gazetted units" as under section 208 of the Act, their status must be published in the Government Gazette. There are currently over 50 "gazetted units" or "gazetted hospitals".

²⁸ see discussion at 4.4.

²⁹ see section 29.

³⁰ see section 32(1).

³¹ see section 32(3).

³² Where a defendant in summary proceedings appears to be a mentally ill person, a Magistrate can order the person to be taken to and detained in a psychiatric hospital for an assessment. Any charges the person is facing in such a case will automatically be dismissed unless the person is brought back to the Magistrate within 6 months of being sent for assessment. The concern raised is that many people admitted in this way are not given a sufficiently thorough assessment, and as a result, may be inappropriately discharged back into the Community.

³³ Particularly in situations where the initial admission was made on an a non-medical assessment, such as where a person has been admitted under section 24 by Police.

³⁴ Although not, of course treatments specifically regulated by other parts of the Act, such as ECT, psychosurgery and special medical treatment.

³⁵ Section 38(1).

³⁶ Section 51.

³⁷ Section 50.

³⁸ The Tribunal is also responsible for the review of forensic patients (see chapter 5) and decisions on some medical treatments and ECT (Chapter 7).

³⁹ *Tracking Tragedy : A systemic look at suicides and homicides amongst mental health inpatients*, First Report of the NSW Mental Health Sentinel Events Review Committee (December 2003), p.20

⁴⁰ Endorsed by Australian Health Ministers Conference in April 2004.

⁴¹ Note that Article 9(4) of the International Covenant on Civil and Political Rights states *Anyone who is deprived of his/her liberty by arrest or detention shall be entitled to take proceedings before a court, in order that the court may decide without delay on the lawfulness of his/her detention and order his/her release if the detention is not lawful.* A refusal by the Executive to approve a recommendation for release may be in breach of Article 9(4), with the UK's decision to retain the executive discretion being found by the European Court of Human Rights to be a breach of a similar provision in the European Convention for the Protection of Human Rights and Fundamental Freedoms.

⁴² *Report to the Honourable R A Phillips MP Minister for Health on the NSW Mental Health Act 1990*, Mental Health Act Implementation Monitoring Committee (August 1992);

⁴³ *Caring for Health Proposals for Reform – Mental Health Act 1990* (NSW DOH, May 1996)

⁴⁴ *ibid*, p.41

⁴⁵ see sections 80(2), 81(2)(b) and 82(4).

⁴⁶ See section 90(3)

⁴⁷ *People with an Intellectual Disability and the Criminal Justice System*, NSW Law Reform Commission (NSWLRC Report 80 1996) pp.188-193.

⁴⁸ *Report to the Honourable R A Phillips MP Minister for Health on the NSW Mental Health Act 1990*, Mental Health Act Implementation Monitoring Committee (August 1992) (pp.33-34); *Caring for Health : Proposals for Reform - Mental Health Act 1990*, Discussion Paper, NSW Department of Health (1996) pp.22-24. Both recommended the provisions be revised.

⁴⁹ *People with an Intellectual Disability and the Criminal Justice System*, NSW Law Reform Commission (NSWLRC Report 80 1996) at p193.

⁵⁰ Recommendation 21, *People with an Intellectual Disability and the Criminal Justice System*, NSW Law Reform Commission (NSWLRC Report 80 1996).

⁵¹ This proposal is in line with recommendation 105 of the *Inquiry into Mental Health Services in New South Wales Final Report* Legislative Council Select Committee on Mental Health (December 2002).

⁵² Formerly Corrections Health Service.

⁵³ in cases of transferees in the last 6 months of their term, this may also include the Department of Juvenile Justice and the Department of Community Services.

⁵⁴ Recommendation 108, *Inquiry into Mental Health Services in New South Wales Final Report* Legislative Council Select Committee on Mental Health (December 2002), p.250.

⁵⁵ An order will also expire when a person is made a forensic patient.

⁵⁶ Or a continued treatment or temporary patient.

⁵⁷ in *Harry v MHRT & Anor* (1994) 3 NSWLR 315.

⁵⁸ and also under section 130, which allows Police assistance to be obtained to apprehend a person who breaches a community counseling order.

⁵⁹ The Act defines psychosurgery to mean (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 neurological procedure carried out for the relief of symptoms of Parkinson's disease.

⁶⁰ Psychosurgery Review Working Group Report, DOH, 17 May 1997, p8.

⁶¹ Ibid.

⁶² ibid, p.2.

⁶³ ie, licensed under the *Private Hospitals and Day Procedures Centres Act*

⁶⁴ the earliest reference to them in NSW Legislation is the *Dangerous Lunatics Act, 1843*

⁶⁵ In a number of rural areas, it has not proved possible to recruit a medical practitioner living in the area. As a result visits are conducted infrequently (mostly at weekends) and usually by a Sydney-based practitioner. This is not satisfactory for the patients and is a significant cost for the Program. Even in rural Areas where a local practitioner has been recruited, the distances to be travelled generally mean that the medical practitioner may not be available to travel to all hospitals and Health Care Agencies in that Area.

⁶⁶ In the 2003 round of recruitment for metropolitan areas, for example, over 200 non-medical applicants applied for 60 appointments. Amongst the unsuccessful non-medical applicants there were many highly qualified applicants with backgrounds in clinical professions other than medicine.

⁶⁷ See Part 36 Rule 2A of the Supreme Court Rules 1970 which provides in part-"The Court may give directions for and in relation to the conduct of proceedings, including the giving of evidence, by any audio-visual method or by telephone...."

⁶⁸ *Telemedicine and Justice* (1998).

⁶⁹ The prescribed fee was originally set by reference to the fee imposed under the Justices Act for copies of depositions, which had a minimum of between \$62-\$72. The fee has effectively never been imposed, as the Mental Health Review Tribunal has, to date, exercised its discretion under section 280(5) to waive these fees.

⁷⁰ In section 237(m).

⁷¹ 21 days.

⁷² Mental Health Legislation Amendment Act 1997.

⁷³ Agreements can only be entered into with those States and Territories that have enacted special interstate law recognition provisions. To date, only NSW, Victoria, Queensland and the ACT have done so.

⁷⁴ The first of these Agreements was signed in April 2002, the latest November 2003.

⁷⁵ Except for decisions made under the Protected Estates Act, where the appeal lies to the Administrative Decisions Tribunal.

⁷⁶ These orders allow for the detention, control and/or coerced treatment of persons who have certain medical conditions, which may present a public health risk if not contained or treated (ie TB, HIV/AIDS). The ADT has jurisdiction to review such orders.

⁷⁷ Recommendation 87, *Inquiry into mental health services in New South Wales Final Report* Legislative Council Select Committee on Mental Health (December 2002), p.224.