Commission for Children and Young People Submission to the Statutory Review of the NSW Mental Health Act 2007

Introduction

The Commission’s submission highlights matters that are relevant to children and young people with a mental illness or who are mentally disordered and makes suggestions as to how the Act could be amended to improve the provision of mental health services to this group.

The submission begins by considering the objects of the Act and the principles for care and treatment before considering relevant specific questions in the Discussion Paper and other matters.

Purposes and principles of the Act

The Commission believes that the purposes of the Act remain valid but suggests that subsection 3 (a) be amended to make it clearer that the coercive powers of the Act are to be used only where this is necessary to protect people who are mentally ill or mentally disordered from causing serious harm to themselves or others (as covered in sections 14 and 15 of the Act).

This could be achieved by rewording subsection 3(a) to say that the objects of the Act are ‘to provide for the care, treatment and control of persons who are mentally ill or mentally disordered where this is necessary for the person’s own protection from serious harm, or for the protection of others from serious harm.’

The Commission notes that section 14 refers to ‘serious harm’ and section 15 to ‘serious physical harm’ and suggests that the terminology of ‘serious harm’ be used throughout the Act.

It is important that the Act use language that reflects a contemporary understanding of mental illness and the rights of patients. The Commission questions whether the Act should continue to refer to the ‘control’ of persons who are mentally ill or disordered.

The Commission supports the current principles for care and treatment included at section 68 of the Act but suggests that subsection 68 (d) be amended to include other treatments in addition to the prescription of medicine as follows:

(d) the prescription of medicine or administering of treatment to a person with a mental illness or mental disorder should meet the health needs of the person and should be given only for therapeutic or diagnostic needs and not as a punishment or for the convenience of others.

Supported versus substituted decision-making

The Discussion Paper asks whether supported decision making is a principle that should be further explored in NSW and what the key issues are that need to be considered.

The Discussion Paper notes that proposed changes to the Victorian and Western Australian Mental Health Acts reflect a move from the substituted decision making
model, where psychiatrists provide substituted consent to treatment for a person who is unable or refusing to consent, towards a supported decision making model. The principles of a supported decision making model described in the Victorian Draft Bill state that a person with a mental illness must, as far as is reasonably possible in the circumstances, be:

- consulted about decisions relating to their mental illness
- supported to make decisions, including in developing a treatment plan, and
- provided with information and support to exercise their rights.

The Discussion Paper notes that the supported decision-making model is consistent with Article 12 of the United Nations Convention on the Rights of Persons with Disabilities, (CRPD), ratified by Australia in 2008, which recognises the legal capacity of persons with a disability.

The Commission supports the model of supported decision-making and the incorporation of this principle into the NSW Act. This model is not only consistent with the CPRD, but also with the International Convention on the Rights of the Child, (CROC) which states that children have a right to express a view freely on all matters concerning them and have this view given due weight in accordance with their age and maturity (Article 12). The NSW Commission for Children and Young People Act 1998 upholds a similar principle (s11 (a)).

In instances where a child is involved, supported decision-making would ideally involve both the child and the parent/guardian and the child’s nominated carer (if different). Children who are under 14 years do not have a legal capacity to consent to medical treatment in NSW and involvement of the parent/guardian is currently required under the Act in any decision-making about admission of children of this age as voluntary patients. The Commission also considers it desirable for parents/guardians to be involved in admission and treatment decisions for children who are 14 years and over, unless this is not in the child’s best interest or against the child’s wishes (taking into account that the child’s mental illness may impair their decision-making).

In order to successfully involve a child or young person in decision-making, information needs to be conveyed in simple terms and language accessible to this group, ideally by someone with experience in communicating effectively with children and young people. The Commission notes that the WA Bill referred to above requires a Youth Advocate to contact a child soon after their admission to a mental health facility, and to provide support and assistance to the child. The comparable service in NSW is the Official Visitors program.

**Treatment of conditions other than a mental illness**

The Discussion Paper explains that the Act currently allows medical treatment such as surgery for conditions other than a mental illness to be carried out on a person with a mental illness who is an involuntary patient or a forensic or correctional patient with a mental illness without their consent, even if they are judged to be competent to make a decision, including when they object to the treatment.

The Discussion Paper compares provisions in the Guardianship Act related to consent to medical treatment with those in the NSW Mental Health Act and identifies
a number of areas in which the latter does not support decision-making of a person with a mental illness, and also provides an inferior substitute decision-making model.

For example the Act:

- does not currently provide for relevant information, such as information on the effects of the treatment or alternative course of treatment, to be provided to the Director General or the MHRT, and.
- does not require the Director-General or the MHRT to consider the views of the patient before deciding whether or not to consent to surgery.

The Discussion Paper explains that the Act focuses on a person’s status under the Act, rather than a direct assessment of their legal capacity to make decisions, while the Guardianship Act focuses on capacity and not status. The Discussion Paper argues that the Act also fails to properly recognise or provide guidance as to the rights of an individual to participate in making decisions on their general medical treatment when they have capacity to make such decisions and to apply their decision making into the future, including through advance care directives.

As stated above, the Commission favours a supported decision-making model over a substitute decision-making model. However if a substitute decision-making model is to be used in instances where medical treatment is required and a person with a mental illness is not competent to make a decision, the Commission favours the substitute decision-making model in the Guardianship Act. In all cases the rights of a person with a mental illness, including their right to consent to medical treatment where they have the capacity to do so should be respected, and in all cases the views of the patient should be considered in making a decision on their behalf. Advanced care directives completed when a person is competent would be an effective way to deal with the issue of consent. The involvement of children and young people with a mental illness and their parent/ guardian in decision-making about their own medical treatment is an important principle consistent with both the CROC and the CPRD.

**Definition of Mental Illness**

The Discussion Paper asks for comment on the current definition of mental illness in the Act, specifically whether personality disorders and dementia are adequately addressed and whether any conditions should be specifically excluded from the definition. The Act currently defines mental illness as:

“a condition that seriously impairs, either temporarily or permanently, the mental functioning of a person and is characterised by the presence in the person of any one or more of the following symptoms:

(a) delusions,

(b) hallucinations,

(c) serious disorder of thought form,

(d) a severe disturbance of mood,
(e) sustained or repeated irrational behaviour indicating the presence of any one or more of the symptoms referred to in paragraphs (a)–(d).” (s 4 (1)).

The Discussion Paper notes that definitions proposed in the Victorian and WA Mental Health Bills are broad and do not list particular symptoms. For example the WA Bill proposes to define mental illness as “a condition that is characterised by a disturbance of thought, mood, volition, perception, orientation or memory; and significantly impairs (temporarily or permanently) the person’s judgment or behaviour”. While the benefit of a wide definition is that it allows services to be provided to people who need them, the Discussion Paper notes that the current symptomatic definition of mental illness came about due to previous difficulties with relying on a specific clinical based diagnosis definition of mental illness as a basis for legal detention.

While the Commission does not have a firm view in this regard, it is suggested that a broad definition such as that set out above, with the appropriate checks and safeguards that currently exist to prevent improper detention, would enable access to services by persons who need them. The continuation of existing provisions which set out what does not constitute a mental illness for the purposes of the Act, for example, engaging in a particular political or religious activity, or engaging in anti-social behaviour, is supported.

**Mental Health Review Tribunal (MHRT) Hearings**

**Review by MHRT at least once every 12 months**

The Commission supports the proposal that patients whose involuntary/voluntary status has changed during their time in a mental health facility should be reviewed by the MHRT at least once in a 12 month period. That is, they should not miss out on having a review because their status changes.

**Initial involuntary treatment in the community**

The Commission does not support the idea of mental health facilities being able to commence involuntary treatment of a person in the community without a Community Treatment Order (CTO) approved by the MHRT.

As the Discussion Paper notes such a proposal would create an additional means by which administrative involuntary orders could be made and may create potential avenues of improper infringements of individual rights.

One of the arguments put forward in favour of this idea appears to be that it is analogous to the current situation under the Act where people are initially detained and treated as an inpatient in a designated mental health facility without the approval of the MHRT. That is, the MHRT holds an inquiry to determine the appropriateness of a person’s detention ‘as soon as practicable’ after a person is detained, which is normally 2-3 weeks after detention. This means that, in most cases, persons are detained and involuntarily treated on the agreement of two medical practitioners, at least one of whom must be a psychiatrist.
This, in the Commission’s view, simply points to the problem of delays in the MHRT reviewing involuntary inpatient detention, and is not an argument in favour of a similar approach to CTOs.

For children and young people in particular, the Commission believes there should be a legislated maximum timeframe of five working days for MHRT review of involuntary admissions.

**Initial assessment of involuntary patient**

The suggestion in the Discussion Paper that an authorised medical officer (AMO) be able to conduct the assessment that would result in a person’s continued detention and involuntary treatment in a mental health facility via video-link to avoid having to transport patients over long distances, sometimes under restraint, is a sensible one. The Discussion Paper explains that currently, if the person is assessed at the declared mental health facility (DMHF) as not meeting the criteria for involuntary admission, then s/he potentially has a long journey back to their place of residence. This proposal potentially reduces or negates the need for a person to find a way to get home over long distances. The Commission is not aware of specific instances of this but would be concerned if a vulnerable young person was left to make their own way home in this circumstance, after having been transported to a DMHF by a health professional, police or ambulance officer. However a person should only be able to be held in a facility awaiting an assessment by video-link for a short period of time (ie several hours), as these facilities would not be a DMHF and would not be subject to scrutiny by Official Visitors (OVs).

**Rights and Responsibilities**

**Review of Treatment Planning and Medication**

The Discussion Paper asks whether a provision should be inserted in the Act to empower consumers to apply to the MHRT for a review or change in medication, or to access a second opinion from a psychiatrist outside the hospital in relation to appropriate or alternative treatment. Currently the Act provides for an involuntary patient or person detained in a DMHF, the person’s lawyer and their primary carer to the right to information about their treatment, including side effects and dosages, but it does not allow them to refuse treatment nor does it include a right of appeal to the MHRT (s 73). Persons with a mental illness or mental disorder are however meant to be involved in the development of treatment plans and plans for ongoing care (s 68 (h)) and consumers have the option of contacting OVs or the NSW Health Care Complaints Commission if they are unhappy with the treatment being received.

It is clear that the medication and other treatment being received by a patient are of crucial importance to the person concerned. For example it is likely to have a significant bearing on their recovery, but may also have adverse side effects that concern the patient and have a negative impact on their overall well-being. Concern about adverse side effects of medication and other forms of treatment identified by mental health patients in Australia include excessive weight gain, diabetes, liver damage, heart damage, memory loss, confusion, fatigue, blurred vision, tremors, nausea, sleeplessness, thirst, constipation, agitation etc (Carney: 2011: 17).
It is also the case that people with health conditions other than a mental illness would consider it a basic right to be able to receive a second opinion on treatment options. In the case of a child or young person, a second opinion from a psychiatrist who specialises in child or adolescent mental health might be desired by the parent/guardian or the young person themselves. The right to request a review of medication and/or alternative treatment or a second opinion from a psychiatrist outside of the hospital is considered to be a basic and important right for consumers of mental health services and the Commission supports amendment of the Act in order to achieve this. If the Act is amended in this way it would be consistent for patients on community treatment orders to have the same right of review. In order to ensure an independent review, the body responsible for conducting the treatment review should be the MHRT.

**Electro-Convulsive Therapy (ECT) for children and adolescents**

According to NSW Health Guidelines on ECT Minimum Standard of Practice in NSW, indications for ECT in adolescents are:

- the presence of major depression, mania, schizoaffective disorder or neuroleptic malignant syndrome AND
- the presence of symptoms serious and disabling enough to threaten the patient’s life or to cause persistent and grave disability AND/OR
- an illness that is resistant to other treatment or where the patient is unable to tolerate medication due to serious side-effects (NSW Health: 2011: 38).

Its use is also being explored in other conditions with a paediatric onset, such as self-injurious behaviours associated with autism and Tourette’s syndrome (Shoirah & Hamoda: 2011). Under the NSW Health Guideline, before making a decision to administer ECT the adequacy of previous treatments is to be assessed and consultation occur with child psychiatrists with expertise in this treatment.

The Discussion Paper asks whether the Act should include any specifications regarding treatment of children with ECT. The Commission considers that some specific requirements may be warranted.

Children and young people are a vulnerable group in regard to provision of mental health treatment as they may have more difficulty than adults in understanding what is communicated to them, particularly if medical or legal terminology is used. They may also find it more difficult than adults to ask questions and convey their wishes about treatment, particularly if they are in an institutional environment that is adult orientated and unlikely to be child friendly. As a consequence it is very important that information about any proposed treatment, its benefits, risks and any alternative treatment is conveyed to children both verbally and in writing in terms and language that they are likely to understand. Ideally, this should be done by mental health professionals with expertise and experience in working with children. This is important for any treatment, including ECT, all of which have potential side effects.
According to the NSW Health Policy Directive on ECT:

- children who are 16 years and over can consent to ECT on their own behalf
- consent from a parent or legal guardian is usually requested if a child is 14 years or over but under 16 years, unless the child objects
- consent must be given by a parent or legal guardian for children under 14 years.¹

The Commission would urge the involvement of all children and young people in their own treatment, including having planned treatment explained to them according to their capacity to understand. This should include explaining the likely benefits of treatment and potential side effects.

It is noted that consent to ECT is not required for involuntary patients. However the Commission considers that an attempt should be made to obtain consent from involuntary patients, using the supported decision-making model, and at the very least the procedure should be explained to them. Under the Victorian Bill it is noted that there is a requirement that both the recommending medical practitioner and the Mental Health Tribunal must have regard to the views of the patient and, if applicable, the nominated person and parent or guardian, in determining an application for ECT involving a child. Similarly the WA Mental Health Bill provides that the patient’s psychiatrist must have regard to the patient’s wishes, to the extent that these can be ascertained, any treatment decision in any advance health directive and the terms of any enduring power of guardianship made by the patient in deciding what treatment to provide the patient. The Commission supports the introduction of similar provisions in the NSW Act.

The Discussion Paper notes that the Victorian Draft Bill to amend the Mental Health Act sets a minimum age of 13 for the provision of ECT to children and the Western Australian Bill sets a minimum age of 12. Media reports cite Medicare statistics from 2007-08 that 203 ECT treatments were performed in Australia on children younger than 14, including 55 aged 4 yrs and younger (‘Child Shock Therapy’ Herald-Sun 25 January 2009, http://www.heraldsun.com.au/news/victoria/child-shock-therapy/story-e6ef7kx-1111118657718 ). The NSW Act currently sets no minimum age for administering ECT and the Commission suggests that the Ministry investigate the merits of introducing a minimum age for treatment, with reference to proposals being put forward in other jurisdictions.

**Advocate/ support person and legal representation**

The Commission believes that children and young people in the mental health system should have access to an advocate, other than their parent or guardian, whose role is to ensure that children understand what is proposed, to the extent that they have capacity to do so, and ensure that they have any questions answered. This is in addition to having mandatory representation by a legal advocate at ECT hearings of the MHRT. It is noted however that media reports and research on the

¹ According to the Minors (Property and Contracts) Act 1970 (NSW), a child aged 14 years or over may consent to his or her medical or dental treatment, however a child aged under 14 does not have the legal capacity to consent on their own behalf.
operation of the MHRT indicate that lawyers cannot counter medical testimony, and unless funds are available to pay for a second medical opinion, there may be limited benefit to their involvement (‘Patient fought shock therapy’ Conrad Walters SMH, 6 June 2009; Carney et al: 3008). This suggests that it is important that funds are made available for this purpose, either through the MHRT or directly through Legal Aid. The Commission believes that this is important not just for ECT hearings, but all appearances of children before the MHRT. The MHRT’s Annual Report 2010-11 indicates that a solicitor represented people in hearings before the MHRT to administer ECT to an involuntary patient in only 38% of cases. No data is provided on the age of people appearing before the MHT in terms of whether a solicitor was present. The Commission would like to see MHT hearing data reports include details of the age of persons appearing before it.

**Psychosurgery**

The Discussion Paper indicates that it is appropriate for the review to consider whether psychosurgery should continue to be prohibited in NSW, when this is not the case in any other Australian jurisdiction.

The RANZCP refer to this practice as neurosurgery for mental disorders. The College describes it as “an established treatment which is effective for a proportion of highly selected patients… used to treat severe and incapacitating mental disorders when all other attempts at treatment have failed and the alternative is continuing suffering for the patient”. The college notes that it is most commonly used to treat severe depression, chronic anxiety and obsessive compulsive disorder (RANZCP: 2009).

The Commission notes that psychosurgery is an invasive procedure, is permanent in nature and can have adverse side effects. These range from the more minor such as confusion and weight gain, to the more serious such as minor personality change (3-7%), stroke (rare) and epilepsy (.4- 5%) (Hay and Sachdev: 1992; RANZCP: 2009). In the UK for example, it is only used when all other treatments have failed for patients with severe illness that is hard to treat, and it cannot be performed without the patient’s consent.

There are few reports concerning psychosurgery in children and adolescents for any condition or disorder and therefore particular caution is warranted in considering lifting the current prohibition in so far children and young people are concerned.

It is noted that WA Mental Health Bill 2011 prohibits psychosurgery on children under 12 yrs, and requires approval by the MHT to undertake psychosurgery on 12-18 year olds and persons above the age of 18 years.

In the Commission’s view, the case for psychosurgery or any other treatment will ultimately depend on balancing the known benefits and risks of treatment with the level and persistence of pain, suffering and disability experienced by a person without treatment.
Declaration of Financial Interest

The Commission supports the disclosure of financial interest by the medical practitioner who proposes that ECT be administered, but considers it unnecessary for the practitioners who administer the treatment to disclose financial interest. In the interests of consistency the requirement to disclose a financial interest should not just be confined to ECT, but also cover medication, surgical procedures, or admission to and treatment within private facilities.

Consumer involvement in the development of treatment plans

The Discussion Paper asks whether the Act currently gives consumers enough opportunity to participate in the development of ongoing treatment plans or whether there needs to be specific provisions to ensure a dialogue between clinician and consumers regarding the development and implementation of a treatment plan.

The current Act makes limited references to involving consumers in the development of treatment plans and does not set out any practical steps to achieve this\(^2\). Nor does it state what should be in a plan, when a plan should be prepared and when it should be reviewed, and who should be involved in the preparation of plans.

It is suggested that a number of changes to the Act be made, based on the provisions in the WA draft Mental Health Bill 2011, which would give more prominence to these plans and to consumer (and where appropriate carer) involvement. For example this Bill has a separate Division devoted to Treatment, Support and Discharge Planning with provisions dealing with each of the matters identified above. In addition s 142 of the Bill is devoted to patient wishes, and requires the patient’s psychiatrist to have regard to any advanced health directive and any enduring power of guardianship. It is considered that the NSW Act should encourage patients to make advanced health directives, that these should be held in the patient’s file and that the patient’s psychiatrist should be required to have regard to these directives in making a decision about the patient’s care and treatment, particularly in the situation where a patient may be not have the capacity to participate in decision-making about their care.

It is important the children have the opportunity to be involved in the development of their treatment plans, depending on their capacity for involvement based on factors such as age, level of maturity and mental state. Health professionals who are developing treatment plans with children should have the capacity to communicate with children in terms and language accessible to children, and children should have access to a support person/ advocate (not necessarily a parent), to support their participation in this process.

\(^2\) S 68 (h) of the Act states that “every effort that is reasonably practicable should be made to involve persons with a mental illness or mental disorder in the development of treatment plans and plans for ongoing care”. The objects of the Act are also (e) “to facilitate the involvement of those persons, and persons caring for them, in decisions involving appropriate care, treatment and control”.

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The Rights of Primary Carers

The Discussion Paper outlines the level of involvement of the primary carer in the patient’s care under the Act, and puts forward the views of some carer groups that the type and detail of information accessible to them be extended and that, in some cases, that this apply to ‘un-nominated' carers or family members who may be affected, for example, by a consumer’s discharge.

In the case of a child or young person under 18 yrs who is an inpatient of a mental health facility or is on a Community Treatment Order, involving the primary carer, usually the child’s parents, in aspects of their care and notifying them of important matters related to the child’s care and treatment is likely to be in the child’s best interests in most case. On this basis the Commission supports the proposal in the Discussion Paper that more detailed information be provided to the primary carer, including:

- advice on medication requirements
- non-pharmaceutical treatments or therapies
- future clinical or therapeutic appointments
- symptom monitoring
- strategies and contingency planning for acute episodes
- case managers and people to contact in case of emergencies.

It is suggested that the Act specify the types of information that should be provided to the primary carer. This would enable them to provide better care to the child or young person upon discharge or if on a CTO.

At the same time, the rights of the child and young person to confidentiality and to have their wishes about who should be able to be involved in decision-making and receive information about their care, are important considerations. The other factor to consider is that the mental health system passing on information about a child/young person’s care and treatment to a range of un-nominated persons, could be perceived by the consumer as a violation of their rights and damage any relationship of trust that may have been established with mental health providers. If this was to occur, it could deter a consumer from seeking help again in the future. Respect for confidentiality is particularly important to children and young people in accessing mental health services (Child Death Review Team: 2003; Kids Help Line: 1996; Fox and Butler: 2007).

Under the current Act the primary carer of a child who is a patient is identified as their parent, although if the child is over 14 the primary carer is the person nominated by the child as such (s71 (b) and (c) ). At the same time a patient who is over 14 years but under 18 years of age cannot exclude a parent from being provided with information about them (s72 (3)). However an authorised medical officer does not have to give effect to a nomination, if doing so may put the patient, the nominated person or any other person at risk of serious harm.

The Commission considers that there may be circumstances where a parent should not be provided with information about a child, particularly when the child has nominated another person as a primary carer. In circumstances where the parent...
may have abused the child (for example a substantiated case of child abuse), or be estranged from them, or not have an ongoing relationship with the child, it might not be appropriate to pass on information about the child’s care and treatment.

Role of Official Visitors (OVs)

The Discussion Paper highlights the role of OVs, and asks if this role needs to be more clearly defined, changed or expanded, with particular regard to proposed changes to the role in other states such as Western Australia.

Elsewhere in this submission the Commission has called for children who are inpatients in mental health facilities and outpatients on CTOs, to have access to an advocate/ support person, able to assist them at important points in their care. This would include admission, the development of treatment and discharge plans and hearings before the MHRT. This is in addition to having mandated legal representation when they appear before the MHRT, and having the assistance of their primary carer.

The role of the Mental Health Advocacy Service (MHAS) proposed under the WA Mental Health Bill is closer to this model than the current OV model in NSW. Currently in NSW OV’s are not automatically available to act as advocates in the way outlined above, although there is potential for them to participate in some of these processes at the patient’s request. In the WA Bill, the functions of a mental health advocate (MHA) are clearly defined as visiting or otherwise contacting consumers; inquiring into, and reporting on the extent to which consumers have been informed by mental health services of their rights under the Act and the extent to which those rights have been observed; hearing, inquiring into and seeking to resolve complaints made by or on behalf of consumers about their detention at, or their treatment or care by, mental health services; assisting identified persons to protect and enforce their rights under the Act; assisting identified persons to access legal services and assisting consumers to access other services. The advocate may also assist with a MHRT hearing and represent a consumer at a hearing. The WA Bill lists a wider range of functions, and these are more orientated towards protecting consumer rights, than is the case in comparative provisions under the NSW Act.

Under this Bill, a MHAS would also have to contact an involuntary patient within 7 days of the making of an order (designating them as an involuntary patient), and in the case of a child, a youth advocate (at least one advocate is to have qualifications, training or experience in dealing with children and young people) must make contact within 24 hrs. There is no comparable youth advocate under the NSW Act, nor are there statutory periods under which new involuntary patients must be contacted. Under the NSW Act an OV must visit a patient no later than 2 days after they have made a request to see an OV.

It is the Commission’s view that current roles and functions of OVs under the NSW Act should be expanded and more clearly defined, along the lines proposed in the WA Bill. In addition the Commission supports the mandating of time periods under which OVs must contact new involuntary patients and both voluntary and involuntary patients if they are children, and the appointing of a youth advocate along the lines proposed in the WA Bill.
The Discussion Paper notes that in all states and territories OVs can report deficiencies but cannot hold a facility accountable, and asks what is the scope and best reporting pathways for OVs. Under the NSW Act OVs must report to the Principal OV (POV) about each visit, and the POV is to refer matters raising any significant public mental health issues or patient safety, care or treatment issues to the Minister or any other appropriate person or body.

The Discussion paper asks whether OVs should have the right to monitor the care and treatment of consumers who are detained under the Act but admitted to wards other than a mental health facility. The Commission notes that under the NSW Health Policy Directive *Children and Adolescents with Mental Health Problems Requiring Inpatient Care*, children and adolescents with a mental illness may be admitted to paediatric hospitals or paediatric wards in general hospitals. It is particularly important for OVs to monitor the care and treatment and offer assistance to children and young people in facilities such as this which are not specialist child and adolescent mental health services, to determine whether there are any deficiencies in care in these settings.

**Mental Health Review Tribunal**

The Discussion Paper asks if the Act should be amended to strengthen or clarify the role of the MHRT to further facilitate the objectives of the Act.

The Commission considers that the operation of the MHRT could be improved to enhance the rights of consumers appearing before it, and in so doing better meet the objectives of the Act to protect the civil rights of persons who may have a mental illness. It is noted that the WA Mental Health Bill sets out procedures for the operation of the equivalent Tribunal in great detail, and includes provisions that reflect principles of natural justice such as the right to be heard (s 436), the right to request reasons for a decision (s 447) and review by the State Administrative Tribunal. It is suggested that provisions under the WA Bill dealing with the operation of the Tribunal be considered for inclusion in the NSW Act, particularly those that would enhance the rights of consumers.

**Access to legal representation**

Given the seriousness of the matters the Tribunal considers, such as making Involuntary Patient Orders, hearing appeals against a refusal to discharge an involuntary patient, approving the use of ECT for involuntary patients, and approving special medical treatment (sterilisation), it is vital that adequate procedures are in place to protect the rights of consumers, particularly vulnerable consumers such as children.

The Commission is of the view that when children appear before the Tribunal, a solicitor should always be present to represent the child, and that an advocate/support person, able to represent their interests, explain what is occurring and support them through the proceedings also be present. This should be in addition to the child’s carer. The Tribunal is a formal, quasi-judicial body, and it is considered that a child or young person is less likely to be able to advocate on their own behalf.
and understand proceedings than an adult. While a parent or guardian may be present, their wishes and those of the child or young person may not be identical, and they also may not fully understand proceedings or be able to advocate effectively.

Statistics published in the MHRT Annual Report July 2010- June 2011 indicate that over this period representation was provided in 61% of all hearings in the Tribunal’s civil jurisdiction and 95.7% of all forensic hearings. The Annual Report notes that due to funding restrictions the Mental Health Advocacy Service (MHAS) has advised the Tribunal that they are not automatically able to provide representation for all categories of matters heard by the Tribunal.

In addition to all forensic cases, representation through the MHAS is usually provided for all mental health inquiries and reviews of involuntary patients during the first 12 months of detention, appeals against an authorised medical officer’s refusal to discharge a patient, and all applications for financial management orders. Representation is also provided for some applications for Community Treatment Orders and some applications for revocation of financial management orders, however this may be on a means and merits test (MHRT Annual Report July 2010-June 2011: p19).

If cost represents a barrier to seeking a second medical opinion, options should be explored to assist patients who do not have access to the necessary financial resources. Carney notes that in Ireland, the Mental Health Commission is responsible for ensuring mandatory legal representation at tribunal hearings and for commissioning an independent medical opinion from a consultant psychiatrist (Carney: 2011: 3).

An article by Carney et al discussing Australian experiences of mental health clients, legal advocates and other stakeholders in the mental health review system also identifies the poor quality of the legal representation received by some clients due to the lack of time the legal advocate devoted to preparation. In some cases the solicitor met the client for the first time on the date of the hearing and the solicitor had not read the client’s file.

It is noted that the WA Bill makes special provisions for the appearance of children at MHRT hearings, and indicates that a party who is a child with no capacity to consent (due to factors such as age and level of maturity) must be represented by the child’s parent or guardian or any other person who can represent the child’s best interests (s 428).

**Understanding of and participation in MHRT proceedings**

The consumer’s failure to understand proceedings was also identified in research conducted by Carney and colleagues, due in part to use of legal and medical terminology, low English language ability and the fact that proceedings were not explained to clients. The ‘trial like’ nature of the MHRT process was also identified as intimidating to clients. If this is the case for mental health consumers in general, problems understanding proceedings are likely to be even greater for children.

It seems clear that systems are needed to ensure that patients understand MHRT processes, to the extent that that have the capacity to do so, taking into account
factors such as age and the state of their mental health. It is recommended that guidelines be developed for the operation of the NSW MHRT intended to facilitate patient understanding of and participation in proceedings, including use of plain English, provision of interpreters and requiring Tribunal members to ask the consumer whether or not they have understood what is occurring and any decision made.

Resourcing of MHRT process

Research by Carney on the operation of MHRTs in NSW and Victoria found that the time spent for all types of mental health reviews averaged 15 minutes, whereas in Britain the average hearing lasts 2.5 hours. Information on the NSW MHRT website indicates that most hearings are completed in 30 minutes. Professor Carney is quoted as stating that ‘by comparison with other parts of the world, we’re providing considerably less resources, and the quality of some decision-making…must suffer.’ (‘Shock therapy forced on patients’, Conrad Walters, SMH, 6 June 2009, http://www.smh.com.au/national/shock...0605-byi6.html). Carney notes that MHTs in Ireland have significantly larger budgets, devoting 16 to 18 times the resources per case than in Australia (Carney: 2011).

Approval of special medical treatment (sterilisation)

In Australia, the High Court has ruled that involuntary sterilisation is illegal unless permission is obtained from a court or tribunal authority and only after proof of a medical emergency (Marion’s case, 1992). In NSW the sterilisation of involuntary mental health patients cannot be undertaken without MHRT approval. The MHRT can consent to special medical treatment if it is satisfied that it is necessary to prevent serious damage to the health of the patient, in compliance with any National Health and Medical Research Council (NHMRC) guidelines. However sterilisation of any patient under the age of 16 years is illegal under the NSW Mental Health Act 2007 (s103).

Australia is a signatory to the International Convention on the Rights of the Child, and the Convention on the Rights of Persons with Disabilities (CRPD). Article 23 of the CRPD contains specific articles on the right of people with a disability to retain their fertility. It is understood that the Committee on the Elimination of Discrimination against Women (CEDAW) has recommended that the Australian government “enact national legislation prohibiting, except where there is a serious threat to life or health, the use of sterilisation on girls, regardless of whether they have a disability and of adult women with disabilities in the absence of their fully informed and free consent” (CEDAW: 2010).

On this basis the Commission opposes the sterilisation of children under the age of 18 years, either forced or voluntary, except in life-saving circumstances, and suggests that the Act be amended to prohibit sterilisation of any patient under 18 years.

It is noted that there is a current Australian Senate Inquiry into the involuntary or coerced sterilisation of people with disabilities in Australia, due to report on 24 April 2013. It is suggested that this review have reference to the results of this Inquiry.
Review of voluntary and involuntary patients

Under the NSW Act, the MHRT reviews the cases of involuntary patients in mental health facilities usually every three or six months, and in appropriate cases every 12 months and voluntary patients in mental health facilities, usually every 12 months. The purpose of the review of voluntary patients includes determining whether the patient consents to continuing as a voluntary patient. The purpose of the review of an involuntary patient is primarily to determine whether the patient is a mentally ill person and whether care in a mental health facility continues to be the most appropriate form of care for the person, or whether the person could, for example, be discharged on a community treatment order.

The NSW Act makes no special provisions for the review of cases of children who are voluntary or involuntary patients, and they are subject to review at the same intervals as adults. The Commission suggests that consideration be given to shorter periods of review for children who are voluntary or involuntary patients. Children develop and change rapidly, and absences from school and family for extended periods may be difficult for children to adjust to upon their return to the community. The timeframes which may be appropriate for adults are almost certainly not so for children and young people.

It is noted that under proposed reforms to the Victorian Mental Health Act, a young person under 18 years will only be able to be placed on a Treatment Order (for either compulsory in-patient treatment or treatment in the community) for a maximum of three months, although the tribunal will be able to make further orders if required. The Victorian Government indicates that this shorter timeframe will ensure that there is greater oversight of compulsory treatment decisions for young people, http://www.health.vic.gov.au/mentalhealth/mhactreform/mhreform.pdf.

Charter for Mental Health Care in NSW

The WA Mental Health Bill states that functions performed under this Act must have regard to the Charter of Mental Health Care Principles, and a mental health service must make every effort to comply with these when providing treatment, care and support to patients. These provisions are included at the beginning of the Bill after Objects, and are important in setting the tone and direction of this legislation.

It is suggested that the NSW Act give a similar prominence to complying with the Charter for Mental Health Care in NSW.

Recognition of the rights of children with a mental illness

It is noted that Part 15 of the WA Bill sets out specific provisions that must be considered in regard to children with a mental illness. These provisions include that in performing a function under this Act, the best interests of the child is the paramount consideration and regard must be had to the child’s wishes (to the extent that they can be ascertained) and the views of the child’s parent or guardian.

The Bill also specifies that a child must not be admitted to a mental health service unless the person in charge is satisfied that the service “can provide the child with
treatment, care and support that is appropriate having regard to the child’s age, maturity, gender, culture and spiritual beliefs” and care can be provided to the child in a part of the service that is separate from any part of the service in which people who are 18 and over are provided with treatment.

There are no comparable provisions in the NSW Act although the recognition of the age-related needs of people with a mental illness is identified as a principle for care and treatment (s 68 (g)). It is suggested that the age related needs of persons also be recognised in the provision that sets out the objectives of the NSW public health system (s105). Clause (d), which states that mental health services should take into account the religious, cultural and language needs of persons, could be amended to include this. Alternatively a new clause could be added that states that mental health services are to “provide services and facilities that are appropriate to the age of the person”.

The NSW Health Policy Directive Children and Adolescents with Mental Health Problems Requiring Inpatient Care refers to the recommendation of the Report of the Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals (Garling Report, recommendation 9b), that children and adolescents should be provided with hospital care in facilities designated and set aside for them. However the Policy Directive predicts that NSW will require more specialist Child and Adolescent Mental Health Service (CAMHS) beds than are currently available in order to achieve this, and that three new specialist CAMHS declared units are planned. While most children and young people with a mental illness receive care in a community setting, the Directive notes that those requiring inpatient care are admitted to 3 types of inpatient units: non-acute CAMH specialist units and paediatric hospitals or paediatric units in general hospitals, acute units (CAMHS specialist or non-specialist units i.e. adult mental health units and paediatric units with CAMHS support), and highly specialised statewide units (Walker Unit 12-17 yr olds & Bronte unit 14-21 yr olds).

The Commission strongly supports children with a mental illness being provided with in-patient care in settings in which they are separated from persons over 18 years. This enables a safer and more child friendly environment to be provided, and for care to be provided that is most appropriate to the needs of children. While the Commission acknowledges that NSW Health may have difficulty in always providing care of this nature due to a lack of CAMHS specialist units, it is recommended that consideration be given to including a provision in the NSW Act which requires care to be provided in this way, along the lines of the wording of the provision in the WA Bill cited above. It is also recommended that a specific part be included in the NSW Act which highlights the rights and special needs of children in a mental health setting, as described above.
References


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