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Subject: Review of the NSW *Mental Health Act* 2007

Dear Ms Broderick

The Mental Health Coordinating Council was invited by the Minister for Mental Health, Kevin Humphries to provide preliminary comment on any matters that should be considered as part of the statutory review of the NSW *Mental Health Act* 2007(MHA). We thank the government for inviting us to participate in this important review, and welcome the opportunity to register matters of particular importance to our members and the community mental health sector.

In the limited time available MHCC have consulted a number of consumers, lawyers and people working in the mental health and disability sectors, and whilst we may have a view on some of the issues listed, we raise them at this point only as matters that require consultation and discussion. MHCC express our willingness to facilitate consumers, carer and service provider consultations when the Government's Discussion Paper is available, and arrange for expert speakers including people with lived experience of mental illness to present the various viewpoints to our sector for consideration.

1. Historically mental health laws all over the world use a risk of harm criteria as the basis for involuntary treatment. The NSW MHA currently permits treatment of persons living with mental illness if it is considered by two doctors to be necessary to prevent serious harm to the person or to others (s14). MHCC are aware that Victoria and Tasmania have exposure mental health bills before parliament that have shifted towards a position whereby mentally ill people who retain legal capacity to make medical decisions for themselves should be able to refuse medical treatment if they do not wish it, regardless of perceived risk of harm without that treatment. This would give persons with mental illness the same rights as all patients in general medical matters - and is reflected in legislation in Scotland (*Mental Health (Care and Treatment) (Scotland) Act* 2003 (UK), and in proposed new legislation in Tasmania, Victoria and India (*Mental Health Care Bill*, 2011). This is believed to more appropriately reflect human rights obligations under the UN Convention on the Rights of Persons with Disabilities. MHCC raise this issue because it is under consideration and likely to be passed in other jurisdictions and we would welcome an opportunity to better understand the arguments for and against in a discussion paper.

2. Following on from this move (in the above mentioned Acts) those 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. MHCC recommend that the issue of people refused admission to mental health facilities and their right to appeal a non-admission decision are matters for consideration.

3. Currently, in s 32 (involuntary detention) the NSW MHA provides that the Mental Health Review Tribunal (MHRT) must conduct a mental health inquiry "as soon as practicable" after admission as an involuntary patient. Until June 2010, this was interpreted to mean "within 7 days" but following the amendments to the MHA that altered Magistrate Inquiries to 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 recent recognition by the Government that such wait times are 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 patients are clear about when they can expect to receive an independent review of detention decisions, if they have not been discharge already. We note that law reform proposals in Tasmania (*Mental Health Bill* 2011 (Tas) guarantee hearings within 4 days of admission for formal review of detention and patient rights protection.

4. The scope of powers to treat involuntary patients under the MHA need to be discussed:

    - In terms of psychiatric treatment, the MHA provides little detail about the basis upon which decisions to treat detained patients should be made, and how, if at all, patients' preferences about treatment should be taken into account when initiating involuntary treatment. This is problematic bearing in mind that some patients retain decision making capacity in relation to certain treatment decisions and may have a point of view about which treatments they prefer, or if they wish to forgo certain treatments entirely, particularly if it is not their first experience of mental illness. It is important to discuss how these preferences should be taken into account by doctors and decisions to override expressed patient preferences be limited to circumstances in which a patient lacks capacity to make a decision, and the particular treatment is manifestly in the person's best interests.

    - Provision for advance directives about treatment could also be considered. Such provisions would allow patients to specify while well, the treatment they wish or do not wish to be given in circumstances where they lose decision making capacity due to mental illness. The law permits general medical patients to make advance directives and their use should be considered as a way of enhancing self-determination for psychiatric patients.

    - The scope of doctors' abilities to provide non-psychiatric treatment is unclear. In particular, there is no clear power for doctors to provide medical treatment without consent to competent detained patients. Although emergency surgical treatment will be permitted after a patient is admitted, this cannot be provided to a competent "assessable person" who may for example be in the Emergency Department of a general hospital waiting for admission under the MHA. (MHCC have been advised that this issue can arise in many different circumstances. For example, patients with anorexia nervosa refuse artificial feeding and hydration, patients with renal conditions refuse haemodialysis; pregnant patients refuse obstetric interventions including Caesarean sections and so on).

The MHA is not clear about what is and is not permitted and doctors have interpreted the provisions differently in various circumstances. Discussion is necessary as to the rights of patients to refuse and receive treatment clearly laid out in the Act.

5. The National Mental Health Seclusion and Restraint Project was a collaborative initiative between the Australian Government and State and Territory Governments. In line with the *National Safety Priorities in Mental Health: a National Plan for Reducing Harm,* the project aimed to reduce and, where possible, eliminate the use of seclusion and restraint in public mental health services. MHCC suggest discussion take place as to whether the key principles for seclusion and reduction practice be clearly reflected in the legislation as outlined in the national Plan for Reducing Harm.

6. Following the inclusion in the MHA 2007 of legislation to improve the rights of carers to be included in information sharing regarding care and treatment plans, discharge etc., (Chapter 4, part 1, Division 2s 73-s79), the possibility of a national register for nominated carers to be established and accessible electronically to care providers in public and community settings would be a welcome point of discussion. We understand that consumers will be able to opt to provide this information via ehealth after July 2012. 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.

7. MHCC would welcome discussion about improvements to the legislation that focus on the role of service/ care coordination as an area for improvement in treatment planning particularly for discharge and for people on CTOs. This necessitates discussion on role delineation and workforce development across professional disciplines working in public, private and the community sectors working with people under the MHA. Whilst this is often thought of as an area for standards and guidelines rather than the legislation, there is no reason as to why the MHRT could not play a more significant role in monitoring care coordination through case manager report mechanisms.

8. Discussion concerning the test/ definition for mental illness, and people caught in the system as shown in the Harry v the Mental Health Review Tribunal & Anor (1994) 33NSWLR 315 would be of value. This relates to matters concerning legal representation for all patients appearing before the MHRT e.g. CTOs. Since there is no objective standard required to be met before an order can be made or renewed by the Tribunal, The only realistic way of avoiding repeated renewals is to convince the health care agency or Tribunal that the person will continue to take medication.

9. The absence of legal representation at most hearings other than involuntary detention particularly for people with mental illness and cognitive disability raises questions as whether representation should not be more widely available as it is in other jurisdictions i.e. the UK. It is very difficult for a consumer to adequately represent themselves in terms of their status under the Act or address the relevant aspects of their treatment plans before the MHRT.

10. MHCC would welcome discussion on the importance of greater access to treating psychiatrists presenting before the MHRT at hearings/reviews. We question the degree to which assessment is possible when psychiatrists characteristically only assess involuntary patients to certify on admission and discharge, and most usually see people on a CTO once every 3 or 6 months during short consultations. Consumer expectation is that they will have time to talk and build a relationship with their treating psychiatrist which often is impossible in the time available.

Similarly, would be really valuable if there were improved guidelines concerning the availability to staff members presenting to the MHRT who are well acquainted with the patient, especially when other a patient's case manager is unavailable.

11. MHCC would also welcome discussion on the enhanced role of the MHRT in questioning clinicians and treating teams on treatment plans and having access to feedback following hearings.

12. Discussion is necessary as to the time allocated to hearings. Statics have shown that hearing times in other jurisdictions are much longer than in NSW, which leads us to query whether tribunal hearings are given adequate time to investigate histories thoroughly enough.

Issues surrounding the functionality of the MHA as a document:

- Chapter 4 s68. Principles of care and treatment. MHCC suggest that consideration be made to the intention of the parliament expressed in the principles to be the frontispiece of the MHA.

- A complete glossary of terms and definitions to be available in one place in the Act, in addition to where relevant to particular chapters.

- Whilst the request for release if refused or not determined within 3 working days, anyone, including the detained person, or their primary carer, can appeal to the Tribunal is identified in the Act (s44) However, there is nowhere that identifies complaints mechanisms that patients may want to access concerning their care and treatment. We suggest that this might be useful information to add to Part 1 – Rights of patients or detained persons and primary carers after s69

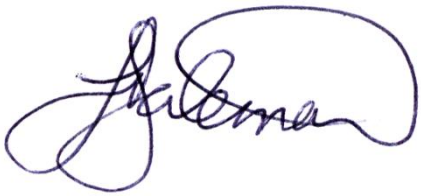
- Likewise it would be useful if the MHA could indicate how a person might challenge decisions concerning their capacity to consent, i.e. to ECT.

- s51 & s52 - it would be useful to medical and admin staff if these two sections more clearly identified that if these criteria are not shown to be met in the documentation presented to the MHRT, that the Tribunal does not have jurisdiction to proceed with the hearing.

- Further to comments by the NSW law Reform Commission in Consultation Paper 5 - *People with cognitive and mental health impairments in the criminal justice system,* outlining the various definitions covering cognitive and mental health impairments relevant to the mental health and criminal justice context. We we ask whether there would be any benefit in clarifying or standardising the terminology and raise for consideration the issue of whether the relevant legislation should contain an overarching definition covering cognitive and mental health impairments. As is stands the MHA and the Mental Health (Forensic Provisions) Act 1990 (NSW) refer variously to "mental illness", "mentally ill person", "mentally disordered person", "mental condition" and "developmental disability".

MHCC look forward to seeing the results of the Government's deliberations in the forthcoming Discussion Paper.

Yours sincerely



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