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Review of the NSW Mental Health Act 2007: Report for NSW Parliament, May 2013

A Summary of Consultation Feedback and Advice was recently published in response to the Review of the *NSW Mental Health Act 2007* which itself required that the Minister review the Act '*to determine whether the policy objectives of the Act remain valid and whether the terms of the Act remain appropriate for securing those objectives*'. This review had to be undertaken five years after the Act was assented to (s 201). A report on the outcome of the review was then required to be tabled in each House of Parliament within 12 months of the review commencing.

The outcomes of the Review indicate that the policy objectives of the NSW Mental Health Act 2007 remain largely valid and provide an appropriate legislative framework for the mental health system. The review summary stated that:

> *'…the structure of the Act is robust, and on balance the content is supported. However, a number of issues have emerged from the consultation, and while some relate more to the implementation of the legislation (rather than the Act itself), there are opportunities to amend some sections of the Act to reflect contemporary language and emerging evidence, improve operational clarity and alignment with other legislative approaches in relevant areas'.*

In view of this statement MHCC determined to provide its members with feedback on how aligned the recommendations are to the issues they identified in their submissions to the Review. The Report for NSW Parliament: May 2013 is available at: http://www.health.nsw.gov.au/mhdao/Documents/Review-of-the-Mental-Health-Act-2007.pdf

Please note that the review items below do not constitute all the issues raised in MHCC's submission. This document merely addresses the items contained in the Report to Parliament. MHCC's Submission to the Discussion Paper: Issues arising under the NSW Mental Health Act 2007 is available at: http://www.mhcc.org.au/documents/Submissions/Sub-Issues-under-NSWMHAct07.pdf

Acronyms:
Accredited Person – AP
Authorised Medical Officer – AMO
Community Treatment Orders – CTO
Designated Mental Health facility - DMHF
Guardianship Act – GA
Mental Health Act 2007 – MHA
Mental Health Review Tribunal - MHRT

For any further information concerning this review please contact Corinne Henderson, Senior Policy Officer at corinne@mhcc.org.au

Review items	Review outcomes	MHCC response
GENERAL CONSENSUS THAT NO LEGISLATIVE CHANGE IS REQUIRED		
4 (a). Definition of mental illness. Section 4 defines 'mental illness'.	It appears that the definition of mental illness is appropriate and no changes to the Act are suggested.	***The review*** *reported general consensus that no legislative change is required for the definition of mental illness*. ***MHCC agree*** *that the current definition of mental illness does not pathologise an individual with a diagnosis. However we propose that the use of the term 'irrational' throughout the MHA is superfluous in the context of severe disorder or thought form. The term 'irrational' is also context specific and may be open to various interpretations.*
GENERAL CONSENSUS THAT SOME LEGISLATIVE CHANGE MAY BE REQUIRED		
1. Objects and principles The first object of the Act is: 'to provide for the care, treatment and control of persons who are mentally ill or mentally disordered'.	It may be appropriate to amend the Act: - by removing the word 'control' from the objects (s3) and title of the Act and replacing it with terms such as 'protection', 'detention' and/or 'involuntary treatment'. - by adding a term which encapsulates the 'recovery-focused care' principle in the principles of care and treatment within the Act.	***MHCC drew*** *attention to the language used in the legislation which could be improved to reflect recovery principles. The NSW Act refers to providing for the 'care, treatment and control' of mentally ill and disordered persons. MHCC proposed that the term control be removed from the MHA. Whilst not a perfect solution, the Victorian legislation uses the language of 'care, treatment and protection' which is preferable.* ***MHCC is*** *also pleased to see the consideration of adding recovery principles into the principles of care and treatment in the Act. However we highlight that 'recovery-focussed care' is a set of principles & not one principle.* ***If the principle of*** *'supported decision-making' were to become a principle it provides an opportunity for more progressive thinking with regards to alternative care options involving substituted decision-making. This could be in relation to involuntary treatment. Ensuring the 'least restrictive care and treatment' by embedding the principle of 'supported decision making' and 'Dignity of Risk' within the Principles as well.*

4 (b). Definition of mental illness – exclusion criteria Under s16, certain words or conduct may not indicate mental illness or disorder, e.g. where the person has a developmental disability of mind.	Consideration could be given to amending the exclusion criteria under s16 (j) to reflect contemporary language such as 'the person has an intellectual disability or developmental disability'.	***MHCC agree with*** *the proposal of more contemporary language and that a number of conditions should explicitly be excluded from the definition of mental illness, including, Intellectual Disability, Autism and any other developmental disabilities as well as Cognitive Disability, unless co-existing with an identified mental illness or mental disorder.*
6. Mental health review tribunal orders delaying discharge of persons When considering an appeal against a refusal to discharge a person, the MHRT can either order that the person continue to be detained or order that the person be discharged. However, the MHRT is not able to make a community treatment order (CTO), nor can it delay a person's discharge under the current wording in the Act (s 44(4)).	It may be appropriate to amend the Act to allow the MHRT, at an appeal hearing against a refusal to discharge a detained person, to be able to make a CTO or to defer the discharge of the person for up to 14 days.	***MHCC support*** *the ability of the MHRT to be able to make a CTO at an appeal hearing as this provides an opportunity for a 'less restrictive alternative' to involuntary status. However, in order to prevent unnecessarily long CTOs, there should be an opportunity for short orders stated in the Act, particularly as a consideration for people with first episode admissions.*
7. Discharge after making a community treatment order The MHRT is required to review each person who has been detained in a DMHF to determine whether their ongoing detention is warranted. There is no power to delay discharge when a CTO is made if the patient does not agree to stay as a voluntary patient (s41).	It may be appropriate to amend the Act to allow the MHRT, when making a CTO in relation to a detained person, to delay the person's discharge for up to 14 days where it is in the person's best interest.	***MHCC recommend*** *that the 14 days should require consent from the person who agrees that they are willing to be detained as a voluntary patient, on the basis that accommodation or other arrangements are to be made .However, at the end of the review period they should be free to discharge themselves even if suitable arrangements have not been made or choose to remain a voluntary patient. If the facility wishes to detain them longer, they would need to institute a hearing to determine whether a person should be held based on 'continuing condition', including any likely deterioration in the person's condition and the likely effects of any such deterioration' if they were to be discharged (s14).*

8. Review by the mental health review tribunal at least once every 12 months Under s9, a voluntary patient must be reviewed by the MHRT at least once every 12 months. There may, however, be circumstances where a voluntary patient has resided in MHFs continuously for more than 12 months without a MHRT review.	It may be appropriate to amend the Act to include a requirement that voluntary patients must be reviewed at least once every 12 months of continuous voluntary and involuntary residence in mental health facilities.	***MHCC support*** *an amendment to include a requirement that voluntary patients must be reviewed based on continuous voluntary and involuntary residence in mental health facilities. However, MHCC recommends that a review must occur every 3 months to ensure accountability and to avoid an individual receiving unnecessarily restrictive care and treatment.*
14. Detention on order of a magistrate or police officer Where a person has been brought to the DMHF for assessment by a police officer under s22 , and the DMHF does not consider that the person meets the criteria for involuntary treatment, the facility can only detain the person for a period not exceeding one hour pending the person's apprehension by a police officer (s32(4)).	It may be appropriate to consider amending s32(4)(a) to extend the length of time that a mental health facility may detain the person pending the person's apprehension by a police officer, from 'a period not exceeding one hour' to the minimum time possible but a period not exceeding two hours.	***MHCC support*** *this amendment however we recommend a stipulation that travel time in the police vehicle not be included in the two hour timeframe to ensure distance issues for people living in rural and remote communities are considered.*
15. Detention of voluntary inpatients Under s 10(1), an AMO may detain a voluntary patient if the officer considers the person to be a mentally ill or disordered person. The Act does not allow for a voluntary patient to be held pending the AMO's assessment. However, a Schedule 1 assessment could be undertaken by an AP.	It may be appropriate to amend the Act to permit the senior nurse on duty to hold a person for up to two hours while awaiting either a Schedule 1 assessment to be undertaken or for an AMO to cause the person to be detained under s10, with a requirement for the nurse being able to demonstrate that they are trying resolve the situation as soon as practicable.	***MHCC agree*** *that it may be appropriate to amend the MHA to permit the senior nurse on duty to hold a person for up to two hours, while waiting for a Schedule 1 assessment, with a requirement for the nurse being able to demonstrate that they are trying to resolve the situation as soon as practicable. MHCC added that this role should only be designated to a Registered Nurse with a minimum of 5 years' mental health experience.*
GENERAL CONSENSUS THAT FURTHER TARGETED CONSULTATION MAY BE APPROPRIATE		

2. Decision making capacity and supported decision making The Act relies on medical practitioners to make decisions about the need for a mentally ill or disordered person to be detained and involuntarily treated, based on the person's risk of harm to themselves or others.	It may be appropriate to undertake further consultation that includes in-depth analysis of the possible models of involuntary provision of treatment, the possible unintended consequences of any changes, and the likely resource implications; and monitoring and evaluation of the implementation of a supported decision making model in other jurisdictions to inform any future possible approach in NSW.	***MHCC suggest*** *that this item should be located under the 'general consensus that some legislative change may be required' section.* ***MHCC agree*** *that further research will be required to implement the most effective and cost effective model however we propose that the MHA should reflect human rights obligations under the UN Convention on the Rights of Persons with Disabilities, Article 12. (Supported decision-making is referred to in the UNCPD). If 'supported decision-making' were to become a principle in the MHA it would provide an opportunity for more progressive thinking with regards to alternative care options involving substituted decision-making, particularly in relation to involuntary treatment.*
3. Treatment for conditions other than a mental illness The Act has provisions providing for a substituted consent regime for non-mental health treatment, particularly surgery. However, these provisions are inconsistent and vary depending on the status of the detained person.	It may be appropriate to undertake further consultation that includes discussion of the potential consequences of a move to align the provisions of the Mental Health Act and the Guardianship Act, particularly in relation to a mentally ill person's decision to refuse potentially life-saving treatment.	***MHCC support*** *further consultation on the issue of better alignment between the MHA and the GA. The provisions in the MHA dealing with 'other medical treatments' should be amended to reflect an emphasis on supported decision-making and the use of advance directives where possible, with substitute decision-making only used as a last resort. There needs also to be reference to other possible substitute decision-makers who may have better knowledge than the AMO and/or the treating team of a consumer's wishes particularly when they may not have capacity to consent at a particular point in time.* ***The current*** *concern seems to focus on the potential for a mentally ill person to refuse potentially life-saving treatment instead focussing on aligning the MHA with the principles of the GA - that as far as possible, people be self-determining. The same respect for choice should be applied as is generally in the community, and only in emergencies or where lack of capacity is well established should a 'best interest' decision prevail.*

5. Non-admission and discharge of persons brought involuntarily to a declared mental health facility Section 27(a) deals, in part, with the initial examination by an AMO of a person detained in a DMHF. If, after the AMO's examination (first Form 1), a person is found to be neither mentally ill nor mentally disordered, the person must not be detained. The Act does allow for persons seeking voluntary admission to a MHF to request that the medical superintendent of the facility reviews a decision by an AMO to refuse admission or discharge (s11).	It may be appropriate to undertake further consultation that includes whether it would be appropriate to amend the Act such that: - where a decision has been made to not involuntarily admit a person, that a psychiatrist or the medical superintendent must undertake an additional assessment of the person where a carer or service provider makes such a request; and/or - where the first Form 1 has been completed by an AMO who is not a psychiatrist, and where they have come to the conclusion that the person does not meet the criteria for detention under the Act, a further Form 1 must be completed by a psychiatrist.	***MHCC propose*** *that people who lack decision-making capacity should be able to access treatment that is in their best interests, without having to show that they are at risk of some kind of "serious harm" additional to the harm involved in just having a treatable illness. A psychiatrist or medical superintendent must undertake an additional assessment and complete a Form 1.* ***MHCC strongly*** *recommend that a follow up mechanism be established so that a community worker is made responsible for follow up of a non-admitted person within 24 hours of assessment. This is in the circumstances of a person who has presented at ED/ MHF who has not met the criteria for admission (but the person or their family are concerned that they may be at risk to self or others if not admitted).*
9. Initial involuntary treatment in the community Involuntary treatment in the community, in the form of CTOs, can only be authorised by the MHRT. In the case of persons living in the community who are not currently on a CTO, a MHRT hearing cannot occur for at least 14 days after a CTO application is made (s52(3)). Such persons cannot be involuntarily treated in the community while awaiting a CTO application to be heard.	It may be appropriate to undertake further consultation that includes: - whether the MHRT should be able to waive the 14 day notice period for urgent CTO applications. - Consideration should be given to establishing appropriate timeframes for the MHRT to hold reviews of urgent CTO applications and that consideration be given to whether these reviews can be held in such a timely fashion that the issues raised in the discussion paper are effectively addressed. - That, if the above MHRT proposal does not effectively address the issues raised in the discussion paper, consideration be given to the development of an initial involuntary community treatment regime that operates on a similar basis to initial involuntary inpatient treatment.	***MHCC*** *support the ability for the MHRT to waive the 14 day notice period for urgent CTO applications, or establish appropriate timeframes for the MHRT to hold reviews of urgent CTO applications.* ***MHCC*** *propose that it is inappropriate under any circumstances for involuntary treatment in the community to be possible without a hearing, to ensure the person concerned be involved in decisions concerning involuntary status.* ***Likewise*** *it is inappropriate in any circumstances for involuntary treatment to be made possible in the community without the MHRT hearing an application for a CTO (s 52(3)). We propose that this is a safeguard which prevents pressure being placed upon clinicians to treat by interested persons (including service providers), and protects consumers from coercive practices.*
10. Role of the mental health review tribunal Section 27(d) includes: "The person must be brought before the Tribunal as soon as	It may be appropriate to undertake further consultation that includes: - whether the proposal that the MHRT and	***The Act*** *provides that the MHRT must conduct a mental health inquiry 'as soon as practicable' after admission as an involuntary patient. Until June 2010, this was*

practicable after admission (subject to meeting the requirements set out above)." In practice, the MHRT generally conducts a mental health inquiry about two weeks after the person is admitted to a MHF.	OVs should be able to refer matters to each other warrants further investigation, noting that there are other mechanisms under the Act that allow for investigation of individual and systemic issues. - whether MHRT proceedings should include consideration of dependent children or other persons, whether there should be a capacity to refer information by the MHRT to others, whether there should be a capacity for the MHRT to proceed where a legal representative is not available, and whether there should be a right for consumers to have a support person accompany them to a MHRT hearing	*interpreted to mean 'within 7 days' but following the amendments to the MHA that required that Magistrates' Inquiries be held by the MHRT saw reviews scheduled for 3-4 weeks after admission, which led to an increase in appeals against discharge (s44). MHCC welcomed the subsequent recognition by the Government that such wait times were unacceptable and the provision of funding to bring hearings forward to two weeks after admission. MHCC suggest that it may be helpful for the MHA to state the timeframe for review to ensure that consumers are clear about when they can expect to receive an independent review of detention decisions, if they have not been discharged already. We advocate that the MHA state that reviews must be held no longer than 5 working days following admission (i.e. 7 days including a weekend).* ***MHCC are** unclear as to what is meant by the proposal that OVs should be able to refer matters to other OVs. What we will say is that current reporting mechanisms should be more transparent and enable greater accountability of individual and systemic issues to be reviewed other than via current direct report to the Minister.* ***The MHRT** should be able to include consideration of children and other dependent persons, and accept submissions from other persons at the hearings. MHRT should only have the capacity to proceed without a lawyer if the person concerned agrees and they should always have the right to be supported by a person of their choice at an inquiry/hearing/appeal etc.*
11. Role of the official visitors Official Visitors (OVs) are involved in the advocacy and care of people under the Act who receive treatment at a MHF. (Chapter 5). This includes raising issues of patient safety, care or treatment, and advocacy on behalf of	It may be appropriate to undertake further consultation that includes: - whether it is appropriate to allow OVs to inspect non mental health facilities where persons who have been detained under the Act are receiving non-mental health	***MHCC recommend** that the role of the OV be substantially expanded. OVs are not as visible in the system as they should be. Often people request to see an OV, but are discharged prior to the OV visit. We also support consideration that OVs visit non mental health facilities where people are receiving non-mental health*

the patient in relation to issues arising in the mental health system. OV Program inspection rights under the Act currently pertain to MHFs only.	treatment. This should include analysis of the financial implications of any such changes. - whether it is appropriate to amend the Act to provide more direction as to the role of the OVs and the types of issues that the OVs should consider when undertaking inspections of DMHFs to ensure that OVs are fulfilling functions in accordance with their role as an independent investigative and governance mechanism over the mental health system.	*treatment such as surgery, chemotherapy etc.* ***The role of the OV*** *needs to be clarified. ''The Official Visitors Program aims to safeguard standards of treatment and care and the rights and dignity of people being treated under the NSW Mental Health Act 2007 while maintaining an independent community perspective". However, the OV program is not strictly independent of the health system since it reports directly to the Minister for Health, and the evaluation and outcomes of OV visits are not publically available.* ***MHCC have*** *strongly recommended (regarding the review of the NSW Disability Services Act 1993) about the need for broad based research and review of all monitoring, safeguards and complaints mechanisms in NSW. MHCC propose that in the Disability Care environment it is crucial to undertake a review that investigates the potential and suitability of an expanded role of the OV Program to encompass community managed mental health services and also consider the remit of the NSW Ombudsman in order to ascertain whether the current role of monitoring safeguards across disability services might be appropriately expanded to include community managed mental health services.*
12. Initial assessment for involuntary detention Under s19, an AP can complete a Schedule 1 allowing a person to be taken to, and initially detained in a DMHF for assessment. Only medical practitioners can complete the Form 1 which allows for a person's continued detention and involuntary treatment at a DMHF	It appears to be appropriate to retain the requirements for Form 1s to be completed by an AMO only. However, it may be appropriate to undertake further consultation about whether the Act should be amended to allow an AMO from another mental health facility within the same LHD to complete the first Form 1 in exceptional circumstances where an AMO is not available at that facility within the initial 12 hour period of detention or whether there are alternative solutions to this issue.	***MHCC suggest*** *that a registered mental health nurse or psychologist with a minimum of 5 years should be able to undertake Form 1 assessments. MHCC emphasise the need for recognition of the competencies and expertise that exist amongst practitioners of disciplines other than medicine/psychiatry.* ***MHCC*** *suggest that registered nurse practitioners are a category of underutilised professionals who could appropriately complete Form 1s, and write prescriptions. This could go some way to filling gaps for accredited persons to undertake roles in rural, regional and remote areas.*

13. Transport of persons for assessments Currently, Form 1 assessments can only occur in a DMHF (s27). As a result, it is necessary for police and ambulance to take the person to a DMHF for assessment, even if the nearest DMHF is located a very long distance from where the transport commenced.	It may be appropriate for further analysis and consultation to be undertaken on this issue, particularly in relation to determining a preferred mechanism(s) to address the concerns raised during the consultation process, including the potential cost implications of any such proposal, the level of involvement by relevant agencies in providing relevant services, as well as to the minimum requirements that would need to be met for a facility to be involved in any such proposal.	***The National safety*** *priorities in mental health: a national plan for reducing harm, 2005. Australian Council for Safety and Quality in Health Care sets out good principles for safe transport of people experiencing mental disorders. As the document makes clear 'mental health consumers have the right to safe transport that minimises interference with their rights, dignity and self-respect and that avoids traumatising family members, particularly children.' Of particular concern to MHCC is the use of restraint, including sedation, during transportation and the experience of significant stigma that adds to psychological distress and creates a negative perception of care. When consumers are transported long distances in order to be assessed, by police rather than the ambulance service, this can be particularly distressing and every effort must be made to avoid adverse events. People should not be transported long distances without a suitably trained member of staff, strictly adhering to clear policies and protocols to ensure that the least restrictive, and safe transport of people experiencing a mental illness is used. Despite being less than desirable, assessments as recommended by video and telephone may be preferable to transportation of people long distances.*
16. Community treatment orders There is no requirement in the Act that the affected person be a mentally ill person for a CTO to be made by the MHRT	It may be appropriate to undertake further analysis and consultation in relation to this issue with a view to determining whether legislative change to the criteria for granting CTOs is warranted.	***To decide*** *if the person is a 'mentally ill person' the Tribunal must consider whether the person is: suffering from a mental illness (as defined by the MHA); and at risk of serious harm to themselves or others.* *The Tribunal will therefore take into account the person's 'continuing condition', including any likely deterioration; and as a consequence of this a significant justification for the use of CTOs.* ***MHCC agree*** *that considerable consultation and review of the literature is necessary since there is contentious evidence as to powers involving the state acting for a*

		person in their 'best interests' when that person is deemed to lack capacity to make appropriate decisions for themselves (Carney et al, 2011). MHCC share the growing legal concern with the application of human rights principles and the therapeutic consequences of such decision making.
17. Private mental health facilities detaining and involuntarily treating person under the act Under the Act, persons may only be detained and involuntarily treated in DMHFs. Private mental health facilities (PMHFs), which are granted licences to operate as such by the DG under s115, may also operate as DMHFs. Currently, no PMHFs are DMHFs.	It might be appropriate to undertake further analysis and consultation in relation to whether there is a need to amend the Act to further promote the capacity for PMHFs to be DMHFs; and/or specify any requirements that PMHFs need to meet before they can become DMHFs; and/or specify any restrictions that should be placed around PMHFs that are also DMHFs.	***MHCC did** not address this question in their submission, but we see no reason in principle that private mental health facilities should not become designated. Analysis and consultation will need to be undertaken to ensure appropriate policy and regulations are in place and that care and treatment are suitably available 24/7. Likewise any conflict of interest matters including financial interests must be addressed. This primarily relates to practitioners referring patients from a public MHF to a private hospital in which they may have a financial interest even if it is only as an employee of that said facility.*
18. Review of treatment planning and medication Section 68(h) provides that every effort that is reasonably practicable should be made to involve consumers in the development of treatment plans and plans for ongoing care.	It may be appropriate to undertake further consultation on this issue, including whether to amend the Act to require carers and consumers to be consulted prior to a CTO being discontinued or revoked; require the MHRT to be advised when a CTO is revoked; and establish a requirement for formal six-monthly review of treatment including CTOs.	***Consumers and carers** are often minimally involved in developing treatment plans, evidenced by the fact that goals identified in involuntary treatment plans, rarely include stated aspirations identified by the consumer.* ***In circumstances** where a person lacks capacity and is unable to contribute to the development of a treatment plan at a point in time, they should be provided with the supports and information to assist involvement at each step of the process where possible.* ***MHCC support** further investigation into the matters concerning consultation with consumers and carers and MHRT notification preceding a CTO being revoked or discontinued. We suggest that there is room for considering opportunities for shorter orders of 3 months which would provide greater impetus to progress goals of treatment, and establish necessary supports in the community - generally progressing recovery with more*

		vigour than when a 6 month review is in place. It is important that 6 months does not lead to under-assertive oversight that ultimately may lead to continued reinstating CTOs. We note that NSW has a very high rate of CTOs compared to other jurisdictions and comment that numbers of CTOs may be a reflection of poor access to services in the community.
19. Consumer engagement in the development of treatment plans It has been suggested that the process of engaging consumers in the development of treatment plans could be beneficial. Advance Care Directives (ACDs) (advance statements/agreements) and could potentially apply to ongoing treatment decisions in a mental health context.	It may be appropriate to undertake further consultation on this issue, including whether the legislation should be amended to require that each consumer is to have a treatment plan that is regularly reviewed, and whether treating teams and the MHRT should be required to have regard to these plans in making decisions about the patient's care and treatment	***There clearly*** *exists strong evidence concerning improved outcome for consumers involved in developing treatment plans. MHCC strongly recommend that consumer input into treatment plans is formally recognised in the MHA to ensure that the treating team take the person's goals for recovery into account. This ensures that recovery principles are embedded in the legislation including the concept of 'nothing about us without us', highlighting the importance of respecting 'lived experience'. The current format of the treatment plan template has a section requiring the Goals and Objectives. Generalised comments on behalf of the treating team are always present, usually identifying their goals for the individual. Almost never is any reference made to consumer identified goals. We propose that a section be specifically added to the template requiring the individual's input into the treatment plan.* ***There is*** *no question in our minds that treating teams should regularly review plans and that the MHRT be required under the MHA to have regard to the consumers preferences in these plans when making decisions about a consumer's care.*
20. The rights of primary carers A primary carer must be appointed for each consumer receiving care and treatment under the Act. The primary carer can either be nominated by the consumer or, in certain situations, appointed according to conditions outlined in s71-72. Currently, other carers,	It may be appropriate to undertake further consultation to consider whether to amend the Act to: - explicitly permit up to two people to be nominated as the primary carer, including a child/adolescent acting as a young carer; - consider differentiating between different	***MHCC strongly support*** *the clarification of the types of information that should be shared with carers and relevant support people.* ***MHCC highlight*** *the issue of primary carers who are children or young adults. In many situations a child may not be known as the primary or nominated carer, but*

such as family members or loved ones, do not have rights to any form of information except if the consumer agrees for information to be provided or if the medical officer believes that they may be at risk (if a patient absconds and there is an Apprehended Violence Order (AVO)).	types of carer and support people; - clarify the types of information that each group should receive; and - (re)name each role with a relevant title.	*particularly in single parent families, this may well be the reality. A young person may be undertaking a range of responsibilities including looking after siblings, and treating teams must pay attention to family dynamics and interests so as to minimise some catastrophic outcomes when a parent becomes hospitalised.* ***MHCC recommended*** *the establishment of a national electronic nominated carer register to be accessible from all gazetted hospitals, public and community mental health services. The registration of one or two primary/nominated carers should be initiated only by a consumer as an advance directive entered into the system by a medical practitioner, when they have capacity or by their guardian if so appointed. The register should state who they wish to be involved in their care and treatment and informed concerning discharge etc. Equally the consumer can identify those people they wish not to be contacted in any circumstances. At the moment it is often unclear as to whether a carer has been nominated or is assumed to have a relationship or interest in the consumer because they are a family member.*
21. Children with mental illness Children can be admitted involuntarily under the Act in the same way as adults. There are, however, some specific provisions that relate to the voluntary admission and treatment of children. The primary carer of a child is generally the parent. Where the child is over the age of 14, they may nominate someone other than a parent as their primary carer. Children generally have the same rights as adults under the Act.	It may be appropriate to undertake further consultation regarding whether the principles for care and treatment should be amended to express the preference for children and adolescents to be treated by a Child & Adolescent (C&A) psychiatrist and/or in a C&A unit, and whether greater emphasis should be given in the principles for care and treatment to providing treatment that is appropriate to the consumer's age and cognitive development. It may also be appropriate to consider the inclusion of a provision in the Act which provides legal representation for all children (16 years and under) when they are subject to a MHRT hearing	***MHCC agree*** *that the principles for care and treatment should be amended to include the preference that children under 16 be treated by a Child & Adolescent psychiatrist and/or in a C&A unit, to provide treatment that is appropriate to the consumer's age and developmental stage and to include a provision in the Act which provides legal representation for all children when they are subject to a MHRT hearing.*

22. Electroconvulsive therapy for children Under the Act, the same rules for consent to electroconvulsive therapy (ECT) treatment apply to children under the age of 18 as they do to adults.	It may be appropriate to undertake further consultation regarding whether ECT should remain a treatment option for children (i.e. no age restriction) and the appropriateness of a requirement for assessment by C&A psychiatrist, preferably with experience in the use of ECT, when ECT is proposed for any child aged 16 years or under.	***MHCC support*** *further consultation regarding ECT as a treatment option for children. It is widely accepted that ECT is an undesirable treatment for any person under the age of 18, because of the possible risks to a developing brain. However, circumstances do arise occasionally where for example a child may have unremitting psychosis that has not responded to any medication. In such circumstances we propose that certain safeguards should be in place to make sure that every care has been taken in assessing the need for this treatment. We propose that 2 independent specialist child psychiatrists should be consulted as well as a psychiatrist with expertise in neuroscience and research in the field of ECT (We recommend that a unanimous decision would need to prevail in order to proceed).*
23. Declaration of financial interest The Act requires that any financial relationship between the medical practitioner proposing and administering ECT and the facility be disclosed to the patient.	It may be appropriate to undertake further consultation on whether, and how, the requirements for declaration of financial interest by medical practitioners prescribing and administering ECT should be amended to address the practical implication issues.	***Medical practitioners*** *should be obliged to disclose any financial or commercial relationship with a facility in which it is proposed they administer the treatment, even if in this instance they are an employee. For example, some medical practitioners may be part-time employees, but be contracted as a private practitioner to undertake other roles or referrals. Disclosure should include any financial relationship across provision of all services including admission to private facilities.* ***MHCC is concerned*** *that the findings suggest further consultation is required as to the requirements for declaration of financial interest be amended. We strongly argue that financial relationships of any kind, across provision of all services including admission to private facilities, must be disclosed.*

24. Psychosurgery Psychosurgery is a prohibited treatment under the Act	It may be appropriate to undertake further consultation on this issue, including: - whether psychosurgery should be renamed 'neurosurgery for mental disorders' and non-ablative brain stimulation techniques should be excluded from the definition of this term; - whether the Act should continue to prohibit ablative neurosurgery and whether to allow non-ablative brain stimulation techniques with robust regulation and oversight and mandatory informed consent by the patient; - whether a review process similar to the previous Psychosurgery Review Board provisions should be reinstated to regulate use of non-ablative brain stimulation techniques.	*MHCC supports further investigation into whether the Act should continue to prohibit ablative neurosurgery, and supports the allowance of non-ablative brain stimulation techniques with robust regulation and oversight. Any consideration of psychosurgery would 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 consent is genuinely informed consent. We stress the point that psychosurgery should be banned as an involuntary procedure in any circumstances.* ***In 2006, MHCC** noted the conclusion reached by the Psychosurgery Review Working Group - that psychosurgery can be effective for, "a very small and specific group of patients suffering from some chronic, disabling and treatment resistant psychiatric illnesses." We acknowledge the submissions from several psychiatrists reiterating this view. This group of consumers should not be disadvantaged by the prohibition of a form of treatment to which they wish to consent and that may give them relief from the severe, long-term distress caused by their mental illness.*