Working For Mental Health

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Director General.
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Response to the Review of the Mental Health Act 1990: NSW Health. Discussion Paper 2:

Dear Sir or Madam,

Thank you for providing the Mental Health Co-ordinating Council (MHCC) with the opportunity to contribute to the review of the NSW Mental Health Act 1990.

MHCC is the state peak body for non-government organisations (NGOs) working for mental health throughout NSW. MHCC represents the views and interests of over 140 NGOs in the formation of policy, and acts as a liaison between the government and non-government sectors. Our member organisations specialise in the provision of rehabilitation services and support for people with a disability due to mental illness. In developing this submission, MHCC has consulted member organisations, consumers, carers and other stakeholders.

MHCC is the peak
Body for mental health
Organisations in NSW
Funded by NSW Health

Part 1: Review of the Mental Health Act 1990

MHCC supports this review of the Mental Health Act 1990. MHCC has been working to progress the ongoing discussion and implementation of the recommendations of the Mental Health Inquiry and other relevant issues. As part of this process, MHCC established a number of working groups. MHCC has sought a wide range of views in the development of this submission. We have consulted with member organisations, our working groups, consumer representatives, carer representatives and other stakeholders.

Part 2: Objects of the Mental Health Act 1990

Q1 & 4 Objects of the Act

MHCC notes that the key focus of the objects clause is to incorporate the spirit of the Act and to set the general parameters of the Act, thus giving guidance and assistance in how the more detailed provisions of the Act should be interpreted.

MHCC supports this concept of overarching guidance. We feel that the objects of the Act should be expanded to include the suggested additional objects contained on page 6 of Discussion Paper 2. In addition, MHCC would like to see the following changes and additions:

- The roles, contributions and needs of carers should be included;
- The word "control" should be deleted. Consultations facilitated by MHCC have identified that while people are happy with the words "care" and "treatment", there is strong resistance to the use of the word "control" within the Act. As key beliefs inherent in the Act focus upon a sense of care and support, the word "control" was cited as being forceful, dominating and limiting in scope. Suggestions for alternatives included "protection" and "support". MHCC believes that these terms promote a sense of progressive care and recovery rather than merely enforcing restraint;
- Consumer participation and access to consumer advocacy should be included within the objects. MHCC believes that consumer participation is an essential part of developing and maintaining service delivery standards and ensuring that the Act remains meaningful and relevant to human services;
- Consumer rights need to be recognised as paramount and should be included within the objects clause;

- The needs of children whose parents are affected by a mental illness require recognition and support within the Act and should be included in the Objects.

Q 2&3 Least restrictive alternative

During MHCC consultations, high levels of concern were expressed by carers and other stakeholders about the concept of "least restrictive environment/alternative". People were very concerned about instances, similar to those highlighted in the Tracking Tragedy Report, where they felt that the Act had been misinterpreted with an emphasis on providing the least restrictive environment/alternative without also providing the best possible care and treatment. This resulted in inadequate supervision and treatment, often with tragic outcomes.

MHCC supports the view of the Mental Health Sentinel Events Review Committee 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. We feel that problems in managing the care of persons with a mental illness are due mainly to inadequate resources and inadequate education of clinicians regarding the intentions of the Act.

Consequently MHCC does not think that it is necessary to change the Act. Rather it is essential that a comprehensive education program is provided for all stakeholders in relation to the essential nature of safety, duty of care and the provision of best practice care and treatment in the least restrictive manner that is consistent with the provision of that best practice care and treatment. It is also essential that services are resourced adequately so that service providers and clinicians have both the education and the resources to be able to provide the level of care and treatment essential in achieving positive outcomes, including the facilitation of rehabilitation.

There was also concern expressed at MHCC consultations that consumers were often released from hospital into the community so as to receive the "least restrictive care" without there being sufficient support and rehabilitation services in the community to address their mental health needs. It was strongly felt that a major increase in resources in the community based sector was required in line with best practice principles of community integration and recovery.

Part 3: Mentally Ill and Mentally Disordered Persons

Q.5 Definition of "mental Illness" used in the Act

MHCC supports the concept of basing the definition of mental illness on signs and symptoms rather than on diagnosis and supports the retention of

that practice in the Act. However, there has been widespread support at MHCC consultations for the Act to be expanded to include personality disorders in the hope that this would assist people with personality disorders in being able to access treatment.

Q.6 Inclusion of "personality disorders" in the definition?

As indicated above, many stakeholders attending the MHCC consultations felt strongly that the definition of mental illness used in the Act should be changed to include personality disorders.

They felt that the change should be made as the current exclusion of personality disorders from the definition has been a contributing factor in many services not offering treatment to those with personality disorders. Whilst it was recognised that within the Act definitions of "mental illness", "mentally ill person" and "mentally disordered person" are used to determine whether a person can be involuntarily admitted and treated for a mental illness or condition, it was felt that the Act was more broadly concerned with the care and treatment of the mentally ill and that in this wider sense, it was important to ensure that people with personality disorders were also entitled to receive equal access to treatment and care as afforded to those with other disorders.

MHCC supports basing the definition of mental illness in the Act on signs and symptoms rather than illnesses, however it was not clear to many stakeholders at MHCC consultations whether the list of symptoms seen in the Act to characterise the presence of a mental illness adequately captured the presence of a personality disorder. It was felt that the signs and symptoms should be amended to include more features that relate to personality disorders.

It was noted by attendees at MHCC consultations that, whilst in 1990 personality disorders were considered untreatable, this is no longer the case. Treatments such as Dialectical Behaviour Therapy[1] have been shown to be effective in treating some people with these conditions. Treatment of personality disorders is often considered to be difficult, expensive and time consuming.

However, the right of all people with mental illnesses to access treatment was felt to be very important, even if some of those people are viewed as being difficult to deal with and the treatments regarded as time consuming for clinicians. It was also noted that the ongoing, multifaceted costs

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[1] **Linehan, M.** (2003). *Dialectical Behaviour Therapy (DBT) for Borderline Personality Disorder.*[Available] http://www.dbtselfhelp.com/html/linehan_dbt.html [Accessed 25/11/2004]

associated with not treating people with personality disorders would be higher than the costs incurred by treatment.

MHCC supports the above concerns raised by member organisations and other stakeholders and strongly recommends that additional resources should be made available for the treatment and support of people with personality disorders. This should include resources for community based treatment as well as education and support for clinicians and community based staff.

Q.7 Inclusion of "Anorexia Nervosa" in the definition of mental illness?

MHCC supports practice of basing the definition of mental illness on signs and symptoms rather than diagnosis. Therefore we do not support the inclusion of Anorexia Nervosa in the definition of mental illness. MHCC is in agreement with the view of the Mental Health Review Tribunal, (as quoted in NSW Health, "Review of the Mental Health Act 1990, Discussion Paper 2) 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 harm) would allow them to be detained and treated.[2] However, MHCC notes that there is often confusion and uncertainty on the part of clinicians in relation to this issue. Consequently we recommend that an education program should be provided for clinicians to clarify these matters. MHCC would also like to see that any educational programs provided in relation to mental health are also made available to staff of non-government organisations

Q. 8 Appropriateness of the definition of mentally ill person

MHCC feels that there is a need to clarify what is meant by "serious harm". Attendees at MHCC consultations felt that serious harm should not be restricted to serious physical harm only. They felt that it should also include serious harm to reputation, financial harm and the serious harm resulting from severe self-neglect.

Many attendees at MHCC consultations also suggested that within the Act the term "mentally ill person" should be replaced by the term "person with a mental illness" as this better accommodates the episodic nature of many mental illnesses and also does not define the person solely in terms of mental illness. Attendees felt that in many instances it was necessary for

[2] **NSW Health,** "Review of the Mental Health Act 1990, Discussion Paper 2: The Mental Health Act 1990", July 2004. p. 8

the Act to refer to a person with “acute mental illness”. This would refer to the times of severe illness when a person needs to receive care in hospital.

Q.9 Appropriateness of provision for short-term detention of “mentally disordered persons”

MHCC agrees that the provision within the Act for short-term detention of “mentally disordered persons” remains appropriate. However many attendees at MHCC consultations expressed concern that the three day period was an inadequate period of time for the following to occur:- for the mentally disordered person to be able to recover from the distressing episode; for clinicians to be able to accurately assess the person; and for clinicians to work with the consumer in planning and implementing comprehensive care, including planning for follow-up and support in the community and linking with appropriate community based organisations.

MHCC is supportive of the above concerns related to the need to allow for proper assessment and treatment planning and acknowledges that these processes require adequate time. In order to maintain consumer protection and rights, MHCC recommends that, where clinicians feel that there is a need to detain the mentally disordered person for a longer period of time, there should be provision for an application to be made to the Mental Health Review Tribunal.

There were differing views at MHCC consultations regarding whether the exclusion of weekends and public holidays from the three day period should be retained. Many felt that, based on their experience, it was helpful to be able to access a longer period of time for the reasons identified above and also to provide a short period of respite for exhausted, stressed carers. However others felt that the words “not including weekends and public holidays” should be removed so that a mentally disordered person could be detained for three days – regardless of whether those days fell on weekends or public holidays.

Concern was also expressed at consultations that mentally disordered persons are sometimes detained longer than is necessary when their period of detention includes a weekend as it was reported that some registrars, who are on duty on the weekend, are reluctant to discharge someone that the consultant has assessed on Friday as needing to remain in hospital over the weekend.

Mental health services need to provide adequate clinical coverage on weekends and public holidays to ensure that some individuals are not unreasonably detained against their will as a result of resource allocation rather than clinical judgement.

Q. 10 Appropriateness of the definition of mentally disordered person

MHCC and member organisations consulted feel that the definition of "mentally disordered person" should be expanded to include protection of self and others from serious danger to reputation, serious financial harm and serious harm resulting from severe self-neglect, in addition to serious physical harm.

Q. 11 Prevention of inappropriate detention

The MHCC and member organisations consulted agreed that Section 11 of the Act remained relevant and was needed so as to prevent a person being inappropriately detained as mentally ill or as a mentally disordered person.

Part 4: Admission To and Care in Hospitals

Q 12 Discharge arrangements for voluntary patients under guardianship

In view of the fact that persons under guardianship have 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, it is MHCC's view that different discharge arrangements should apply for voluntary patients under guardianship. The person's guardian should be contacted and proper discharge arrangements should be made before the person is discharged into the community.

Q 13 Police assistance

In the interests of both persons requiring transportation to hospital and the resources of the NSW Police force, MHCC believes the NSW Mental Health Act should follow the provisions demonstrated in Victoria and South Australia that authorise Police to take part in transportation rather than requiring their involvement.

During MHCC consultations, attendees recognised the need for police involvement in some transportation situations, however much concern was expressed regarding the constant use of Police for transportation of people with mental illness. While frequently expressing appreciation for the kindly and humane manner of many police, attendees were concerned that police involvement increased issues of stigma and connotations of criminal behaviour aligned with mental illness.

Due to Occupational Health and Safety concerns as well as the safety of the consumer, MHCC believes it is important that police are involved in the admission process where there are concerns about high levels of aggression and risk of harm. It is also important that the police receive training in mental health .

Q 14 Risk assessment

It would be helpful to have a risk assessment completed. MHCC feels that the person authorising the schedule should have undergone sufficient training to be in a position to determine the level of risk involved.

Q 15 Restraint and sedation

MHCC supports the proposed amendments concerning the transportation of a person to hospital, the use of restraint, sedation and the ability to search a person for materials or substances which may cause harm to the person or those assisting transportation. Establishing clear provisions for authorisation of transportation, restraint and sedation would provide a practical means of assessing any risk factors involved whilst including and defining the use of health professionals and Ambulance officers. MHCC further supports a clarification of the roles of both Ambulance and Police officers regarding their ability to search a person to remove such objects as may impede the safe transportation of the person, for all involved.

Q 16 Ambulance service

Additional amendments to the act to recognise the role of the NSW Ambulance service and Ambulance officers we believe would also clarify the important functions the Ambulance service already performs whilst further recognising and promoting mental illness as a health issue rather than a criminal or justice issue. The authorisation of Ambulance officers to assess and transport a person that they have reasonable grounds to believe to be mentally disturbed would provide a more active and comprehensive support service for people requiring immediate care and assistance. However, safety concerns in relation to the person being transported and the ambulance officers would need to be addressed. Additional training in mental health would be required. MHCC would also like to see the use of ambulances that meet the safety needs of people with mental health problems.

Q 17 Section 21 and 22

In regard to other changes required within the provisions for filling out a schedule (Section 21 &22), MHCC supports the use of a telephone examination by a medical practitioner or accredited person to be authorised

in emergency situations with an attendant clause requiring some form of face to face examination to be completed within a designated time frame.

Discussion Paper 2 does not provide adequate clarity in relation to the authorisation of medication by telephone, on the evidence of a Nurse or a Police Officer. MHCC has concerns regarding the way in which this would operate. For example who would administer the medication? If they are in a remote area, where would they get urgent medication from ? Until issues such as these are clarified, it is difficult to comment.

In relation to the question regarding whether general practitioners should have to seek advice from a mental health advisory service before completing a schedule, MHCC feels that they should not have to seek advice, rather they should have the option of seeking advice. In addition MHCC supports education and training programs for general practitioners within the area of mental health, particularly in rural areas.

Q 18 Detention and scheduling

MHCC strongly recommends that there should be sufficient mental health resources so that carers can ask for help from mental health professionals who can provide assistance and make the decision regarding the necessity for scheduling. Attendees at MHCC consultations commented on the negative effect on the relationship between the consumer and the family when the family had to make a decision to schedule the consumer.

Q 19 Emergency Departments

MHCC supports the use of emergency departments as gazetted units in order to allow persons affected by mental illness optimum access to effective health care services for both their emergency mental and physical health needs. Such use is supported on the proviso that further processes are implemented to provide purpose built rooms for the specific care and treatment of persons affected by mental illness.

Q 20 Psychiatric emergency centre

MHCC supports an amendment of the Act to allow admission to hospital via a psychiatric emergency centre. A specially designated psychiatric emergency centre, linked to the emergency department would be ideal as it would provide the necessary range of medical and psychiatric expertise in an environment that facilitates flexibility and an immediate response.

In relation to admissions generally, the point was made frequently at MHCC consultations that many admissions would not be needed if there were better community services, more early intervention and more emphasis on responding to families' needs when they asked for help.

Q 21 & 23 Initial assessment

MHCC acknowledges both the limited availability of psychiatrists and the recurring instances of inexperienced and inadequately supported registrars and interns making poorly judged decisions. We support the idea of focussing on the skill set necessary to make a proper evaluation of a person's mental state, rather than starting from the perspective of professional boundaries. We support the introduction of skills-based criteria in the act and the authorising of persons endorsed with such skills to conduct initial examinations.

Attendees at MHCC consultations nominated a Mental Health Clinical Nurse Consultant and/or a Mental Health Nurse Practitioner, in combination with a Psychiatric Registrar, carrying out a joint assessment, as suitable clinicians to conduct the initial examination at hospital. MHCC supports this suggestion with the proviso that the above clinicians receive appropriate ongoing education and clinical supervision.

Q 22 Psychiatrists and registrars

In addition to the points made above, MHCC feels that psychiatrists should be more involved, particularly in overseeing the assessments and treatments provided by registrars, especially junior registrars and interns. Carer consultations suggested greater involvement of psychiatrists in assessments carried out on admission and prior to discharge would be advisable.

Q 24 Initial examination

MHCC does not agree that the period within which the initial examination must be conducted should be longer than 12 hours. The 12 hour period should remain as it is a significant safeguard for consumers. MHCC does not support any weakening of existing safeguards. If the number of clinicians authorised to conduct initial assessments was expanded as suggested by MHCC in **Q 21, 22 and 23**, it would be easier to maintain the 12 hour time limit set for initial examination.

Q 25 Bicultural mental health consultant

In the interests of promoting greater access and more effective services within the field of mental health, MHCC supports the suggested required use of a bicultural mental health consultant when a person is from a culturally and linguistically diverse background. MHCC acknowledges the requirement of extra resources needed to facilitate such a broad coverage. However, we believe this measure would significantly enhance care and treatment services available for all persons affected by mental illness.

Q 26 Consent to treatment

MHCC supports a review of the processes involved in the authorising of non-psychiatric care and treatment for involuntary patients. The proposed treatment should be explained and the patient given appropriate opportunity to provide consent. If the patient is unable or unwilling to consent, his or her guardian, if the patient has one, should make the decision on the patient's behalf. If the patient does not have a guardian, or the guardian cannot be contacted, the matter should be heard and decided by the Mental Health Review Tribunal.

Q 27 Consent to medication

MHCC agrees that a guardian should retain the ability to consent to medication for the person, while the person is involuntarily detained in a hospital. The patient's consent should be firstly sought. The guardian should also be notified regarding any changes or developments, such as transfer, leave or discharge.

Q 28 & 29 Detention of mentally disordered persons

A suggestion was made at MHCC consultations that the provisions be adjusted to allow 2x5 day detention periods within each month as opposed to the current 3x3 day periods. The reason for the lengthier time frame per admission was that the longer time allows for a more comprehensive assessment of the detained person than a 3 day period.

Another suggestion at the consultation was that the time limits should be removed completely, with the consumer being able to access care, protection and treatment in a psychiatric unit if they are suicidal or seriously out of control and are a danger to themselves or others, with the decision to admit or discharge being based on individual need and clinical judgement.

Attendees at MHCC consultations felt strongly that adequate time is essential in order to enable clinicians to effectively assess a person's condition and carry out their duty of care to prevent a patient from self-harm or from harming others. Clinicians also need adequate time to develop and implement a comprehensive treatment plan. Good discharge planning and linkage to community based supports is also essential in order to facilitate recovery and reduce frequent readmissions.

MHCC supports the above suggestions and highlights the need for increased resources for treatments such as Dialectical Behaviour Therapy, which appears to be helpful in treating many people with personality disorders. If time limits were abolished, persons detained as mentally disordered persons should be able to appeal to the Mental Health Review Tribunal if they disagree with their detention.

Q 30, 31, 32 & 33 Mental Health Review Tribunal and Magistrate
MHCC recommends that the Hearings currently being carried out by the Magistrate should be transferred to the Mental Health Review Tribunal sitting as a three member multidisciplinary panel. This approach has many advantages. It represents best practice by incorporating a multidisciplinary focus into an independent, impartial tribunal with at least one member being an independent, qualified mental health clinician. This approach complies with United Nations Principle 17.1, which states that the review body should be "a judicial or other independent and impartial body", which will "in formulating its decisions, have the assistance of one or more qualified and independent mental health practitioners and take their advice into account"

The above approach was strongly supported by many attendees at MHCC consultations. They expressed the view very strongly that people with mental illness are not criminals and, as such, should not be seen by the Magistrate who is part of the legal system. They reported feeling a strong sense of stigma associated with appearing before a Magistrate.

Conversely, very strong support was given by carers and consumers for transferring initial hearings to the Tribunal, sitting as a three member panel. Carers and consumers at MHCC consultations viewed the Tribunal as being much less intimidating and traumatic than going before the Magistrate. They saw the Tribunal as more supportive and understanding as well as more focussed on the needs of the consumer. The tribunal was also seen as providing the opportunity for detailed and fair discussion with various viewpoints being considered before a decision was made.

It was also considered important that the initial review process should incorporate a focus on the needs of the consumer for comprehensive treatment and care. It was felt by people at MHCC consultations, that the Tribunal was ideally placed to incorporate this focus. However, the Magistrate was viewed as not having sufficient expertise in mental health to be able to incorporate this focus.

Another major concern in relation to Magistrates' hearings is the fact that approximately half the hearings are adjourned. This results in the person being detained involuntarily but without the right to appeal to the Tribunal or the Medical Superintendent for discharge.

Face to face hearings should be carried out wherever possible in order to provide optimum conditions for a holistic, accurate review. Video conferencing is recommended as being the only other acceptable form of conducting hearings when the Tribunal is unable to meet the person face to face. MHCC feels that telephone hearings are inadequate in providing a comprehensive and fair review. This issue was raised frequently in MHCC

consultations, with many consumers and carers expressing the view that every attempt possible should be made to conduct hearings in person in order to accurately assess the person in a holistic manner.

MHCC acknowledges that an increase in resources would be required to enable the Tribunal to oversee the initial review process in the manner outlined above, however, we feel that this is very important in the interests of achieving greater levels of fairness and expertise within the review process.

Q 34, 35 & 36 Leave and transfer provisions

MHCC supports the use of leave provisions to gradually assist consumers in their reintegration back into the community after acute illness. Many carers, consumers and community based workers at MHCC consultations felt that long stay patients required greater flexibility in their leave provisions to avoid the high risk of relocation trauma upon release back into their communities. Ideally hospital stay should be as short as possible with flexible provision of rehabilitation and support provided in the community to the level of assessed need.

MHCC agrees that there should be greater consistency between the treatment of all persons who are involuntarily detained, whether before or after their appearance before a Magistrate.[3] This should ensure that all involuntary patients are allowed transfer for medical care if needed. Within these guidelines, attendees at MHCC consultations supported the use of discretion by the medical superintendent in regard to decision making related to the transfer of patients.

Q 37 Use of "reasonable force"

The use of "reasonable force" is generally advised to be permitted only in cases where the person is at risk of harming themselves or others. The boundaries of "reasonable force" should be clearly defined and respected. Further, the emphasis in the apprehension of an absconding patient should be on returning the patient for necessary care, protection and treatment in the most humane manner possible. It should be viewed as a health issue not a criminal justice matter.

Q 38 & 39 Access to firearms

MHCC agrees that the Mental Health Act already allows discharge to be refused if the person is considered to be a "mentally ill person". That is a person who is in need of care, treatment or control for their own protection or the protection of others from serious harm. However, there appears to be some confusion and uncertainty regarding this on the part of some service providers and clinicians. Therefore MHCC recommends that an intensive

[3] Please see Q 30,31,32&33 and note that MHCC would prefer the review by the Magistrate to be carried out by the Mental Health Review Tribunal.

education program be devised and carried out in relation to this important issue.

MHCC also supports the requirement that a responsible clinician who is concerned about a patient's access to firearms should contact the police at the nearest Local Area Command.

Q 40 Role of police

MHCC supports police having the necessary legislative power to seize a weapon when a mentally ill person who is at high risk of harming self or others has access to that weapon.

Part 5. Management of Forensic Patients under the Act

5.1 Categories of Forensic Patients

The legislation currently provides for five categories of forensic patients. Categories 1, 2, 3 are those that refer to persons determined under the terms of the Act to have diagnoses. Categories 4 & 5 refer to inmates who become mentally ill or have been referred. However category 4 refers to those who have pleaded guilty, and category 5 refers to those who may not have been through the court process and may not have been given a diagnosis and may be able to go back to the court.

Therefore, is our view, that it is necessary to establish 3 different categories to allow for different approaches to the management and care of these groups in respect to security, leave, release, prison status and transfer provision. Those currently in category 1, 2 or 3 would be in the proposed category 1. Those currently in category 4 would be in the proposed category 2. Those currently in category 5 would be in the proposed category 3. People on remand would also be considered under the proposed category 3.

We also wish to express the view that we do not believe that anyone with a mental illness should be in jail. This is not a suitable environment in which a person with a mental illness can receive the appropriate treatment required.

With regard to forensic patients, the Act should be developed in the context of effective treatment with an emphasis on relapse prevention and recovery.[4] [5]

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[4] **Rickwood, D.** Pathways of Recovery: Preventing Relapse, 2004, National Mental Health Promotion and Prevention Working Party, Australian Government.

[5] **Anthony, W.A.** A Recovery-oriented Service System: Setting some system level standards, 2000, *Psychiatric Rehabilitation Journal,* 24(2), 159-168

Q 41 Categories of forensic patients

MHCC supports amendment of the Act in relation to categories of forensic patients, however we support the formation of three categories, as this allows for differing appropriate approaches to be instituted**.** This measure was raised by attendees at MHCC consultations and received strong support.

5.2 Executive Discretion in relation to the Release of Forensic Patients.

The reason for retention of executive discretion centres around the concept that the Mental Health Review Tribunal deals with issues of a clinical nature, and is not constituted to consider broader community issues, which are the province of the executive. It is our view that the amendment of Mental Health Acts in other states, and information from overseas provides evidence that this is an unfounded claim, based on the desire for the government to maintain control of the law and order agenda. To counter this argument we question whether the executive has the capacity to make a clinical decision.

We support the establishment of a two tiered structure as the most appropriate decision making process 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.

It was felt that the Supreme Court as an impartial body with a superior ability to review evidence would result in a greater likelihood of justice being done as well 'being seen to be done.' Support was expressed for this two tiered structure at MHCC consultations. However concern was raised in relation to the potential cost to forensic patients or carers of referring matters to the Supreme Court.

Q 42 Release of forensic patients

- Yes, because it is not a political decision to be affected by media propaganda, misinformation and stigma about mental illness and risk to public safety.
- Decisions about forensic patients' releases should be made by the Tribunal with appeals possible through the Supreme Court. This would then be a transparent process. The executive as well as the forensic patient could make such appeals.

- During MHCC consultations the point was made that forensic patients were often held for a longer period than they would have been had they been found guilty.

Q 43 Role of Tribunal

- In this revised system, the Tribunal should be designed to be an autonomous body that would report to the Supreme Court.
- They should also make decisions about routine transfer and review of leave provision.

5.3 Public safety criteria for recommendations of the Tribunal.

The Tribunal works from the premise that, when releasing a patient, the safety of members of the public will not be "seriously endangered" by that person's release. Whilst this seems a reasonable statement it is surely a question of interpretation. There needs to be more discussion and clarification around these issues.

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Evidence based practice highlights that recovery is inhibited if rehabilitation needs fail to be met. Mental illness is currently treated in jail primarily with medication. There is little access to psycho-social support. Until such needs are met within correctional services, and access to community services made available post release, recovery will continue to be hampered by the environment and length of incarceration making release recommendations all the more problematic.

MHCC strongly supports the improvements planned for forensic patients in NSW. We feel that it is essential that comprehensive forensic mental health care, with an emphasis on recovery and with strong links to community based treatment and support networks for forensic patients when they are released, is instituted for all prisoners with mental health problems. This issue was raised as being of crucial importance at MHCC consultations.

Q 44 Level of risk

MHCC supports consideration of level of risk. As persons progress through the system they should be re-categorised according to their level of risk

If a forensic patient is still suffering from mental illness and needs to be held in a secure environment, MHCC believes that this should be the least restrictive environment possible, depending on the level of risk.

Q 45 Leave considerations

Yes, similar guidelines to those outlined in Q 44 should be applied to leave considerations.

Q 46 Notification regarding proposed release
MHCC recommends that the Tribunal should make decisions in relation to the release of forensic patients. As part of this process the Tribunal should decide who needs to be notified. Those who are notified should present their concerns to the Tribunal so that they can be considered by the Tribunal.

Q 47 Victims of crime
Victims of crime should receive support and appropriate treatment where necessary. Attendees at MHCC consultations felt that it was preferable that the victim was not at hearings as this caused more distress for the patient and made recovery more difficult.

Q 48, 49, 50, 51 Transfer and Review of Mentally ill Prisoners in Hospitals

Yes. There should be a time-limit to validity of certificate, so that if a person is well, they should not spend longer in a hospital than is necessary. However every effort should be made to ensure that the person receives comprehensive care and treatment as needed.

Q 52 Juveniles in the forensic system
Yes, there should be special facilities and programs available to juveniles that address their specific needs.

Q 53 Conditions for conditional release of forensic patients
MHCC does not support the setting out of a list of conditions. We would prefer to see an individual care plan developed by the clinical team and reviewed by the Tribunal, with a limiting term that should be inclusive of any time on unconditional release. This should be in line with evidence-based practice.

Q 54 Conditions for conditional release
MHCC feels that the preferred model would be for the clinical team to devise a comprehensive care plan, which included links to community based mental health facilities. This plan would then be reviewed by the Tribunal.

Q 55 Interagency cooperation
Yes. The act should recognise interagency cooperation and planning for forensic patients. Therefore special services need to be established in the community. These should include experienced forensic case managers who support and recognise transitional needs, ensuring maximum potential for rehabilitation.

Q 56 Exit and transition planning
MHCC feels that exit and transition planning is an essential part of comprehensive treatment and care. We advocate strongly that this planning should include linking the person to community based treatment and support.

MHCC would also like to raise the following related matter. During MHCC consultations, the issue was raised as to the availability of a transition process, following a patient's time as a forensic inpatient. This process would need to recognise, as a human rights issue, non-inmate status. It was thought that the process should also include a registry of persons in forensic health monitored not only to assess their support needs, but to acquire research data as to readmission into forensic facilities.

Q 57 Breach of release
The Tribunal should have determining powers. Currently in instances of breach of release a patient is often sent to a correctional facility rather than a hospital. MHCC feels that the patient should be taken to a hospital or gazetted emergency department for a mental state assessment. MHCC also believes that there must be flexibility related to reasons for the breach occurring.

Q 58 Less serious breaches
MHCC recommends that alternative processes should be allowed for less serious breaches. Assessment should be made on an individual basis. Each case should be brought before the Tribunal.

Part 6 Care and Treatment Outside Hospital

Q 59 Community treatment orders and community counselling orders
MHCC believes that Community Treatment Orders and Community Counselling Orders should be consolidated into one order. The newly amalgamated order should be renamed. Importantly, the new order should reflect the strengths of Community Treatment Orders and Community Counselling Orders. Currently, Community Treatment Orders are not sufficiently linked into care planning and rehabilitation.

The new order should reflect a more holistic approach to prevention, treatment, counselling and support. If the Act was not changed to consolidate Community Treatment Orders and Community Counselling Orders into one order, Community Treatment Orders should be amended so they have a closer link to the broad range of rehabilitation and recovery services offered by NGOs. There was widespread support for the above approach in MHCC consultations.

Q 60 Initiating an order in the community

MHCC believes that the Act should be amended to allow orders to be initiated in the community. A potentially positive benefit from this is that orders could be structured to have a stronger link to early intervention and community management. (This is perhaps in line with the original intention of Community Counselling Orders.) If the Act is to be amended to allow orders to be initiated in the community, particular care should be taken to ensure that the process of issuing orders is not abused.

We agree with Discussion Paper 2 which argues that "the standard applied (to issuing orders in the community should) not (be) lower than that which operates when a CTO is made in an institutional setting" (p. 38). Guidelines should be developed so that orders are issued and used appropriately. Mental health staff should receive training to assist them to understand the process of initiating orders in the community.

MHCC would like to see an additional level of protection and stringency in this process. We strongly recommend that orders should be authorised by the Tribunal. Attendees at MHCC consultations expressed the view that, without this, there may be a risk that orders could be misused as a form of inappropriate control over mental health consumers living in the community.

MHCC believes the Act should consider which staff should be able to initiate a community order. Some workers may face the dilemma of initiating an order for a consumer for whom they are providing support. Attendees at MHCC consultations felt that such a situation could present a significant conflict for that particular staff member.

Q 62 Community orders for a person in prison

As a general principle, MHCC believes that community orders should be able to be initiated for a person who is in prison. In addition, we believe that the Act should ensure that an inmate's mental health and community support needs are comprehensively assessed prior to release. Such an assessment, followed by referral to community support services, would reduce the likelihood of relapse and assist client to integration into the community.

Q 63, 64, 65 Community orders
MHCC believes the suggestion in Discussion Paper 2 that "a medical practitioner should be required to give evidence that the affected person is likely to become a mentally ill person within 3 months if the order is not renewed" (p. 39) is appropriate. In addition, we also believe that a decision to renew a community order should be based on input from the consumer, carers, family members, mental health workers and community support workers.

MHCC believes that the Act should not be amended to extend orders from six to 12 months. We see the six month order as an important safeguard for consumers. This position received support at MHCC consultations. As one of our members told us, from the consumer's perspective, a six month order means there is always 'light at the end of the tunnel'.

Q 66 Discharge reports
MHCC supports the proposal that sections 126 and 136 be revised. MHCC does not believe it is appropriate that discharge reports be written for the Director General of the Department of Health.

Rather, we believe the Act should be amended to alter the focus of discharge reports. Firstly, discharge reports should examine and describe the effectiveness of the community order. This should take into account the views of various parties, including the consumer, carers, community mental health staff, psychiatrist, and community support workers. Secondly, discharge reports should have a strong focus on future care plans and case management and be forwarded to consumer's case manager and/or psychiatrist.

Q 67 and 68 Breach of community orders
MHCC believes that it is important that the Act maintains provisions for three notifications before a breach is issued unless there are safety concerns. People at MHCC consultations felt that there may be mitigating circumstances that need to be taken into account. It was also felt that consumers should have the opportunity to demonstrate their willingness to follow the plan.

Due to Occupational Health and Safety concerns as well as the safety of the consumer, MHCC believes it is important that police are involved in the breach process where there are concerns about high levels of aggression and risk of harm. It is also important that the police receive training in mental health .

Q 69 and 70 Review of person admitted on breach of community order
MHCC strongly believes that a person admitted on breach of a community order be reviewed within a 12 hour period. The Act should clarify the purpose of the review and the responsibilities of the treating hospital team with regard to the review.

We also believe that a person admitted on a breach of a community order be reviewed by the Tribunal as soon as practicable. This is important to ensure that the person's civil and medical rights are upheld. The Mental Health Tribunal is the appropriate forum to independently review the person's needs.

Q 71 Continuity of community order
MHCC does not believe that a community order should automatically expire on involuntary admission to hospital. We believe the Act should allow for community orders to continue post-discharge as this is less likely to disrupt a person's care.

General comments
As a general principle, MHCC believes that proposed amendments to the Mental Health Act, 1990 should be supported by the latest evidence. Any changes to the Act, such as consolidating Community Treatment Orders and Community Counselling Orders, or introducing Community Treatment Orders for prisoners prior to release, should be backed by evidence and incorporate key findings from other jurisdictions, such as Queensland and Victoria.

Part 7: Medical and Therapeutic Treatments

Q 72 Psychosurgery
MHCC is aware of the arguments against the use of psychosurgery, however we also note the conclusion of the Psychosurgery Review Working Group, that psychosurgery can be effective for "a very small and specific group of patients suffering from some chronic, disabling and treatment resistant psychiatric illnesses."

MHCC feels that this group of consumers should not be disadvantaged by the prohibition of a form of treatment that may give them relief from the severe, long term distress caused by their mental illness. Any consideration of psychosurgery would have to come with the proviso that rigorous measures are put in place to ensure that consumers are fully informed of their rights, options and possible consequences of the procedure and that any consent is a genuinely informed consent.

Q 73 Psychosurgery

MHCC supports the following recommendations of the Psychosurgery Review Working Group:

- Persons incapable of giving informed consent and patients under the age of 18 should be ineligible for psychosurgery;
- Psychosurgery should not be available for the treatment of 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.

In addition to the above recommendations, MHCC would like the Psychosurgery Review Board to include persons who, in addition to having a thorough knowledge and understanding of all current methods of treatment available, are also expert in new and emerging treatments, which may be effective in treating the consumer who has not been helped by previous treatments and who is now considering psychosurgery.

MHCC recommends that, in the above situation, the Review Board should ensure that the consumer is informed about any new, safe treatments available, and is given the opportunity to trial them before making the decision to proceed on to psychosurgery.

Q 74 ECT

During MHCC consultations concern was expressed about the suicide risk that occurs when patients who have been very depressed and lethargic are treated with ECT, and, as a consequence, become less lethargic and more active while, at the same time, remaining depressed and suicidal. The concern is that the person becomes more able to plan and carry out a suicidal act during the initial stages of treatment and that there is insufficient awareness, care and protection of the consumer by clinicians.

The view was expressed that, because of this risk, people receiving ECT should be treated as inpatients and provided with close observation and support until the period of risk had subsided.

Other issues raised during MHCC consultations were: the need for consumers to be informed about how long the treatment team felt that the course of ECT needed to be; the need for a prompt appeal process for consumers when they feel that the treatment is not working for them; the need for strict monitoring of long term ECT; and the need for a comprehensive review of ECT in the private mental health system.

MHCC notes that the last point will be even more crucial if private hospitals are allowed to admit and detain people for involuntary treatment as discussed in Part 8 of the discussion paper.

Q 75 ECT

MHCC feels that the length of a course of ECT should be decided by clinicians based on their clinical expertise and guided by regular, comprehensive reviews of the consumer's progress and mental and physical state.

MHCC recommends that in a situation where a consumer's order for detention in hospital has expired and the consumer is part way through a course of ECT that the clinicians feel would be in the best interests of the consumer to complete, then the clinicians need to make another application to the Mental Health Review Tribunal to continue detaining the consumer in hospital and to continue the course of ECT.

Q 76 Maintenance ECT

MHCC feels that the small number of consumers who benefit from maintenance ECT should be able to access this form of treatment in the safest possible manner and with the protection of the Mental Health Act.

Consequently MHCC recommends that the Mental Health Review Tribunal should be able to authorise maintenance ECT as part of a CTO with the following safeguards: The treating psychiatrist should prepare the CTO; the consumer should be brought into hospital to have ECT; the consumer should have a physical assessment by the anaesthetist prior to ECT; the consumer would need to be reviewed regularly by the treating psychiatrist, who should have to reapply to the Tribunal at regular six monthly intervals for authorisation to continue maintenance ECT if the psychiatrist feels that this is necessary.

Q 77 General surgery notification

MHCC considers that notification of relatives regarding the need for general surgery is important and should continue. However, the current requirement that a fourteen day period must expire from the time that notice is given until the application for surgery can be heard is inappropriate and should be removed.

Q 78 Consent for general surgery
The consumer should be given every opportunity to provide consent. Where the consumer is unable to do so, the consumer's guardian should provide consent. If the consumer does not have a guardian, or the guardian is not available, the Mental Health Review Tribunal should review the matter and provide consent. If the matter is urgent, the Medical Superintendent should be able to provide consent.

Chapter 8: Establishment of Hospitals and Official Visitors

Q 79 Involuntary treatment in private authorised hospitals
MHCC recommends further consultation and discussion in relation to this matter. There are many important issues that would need to be addressed before MHCC would be in a position to be able to support or reject a proposed amendment to the Act to allow private hospitals to admit and detain people for involuntary treatment.

These issues include the need for a thorough examination of the link between the length of time a patient could be treated and the methods of treatment provided and the provisions of Health Insurance Funds. MHCC would have concerns related to the type and length of care being influenced by insurance concerns rather than clinical need.

Further areas that would need to be addressed include the need for comprehensive, holistic care, which includes community care, early intervention, follow up and support in the community.

The issue of involuntary treatment in private authorized hospitals was discussed at MHCC consultations. Advantages identified included the following: provision of a wider range and location of treatment options for consumers; reduction in the stress caused to consumers (and their carers) who are voluntary patients in private authorized hospitals in the event of the patient's condition deteriorating and the need for involuntary status to be invoked; and utilizing current systems servicing the growing numbers of consumers choosing private health care.

Disadvantages identified at consultations included the fact that, as private hospitals are not gazetted, they do not currently have the infrastructure to respond to the needs of patients who require involuntary detention. Further areas of concern expressed about private hospitals include issues surrounding privacy, accountability and the influence of the profit motive within the private sector.

As the private sector is perceived by many to be influenced by the profit motive, the purpose of private hospitals in detaining patients involuntarily would need to be open to thorough inspection and review processes. MHCC feels strongly that a transparent review process, to ensure private hospitals are subject to the same requirements concerning duty of care as those currently operating within the public sector, would be essential.

Attendees at consultations stressed that it would be essential that private hospitals would be subject to operating in accordance with the Mental Health Act. Ongoing review processes to monitor procedures and enforce a standard of accountability within the guidelines set by the Act and the United Nations Principles would also need to be established and maintained. MHCC would also see it as essential that the Mental Health Review Tribunal would be involved in the review process, including replacing the Magistrate at the initial review.

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Comments relating to the qualifications of the Principle Official Visitor and Official Visitors

MHCC is in agreement with the suggestions concerning qualifications required by the Principal Official Visitor and Official Visitors contained in Discussion Paper 2. The omission of the phrase 'a medical practitioner, barrister, solicitor or other suitably qualified person' and its replacement with words such as 'clinician or person with health or related qualification' was felt to be more appropriate. It is felt that this will enable a broader range of individuals to take on the role, thus strengthening the service.

MHCC also agrees with the suggested replacement of the words 'medical practitioner' with 'clinician' in relation to the appointment of Official Visitors. In addressing the qualifications for the position of official visitor, MHCC suggests that the position should also be open to those with relevant personal and professional experience and skills which enable them to take an independent and informed view of services provided in hospitals and health care facilities.

Comments relating to the functions of principal official visitor

MHCC is in agreement with the suggestion that the current functions of the Principle Official Visitor be revised to recognise a broader role, as detailed in Discussion Paper 2. Incorporating these newly defined functions into the Act will strengthen the role.

Comments relating to visits to health care agencies every six months.

MHCC is not in agreement with the suggestion that the frequency of visits by Official Visitors to health care agencies could be reduced from the current six-month provisions. MHCC supports the six monthly visits as a safeguard for consumers. If there were to be a change in the frequency of

visits, MHCC would prefer to see the frequency of visits increased rather than decreased.

Q 80 Access to official visitor
MHCC is of the view that families and carers should be able to arrange for a patient to have access to an official visitor.

The view was expressed strongly at MHCC consultations with carer groups that carers should also have access to an official visitor to discuss their concerns regarding the consumer's welfare.

MHCC also feels that Official Visitors should be able to bring matters to the attention of the Mental Health Review Tribunal where appropriate.

OTHER RECOMMENDATIONS

1. Location of Official Visitors
MHCC feels that independence, transparency and accountability are important components of the Official Visitors program. MHCC is concerned that having the Principal Official Visitor's support staff based in the Centre for Mental Health could be seen as compromising the independence of the program.

As the Principal Official Visitor is ideally placed to provide the Minister with valuable, independent feedback, it is crucial that the position is not only independent but is also seen as being independent. Consequently, MHCC would like to see consideration given to the office of the Principal Official Visitor being based in a more independent location, such as the Ombudsman's Office or the Health Care Complaints Commission**.**

2. When visits by official visitors do not take place.
MHCC would like to see procedures incorporated in the Act regarding overdue official visits to a hospital or health care agency. Consumers are significantly more vulnerable when visits do not take place, and a procedure needs to be put in place to address this.

MHCC notes that some official visits have not taken place due to inadequate numbers of Medical Practitioners. We strongly support the utilisation of a wider range of clinicians with mental health experience in order to address this shortage.

3. Access to Consumer Consultants.
The view was expressed strongly during MHCC consultations, that consumers should have the right to access a Consumer Consultant as well as an Official Visitor.

Part 9 Proceedings of the Mental Health Review Tribunal

Q. 81 Tribunal hearings

During MHCC consultations, it was recommended that Interpreters used in Tribunal hearings should all have training in mental health. This is particularly important when working with people who are having a psychotic episode and who are not speaking in English.

Some carers and consumers at MHCC consultations felt that victims should not be present at hearings. It was felt that their presence makes the situation extremely difficult for the consumer who already feels very concerned about what has occurred. Attendees felt that consumers were at risk of suicide due to the high level of guilt, shame and embarrassment that they feel about what they have done whilst they were mentally ill. The suggestion was made that victims' statements should be provided by another means.

MHCC understands these concerns, however we are also concerned about the needs and rights of victims for support. If it is felt that having the victim present at Tribunal hearings is not helpful to the process, it is important that the victim is provided with the opportunity to engage in the process in some other way. Possible examples may include reading the transcript with support.

Q 82 and 83 Video and telephone conferencing

MHCC recommends that the Act should be amended to specifically recognise the use of video and telephone conferencing. This should be done in a manner that enables the use of these technologies to be considered on a case by case basis, with guidelines provided about when and how they should or should not be used. For example, attendees at MHCC consultations felt that it may be inappropriate to use videoconferencing with a person who is experiencing psychosis as the person may find that the experience increases their sense of confusion about what is real and what is not.

The needs of the consumer should be paramount and the choice of interview format should be the one that provides the best possible format for the individual consumer. Generally it is recommended that face to face be first the choice for interview format and teleconferencing and video conferencing be used only in exceptional circumstances.

Q 84 Reasons for tribunal decisions
The MHCC and member organisations consulted agree that the Mental Health Act does not need to be amended to require the Mental Health Review Tribunal to provide a person with a copy of its reasons in every case. Furthermore the Tribunal should not provide a person with a copy of its reasons unless they have been requested to do so by that person. Consumers and carers at MHCC consultations felt that it could be a very devastating experience for an individual to see the reasons in writing.

The Tribunal should make it very clear that copies of its reasons can be obtained at any time upon request. Hospitals should also make it clear that copies of the Tribunal's reasons can be obtained at any time. Patients should be informed about their right to request a copy of the Reasons during their review process and also while they are in hospital. People should also be informed that they can request a transcript of the tape made of the interview.

Q. 85 Closure of hearings
MHCC recommends that the Act be amended to allow the Mental Health Review Tribunal to close a hearing of its own right. This is important in circumstances where it would disadvantage the consumer if it was open.

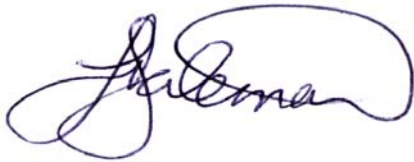
10.3 Discharge Planning

Q 90 Follow up after discharge
MHCC agrees with the Parliamentary Select Committee who found that inadequate follow up care was having a major impact on consumers' ability to live in the community with, at times, tragic consequences such as suicide. We support amending the Act to require a post discharge assessment, within five days, for all persons who have attempted suicide and been admitted, not only those who were admitted as mentally disordered persons.

MHCC would also like to see adequate resources allocated to community based mental health services so that consumers could be linked in with these services as part of discharge planning. MHCC feels very strongly that this would be a very positive measure for consumers and carers and would make a marked contribution to improved outcomes in mental health care.

Thank you for seeking our involvement in this legislative reform review. We look forward to participating in future discussion papers. Should you wish to discuss any issues surrounding this submission please contact Ann MacLochlainn or myself at MHCC, on 9555 8388.

Yours faithfully,



Jenna Bateman
Executive Officer.